Bijlage 8 Evidencetabellen

Uitgangsvraag 3.3 Operatieve benadering

Uitgangsvraag:
Wat is het effect van operatie op morbiditeit, functie, kwaliteit van leven en overleving bij een ileus bij patiënten met kanker in de palliatieve fase?

Patiëntengroep: Patiënten met ileus en kanker
Intervention: Operatie
Comparison: Geen operatie
Outcome: Braken, mortaliteit, morbiditeit en kwaliteit van leven

Primary studies

<table>
<thead>
<tr>
<th>I Study ID</th>
<th>II Method</th>
<th>III Patient characteristics</th>
<th>IV Intervention(s)</th>
<th>V Results</th>
<th>VII Critical appraisal of study quality</th>
<th>GRADE assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiori et al. (2012) and Fiori et al. (2004)</td>
<td>• RCT</td>
<td>• Eligibility criteria: Patients with malignant rectosigmoidal obstruction</td>
<td>• endoscopic stenting versus</td>
<td>Vomiting: Not reported</td>
<td>• Unclear risk of bias due to no description of allocation concealment, blinding, incomplete outcome data, and selective outcome reporting.</td>
<td>• Low quality of evidence due to risk of bias and imprecision.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mortality (defined as early mortality during hospital stay):</td>
<td>• Intervention: 0/11</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Control: 0/11</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Morbidity:</td>
<td>• Intervention: 0/11</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Control: 1/11 (colostomy prolapse 3 days after the operation).</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Quality of life:</td>
<td>• Not reported</td>
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</tbody>
</table>

Referenties

**Uitgangsvraag 3.4 Stentplaatsing**

Uitgangsvraag:
Wat is het effect van stentplaatsing op morbiditeit, functie, kwaliteit van leven en overleving bij een ileus bij patiënten met kanker in de palliatieve fase?

Patiëntengroep: Patiënten met ileus en kanker
Intervention: Stent
Comparison: Geen stent
Outcome: Braken, mortaliteit, morbiditeit en kwaliteit van leven

**Primary studies**

<table>
<thead>
<tr>
<th>I Study ID</th>
<th>II Method</th>
<th>III Patient characteristics</th>
<th>IV Intervention(s)</th>
<th>V Results</th>
<th>VII Critical appraisal of study quality</th>
<th>GRADE assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fiori et al. (2012) and Fiori et al. (2004)</td>
<td>• RCT</td>
<td>• Eligibility criteria: Patients with malignant rectosigmoidal obstruction</td>
<td>• endoscopic stenting (n=11) versus</td>
<td>Vomiting: Not reported</td>
<td>Unclear risk of bias due to no description of allocation concealment, blinding, incomplete outcome data, and selective outcome reporting.</td>
<td>• Low quality of evidence due to risk of bias and imprecision.</td>
</tr>
<tr>
<td>• Setting: Department of Surgery &quot;Pietro Valdoni&quot; of the University of Rome &quot;La Sapienza&quot;, Italy</td>
<td>• Sample size: 22</td>
<td>• Patient characteristics:</td>
<td>• Colostomy (n=11)</td>
<td>Mortality (defined as early mortality during hospital stay): Intervention: 0/11 Control: 0/11</td>
<td>• High risk of bias due to no blinding of surgeons and patients.</td>
<td></td>
</tr>
<tr>
<td>• Follow-up: not reported</td>
<td>• Sex: 13 men and 9 women.</td>
<td></td>
<td></td>
<td>Morbidity: Intervention: 0/11 Control: 1/11 (colostomy prolapse 3 days after the operation).</td>
<td>• Low quality of evidence due to risk of bias and imprecision.</td>
<td></td>
</tr>
<tr>
<td>• No protocol existence reported.</td>
<td></td>
<td></td>
<td></td>
<td>P-value: Not significant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eligibility criteria:</td>
<td>• Age: stent: 77.2 (SD:3.3), colostomy: 76 (SD:4.6)</td>
<td></td>
<td></td>
<td>Quality of life: Not reported</td>
<td></td>
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</tr>
<tr>
<td>• All patients ≥18 years who presented between September 2006 and November 2011 with a malignant LBO, deemed not curable by surgical intervention (assessed in a multidisciplinary team meeting where possible because of the</td>
<td>• Sex: 13 men and 9 women.</td>
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<tr>
<td>• Setting: Royal Prince Alfred Hospital, Sydney, and Western Hospital, Melbourne.</td>
<td>• Sample size: 56</td>
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<tr>
<td>• Follow-up: 12 months.</td>
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<tr>
<td>• RCT</td>
<td>• Eligibility criteria:</td>
<td>• stent insertion group (n=26) versus</td>
<td>Vomiting: Not reported</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Conflicts of interest reported and none known.</td>
<td>• All patients ≥18 years who presented between September 2006 and November 2011 with a malignant LBO, deemed not curable by surgical intervention (assessed in a multidisciplinary team meeting where possible because of the</td>
<td></td>
<td>Mortality (defined as median survival): Intervention: 5.2 months (SE:3.1, 95%-CI: 0.0-11.5) Control: 5.5 months (SE:0.6, 95%-CI: 4.2-6.7)</td>
<td></td>
<td>• High risk of bias due to no blinding of surgeons and patients.</td>
<td></td>
</tr>
<tr>
<td>• Setting: Royal Prince Alfred Hospital, Sydney, and Western Hospital, Melbourne.</td>
<td>• surgical decompression group (n=26)</td>
<td></td>
<td>P-value: 0.61</td>
<td></td>
<td>• Low quality of evidence due to risk of bias and imprecision.</td>
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<tr>
<td>• Sample size: 56</td>
<td></td>
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<tr>
<td>• Follow-up: 12 months.</td>
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</tbody>
</table>
### Systematic reviews

