Managing GI Issues of Obstruction, Jaundice, Feeding and Constipation at the End of Life

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Outline

• Esophageal Obstruction
• Bowel Obstruction
• Biliary Obstruction
• Enteral Nutrition & Feeding Issues
• Constipation

Esophageal Obstruction
89 yo M with Stage IV esophageal adenocarcinoma and progressive dysphagia enrolls in hospice.

Should enteral nutrition be addressed?

- Yes
- Nutrition
- Aspiration
- Social Eating

What are options for enteral nutrition?

1. Feeding Tubes
   - PEG
   - PEJ
   - G Tube with J Extension

2. Esophageal Stent Placement
   These are NOT mutually exclusive.
What are the indications and contraindications for esophageal stent placement in malignancy?

**INDICATIONS**
- Malignancy in the chest (either primary or secondary to the esophagus) leading to stricture formation and dysphagia
- Tracheo-esophageal Fistula

**CONTRAINDICATIONS**
- Life Expectancy <30 days
- Coagulopathy
- Cardiopulmonary disease at too high a risk for GA
- Mass primarily located <25cm from incisors*
- Primary Pulmonary Lesions may cause the compression of the airway as the stent expands.*
- Actively bleeding esophageal mass.*

*Relative Contraindication

Sharma et al AJG 2010; Varadarajulu et al GIE 2011; Ross et al Self Expandable Stents in the GI Tract 2012

Malignant Esophageal Obstruction
Malignant Esophageal Obstruction

Tracheo-Esophageal Fistula

Bronchoscopy

EGD

Tracheo-Esophageal Fistula
Proximal Esophageal Carcinoma with Invasion of the Adjoining Airway

What are the outcomes for esophageal stent placement for malignant dysphagia?

<table>
<thead>
<tr>
<th>Author referenced</th>
<th>Study type</th>
<th>Stent type</th>
<th>Technical solution</th>
<th>Dysphagia relief</th>
<th>Complications</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sabharwal et al (2003)</td>
<td>RCT (8)</td>
<td>Expandable, Self-expandable</td>
<td>Comparable/Comparable</td>
<td>None</td>
<td>None</td>
<td>Not specified Median 104/137 (0.2) days</td>
</tr>
<tr>
<td>Siersma et al (2006)</td>
<td>RCT (13)</td>
<td>Self-expandable, Fully covered</td>
<td>Comparable/Comparable</td>
<td>Some dysphagia</td>
<td>Some dysphagia</td>
<td>Not specified Median 104/137 (0.2) days</td>
</tr>
<tr>
<td>Siddiqui (2012)</td>
<td>RCT (15)</td>
<td>Balloon-expandable, Self-expandable</td>
<td>Comparable/Comparable</td>
<td>Some dysphagia</td>
<td>Some dysphagia</td>
<td>Not specified Median 104/137 (0.2) days</td>
</tr>
</tbody>
</table>

SEMS improve (not resolve) dysphagia in 90% in intrinsic disease (3->1) but are less successful (3->2) in extrinsic compression.

- Able to consume a normal diet
- Dysphagia with certain solid foods
- Able to swallow semi-solid soft foods
- Able to swallow liquids only
- Unable to swallow solid (complete dysphagia)
What complications may arise from esophageal stent placement?

Immediate (at the time of placement)
- Aspiration
- Airway compromise
- Malposition
- Delivery system entrapment
- Stent dislodgement
- Perforation
  0.6%

Homann Dij Ds Sci 2008 Sharma et al AJG 2010

Early (up to 1 week after stent placement)
- Bleeding
- Chest pain
- Nausea
  47%

Late (beyond 1 week of successful stent placement)
- Recurrent dysphagia due to obstruction from tumor or food impaction
  37%
- Migration
  21%
- Tracheoesophageal fistula
  9%
- Bleeding
  9%
- Gastroesophageal reflux disease/aspiration

What diet would be appropriate after esophageal stent placement?

- **Stage 1**
  - Fluids Only

- **Stage 2**
  - Smooth or pureed foods (applesauce, yogurt, ice cream, pudding, jello)
  - Soft consistency (scrambled eggs, cottage cheese, steamed fish, mashed potatoes, pudding)

- **Stage 3**
  - Liberalize to a wide variety of foods and fluids avoiding problematic foods.
What diet would be appropriate after esophageal stent placement?

**Foods to Avoid**
- Bread & Toast
- Tough Meat
- Hard Boiled or Fried Eggs
- Fish with Bones
- Pithy Fruits
- Stringy Vegetables
- Potato Skins
- Salad
- Raw Vegetables
- Chips
- Ice Cream/Yogurt with chunks of fruit, cereal, nuts

**Strategies to Swallow**
- Slow, Small, Frequent (5-6) Meals
- Cut food into small pieces
- Moisten food with gravy, sauce, and plenty of water
- Sit upright at meal times and for 1-2hrs post
- Work with pharmacist about switching pills to liquid form if possible or to crush in applesauce otherwise

Is there a role for concurrent PEG tube placement with esophageal stent placement?

<table>
<thead>
<tr>
<th>Change</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Change 30d (n=38)</td>
<td>-.9%</td>
</tr>
<tr>
<td>Weight Change 60d (n=25)</td>
<td>-.14%</td>
</tr>
<tr>
<td>Albumin Change in 30d (n=35)</td>
<td>-.46 g/dL</td>
</tr>
<tr>
<td>Albumin Change in 60d (n=20)</td>
<td>-.62 g/dL</td>
</tr>
</tbody>
</table>

**Patients with concurrent PEG**
- Weight loss at 30d - .1% NS
- Albumin Change in 30d - .36 g/dL NS

Das et al DDW 2017

Bowel Obstruction
65 yo M with Metastatic Pancreatic Cancer with a history of biliary obstruction and metallic biliary stent placement now presents with gastric outlet obstruction. He is not interested in further chemotherapy and is interested in focusing on quality of life.
What are the options for the management of his gastric outlet obstruction?

1. Duodenal/Enteral Stent Placement
2. Surgical Gastrojejunostomy
3. Palliative Venting Gastrostomy

What are the relative merits of a surgical GJ vs enteral stenting vs venting G-Tube?

SUSTENT Study: Gastrojejunostomy vs Enteral Stent

No difference in survival or quality of life scores

Jeumink et al GIE 2010
SUSTENT Study: Gastrojejunostomy vs Enteral Stent

Recurrence of Obstructive Symptoms:
- STENT: 5/18 (28%)
- GJ: 1/21 (5%)

Time to Recurrence of Obstruction
- STENT: 30 days
- GJ: 72 days

More durable relief of obstruction with surgical GJ

More re-interventions required in enteral stents

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**Means**

<table>
<thead>
<tr>
<th></th>
<th>ES</th>
<th>GJ</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to oral intake</td>
<td>3.55</td>
<td>7.15</td>
<td>0.11</td>
</tr>
<tr>
<td>Hospital stay (days)</td>
<td>5.1</td>
<td>12.13</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Non RCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to oral intake</td>
<td>1.48</td>
<td>8.07</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Hospital stay