<table>
<thead>
<tr>
<th>I Study ID</th>
<th>II Method</th>
<th>III Patient characteristics</th>
<th>IV Intervention(s)</th>
<th>V Results</th>
<th>VII Critical appraisal of study quality</th>
<th>GRADE assessment</th>
</tr>
</thead>
</table>
| Cirocchi et al. (2013) | Design: systematic review with meta-analysis. Conflicts of interest reported and none known. Search date: December 2011 Searched databases: Medline, Central, and Science Citation Index Included study designs: only RCTs. Number of included studies: 3 studies. No protocol reported. | Eligibility criteria: Adult patients with large bowel obstruction secondary to left colon and rectal cancer were enrolled irrespective of gender and comorbidities. | Emergency surgery versus colonic stenting and subsequently elective surgical resection | Vomiting
- Not reported
Mortality (defined as thirty days postoperative mortality)
- Control: 9%
- Intervention: 8.2%
- OR: 0.99 (95%-CI: 0.23-4.19)
Morbidity (defined as overall complication rate)
- Control: 48.45%
- Intervention: 51%
- OR: 0.90 (95%-CI:0.52-1.58)
Quality of life:
- Not reported | Unclear risk of bias due to no description of a protocol and assessment of publication bias. | Low quality of evidence due to risk of bias and imprecision. |
Referenties

**Cirocchi, 2013 #41; Fiori, 2004 #177; Young, 2015 #233**
Uitgangsvraag 3.5 Maaghevel

Wat is het effect van een maaghevel op braken en kwaliteit van leven bij een ileus bij patiënten met kanker in de palliatieve fase?

Patiëntengroep: Patiënten met ileus en kanker
Intervention: Een maaghevel
Comparison: Geen maaghevel
Outcome: Braken en kwaliteit van leven.

Beschrijving van de studies

Er is geen enkele gerandomiseerde vergelijkende studie gevonden die het effect evaluateerde van een maaghevel op het braken en kwaliteit van leven bij patiënten met ileus en kanker.

Conclusies

Er kan op basis van het systematische literatuuronderzoek geen uitspraak worden gedaan over de invloed van een maaghevel op braken en kwaliteit van leven bij patiënten met ileus en kanker in de palliatieve fase.
Uitgangsvraag 3.6.2 Octreotide/lanreotide

Uitgangsvraag:
Wat is het effect van octreotide / lanreotide op braken, maaghevelproductie en kwaliteit van leven bij een ileus bij patiënten met kanker in de palliatieve fase?

Patiëntengroep: Patiënten met ileus en kanker
Intervention: Octreotide / Lanreotide
Comparison: Geen octreotide / lanreotide
Outcome: Braken, kwaliteit van leven en GI-secretions

Primary studies

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Method</th>
<th>Patient characteristics</th>
<th>Intervention(s)</th>
<th>Results</th>
<th>Critical appraisal of study quality</th>
<th>GRADE assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currow et al. (2015)</td>
<td>RCT</td>
<td>Eligibility criteria: People with vomiting secondary to a malignant bowel obstruction where surgery or further anticancer therapies were not immediately appropriate were eligible</td>
<td>Subcutaneous infusion of octreotide (600 mg/24 hours) (n=52) versus Placebo (n=54)</td>
<td>Free of vomiting at day three: Intervention: 17/52 Control: 14/54 P-value: 0.67 Days free of vomiting: Intervention: 1.87 (SD: 1.10) Control: 1.69 (SD: 1.15) P-value: 0.47 Quality of life: Not reported GI-secretions: Not reported</td>
<td>Unclear risk of bias due to no description of selective outcome reporting.</td>
<td>Low quality of evidence due to risk of bias and imprecision.</td>
</tr>
<tr>
<td>Laval et al. (2012)</td>
<td>RCT</td>
<td>Eligibility criteria: Patients aged above or equal to 18 years with inoperable symptomatic bowel obstruction.</td>
<td>Octreotide 600 mg/day (n=32) versus Placebo (n=32)</td>
<td>&lt;2 episodes of vomiting per day between days 10 and 13: Intervention: 19/21 Control: 13/15 P-value: Not significant Quality of life: Not reported GI-secretions: Not reported</td>
<td>High risk of bias due to high number of missing patients in the outcomes of interest.</td>
<td>Low quality of evidence due to risk of bias and imprecision.</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Design</td>
<td>Study Details</td>
<td>Eligibility Criteria</td>
<td>Time without vomiting over days 1-7 (days, SD)</td>
<td>Vomiting episodes at day three</td>
<td>Quality of life</td>
</tr>
<tr>
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</tr>
<tr>
<td>Mariani et al.</td>
<td>RCT</td>
<td>Several conflicts of interest reported. Setting: 22 hospitals across Belgium, France, and the Netherlands. Sample size: 80 Follow-up: 10-days Protocol: NCT00216372.</td>
<td>Adults (older than 18 years of age) with peritoneal carcinomatosis (confirmed by computed tomography within the previous 3 months) were eligible if they had a digestive obstruction (stomach, duodenum, or small bowel) of malignant origin and were experiencing two or more vomiting episodes per day or had an NGT, and if surgery was inappropriate. Patient characteristics: Age: intervention: 62.5 (SD:10.0), control: 62.2 (SD:13.2) Sex (% female): intervention: 81.4, placebo: 83.8</td>
<td>Lanreotide microparticles, 30 mg (n=43) versus Placebo (n=37)</td>
<td>Intervention: 5.0 (SD: 2.0) Control: 4.6 (SD: 2.6) P-value: 0.77 Quality of life: Not reported GI-secretions: Not reported</td>
<td>Low risk of bias.</td>
</tr>
<tr>
<td>Mercadente et al.</td>
<td>RCT</td>
<td>No conflicts of interest reported. Two different settings: home care and surgical or oncological ward. Sample size: 18 Follow-up: 3 days No protocol existence reported.</td>
<td>Eligibility criteria: Patients with inoperable bowel obstruction. Patient characteristics: No average age reported. No details about gender reported.</td>
<td>Octreotide 0.3 mg daily (n=9) versus 60 mg of hyoscine butylbromide (n=9)</td>
<td>Intervention: 1.0 (SD: 0.6) Control: 2.4 (SD: 0.7) P-value: not significant Quality of life: Not reported GI-secretions: Not reported</td>
<td>Unclear risk of bias due to no description of randomisation, allocation concealment, blinding, selective outcome reporting, and incomplete outcome data.</td>
</tr>
<tr>
<td>Mystakidou et al</td>
<td>RCT</td>
<td>No conflicts of interest reported. Setting: Palliative Care Unit of the Areteion Hospital, Athens, Greece. Sample size: 68 Follow-up: until death of patients. No protocol existence reported.</td>
<td>Eligibility criteria: Advanced cancer with metastasis which was no longer responsive to antitumor treatment. The patients were under analgesic medication according to the WHO analgesic ladder. Patients characteristics:</td>
<td>Chlorpromazine (15-25 mg/day) in addition to hyoscine butylbromide (60-80 mg/day) (n=34) versus Chlorpromazine (15-25 mg/day) with octreotide</td>
<td>Number of vomiting episodes per day measured on the day before death Intervention: 0.59 (SD:0.50) Control: 0.55 (SD: 0.51) MD: 0.04 (95%-CI: -0.24-0.32)* GI-secretions: Not reported</td>
<td>High risk of bias due to the a high number of patients lost to follow-up.</td>
</tr>
</tbody>
</table>
• Age (median – range): intervention: 63 (47-74), control: 64.5 (42.77).

(0.6-0.8mg/day).

• Eligibility criteria: Diagnosis of documented recurrence of ovarian cancer and the presence of a bowel obstruction based on a compilation of clinical signs, symptoms, and/or radiographic evidence

• Patient characteristics: Age: Intervention: 54.2 (SD: 7.3), control: 53.2 (SD:7.9) All females

• Vomiting episodes at day three
  • Intervention: 1.2 (SD: 0.5)
  • Control: 2.0 (SD: 0.8)
  • P-value: not significant

Quality of life: Not reported

GI-secretions: Not reported

• Peng et al. (2015)
  • RCT
  • Conflict of interest reported and none known.
  • Setting: general surgery, Qilu Hospital of Shandong University
  • Sample size: 97
  • Follow-up: 3 days
  • No protocol existence reported.

• Eligibility criteria: All the patients presented with a decompressive nasogastric tube and a clinical and/or radiological and/or surgical diagnosis of inoperable bowel obstruction in whom available oncologic therapies for tumor control had been exhausted.

• Patients characteristics:
  • Mean age (SD): 61.12 (9.0)
  • Gender: 11 female / 6 male.

• Vomiting episodes at day three
  • Not reported

Quality of life: Not reported

GI-secretions: No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Oceotride and scopolamine butylbromide group (p=0.016 & p=0.020)

• Ripamonti et al. (2000).
  • RCT
  • No conflicts of interest reported.
  • Setting: Oncological Surgery Divisions of the National Cancer Institute of Milan.
  • Sample size: 17
  • Follow-up: 3 days
  • No protocol existence reported.

• Eligibility criteria: All the patients presented with a decompressive nasogastric tube and a clinical and/or radiological and/or surgical diagnosis of inoperable bowel obstruction in whom available oncologic therapies for tumor control had been exhausted.

• Patients characteristics:
  • Mean age (SD): 61.12 (3.0)
  • Gender: 11 female / 6 male.

• Vomiting episodes at day three
  • Not reported

Quality of life: Not reported

GI-secretions: No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Oceotride and scopolamine butylbromide group (p=0.016 & p=0.020)
**Uitgangsvraag 3.6.4 Scopolaminebutyl**

**Uitgangsvraag:**
Wat is het effect van scopolaminebutyl op braken, maaghevelproductie en kwaliteit van leven bij een ileus bij patiënten met kanker in de palliatieve fase?

**Patiëntengroep:** Patiënten met ileus en kanker  
**Intervention:** Butylscopolamine  
**Comparison:** Geen butylscopolamine  
**Outcome:** Braken en kwaliteit van leven.

### Primary studies

<table>
<thead>
<tr>
<th>ID Study</th>
<th>Method</th>
<th>Patient characteristics</th>
<th>Intervention(s)</th>
<th>Results</th>
<th>Critical appraisal of study quality</th>
<th>GRADE assessment</th>
</tr>
</thead>
</table>
| Mercadente et al. (2000) | RCT | Eligibility criteria: Patients with inoperable bowel obstruction.  
Patient characteristics: No average age reported.  
No details about gender reported. | 60 mg of hyoscine butylbromide (n=9) Versus Octreotide 0.3 mg daily (n=9) | Vomiting episodes at day three  
Intervention: 2.4 (SD: 0.7)  
Control: 1.0 (SD: 0.6)  
P-value: not significant | Unclear risk of bias due to no description of randomisation, allocation concealment, blinding, selective outcome reporting, and incomplete outcome data. | Low quality of evidence due to risk of bias and imprecision. |
| Mystakidou et al (2002) | RCT | Eligibility criteria: Advanced cancer with metastasis which was no longer responsive to antitumor treatment. The patients were under analgesic medication according to the WHO analgesic ladder.  
Patients characteristics: Age (median – range): intervention: 63 (47-74), control: 64.5 (42.77). | Chlorpromazine (15-25 mg/day) in addition to hyoscine butylbromide (60-80 mg/day) (n=34) versus Chlorpromazine (15-25 mg/day) with octreotide (0.6-0.8mg/day). (n=22) | Number of vomiting episodes per day measured on the day before death  
Intervention: 0.59 (SD:0.50)  
Control: 0.55 (SD: 0.51)  
MD: 0.04 (95%-CI: -0.24-0.32)* | High risk of bias due to the a high number of patients lost to follow-up. | Low quality of evidence due to risk of bias and imprecision. |
<table>
<thead>
<tr>
<th><strong>Peng et al. (2015)</strong></th>
<th><strong>Ripamonti et al. (2000).</strong></th>
<th><strong>Gender:</strong> intervention: 18 female, 16 male. Control: 14 female, 20 male.</th>
<th><strong>Eligibility criteria:</strong> Diagnosis of documented recurrence of ovarian cancer and the presence of a bowel obstruction based on a compilation of clinical signs, symptoms, and/or radiographic evidence.</th>
<th><strong>60 mg of scopolamine butylibromide (n=49) versus</strong></th>
<th><strong>Vomiting episodes at day three</strong></th>
<th><strong>Unclear risk of bias due to no description of allocation concealment, blinding, selective outcome reporting, and incomplete outcome data.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RCT</td>
<td>RCT</td>
<td>Conflict of interest reported and none known.</td>
<td>Setting: general surgery, Qilu Hospital of Shandong University</td>
<td>Octreotide 0.3 mg daily (n=48)</td>
<td><strong>Intervention:</strong> 2.0 (SD: 0.8)</td>
<td><strong>Quality of life:</strong> Not reported</td>
</tr>
<tr>
<td>Setting: general surgery, Qilu Hospital of Shandong University</td>
<td>Setting: Oncological Surgery Divisions of the National Cancer Institute of Milan.</td>
<td>Sample size: 97</td>
<td>Age: Intervention: 54.2 (SD: 7.3), control: 53.2 (SD:7.9)</td>
<td></td>
<td><strong>Control:</strong> 1.2 (SD: 0.5)</td>
<td><strong>Quality of life:</strong> Not reported</td>
</tr>
<tr>
<td>Sample size: 97</td>
<td>Sample size: 17</td>
<td>Follow-up: 3 days</td>
<td>All females</td>
<td></td>
<td><strong>P-value:</strong> not significant</td>
<td><strong>GI-secretions:</strong> No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Octreotide and scopolamine butylibromide group (p=0.016 &amp; p=0.020)</td>
</tr>
<tr>
<td>No protocol existence reported.</td>
<td>No protocol existence reported.</td>
<td>Eligibility criteria: All the patients presented with a decompressive nasogastric tube and a clinical and/or radiological and/or surgical diagnosis of inoperable bowel obstruction in whom available oncologic therapies for tumor control had been exhausted.</td>
<td>Eligibility criteria: All the patients presented with a decompressive nasogastric tube and a clinical and/or radiological and/or surgical diagnosis of inoperable bowel obstruction in whom available oncologic therapies for tumor control had been exhausted.</td>
<td>Eligibility criteria: All the patients presented with a decompressive nasogastric tube and a clinical and/or radiological and/or surgical diagnosis of inoperable bowel obstruction in whom available oncologic therapies for tumor control had been exhausted.</td>
<td><strong>Quality of life:</strong> Not reported</td>
<td><strong>Quality of life:</strong> Not reported</td>
</tr>
<tr>
<td>Patients characteristics: Mean age (SD): 61.12 (9.0)</td>
<td></td>
<td>Gender: 11 female / 6 male.</td>
<td>Patients characteristics: Mean age (SD): 61.12 (9.0)</td>
<td></td>
<td></td>
<td><strong>GI-secretions:</strong> No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Octreotide and scopolamine butylibromide group (p=0.016 &amp; p=0.020)</td>
</tr>
<tr>
<td><strong>Octreotide 0.3 mg daily (n=48)</strong></td>
<td><strong>Octreotide 0.3 mg daily (n=9)</strong></td>
<td></td>
<td><strong>Scopolamine butylibromide (n=8)</strong></td>
<td></td>
<td></td>
<td><strong>Quality of life:</strong> Not reported</td>
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<td><strong>GI-secretions:</strong> No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Octreotide and scopolamine butylibromide group (p=0.016 &amp; p=0.020)</td>
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<td><strong>Quality of life:</strong> Not reported</td>
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<td></td>
<td><strong>GI-secretions:</strong> No quantitative values of GI secretion reported excepted for a statistically significant lower GI-secretions between the Octreotide and scopolamine butylibromide group (p=0.016 &amp; p=0.020)</td>
</tr>
</tbody>
</table>

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**Referenties**

[1-4]


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* self-calculated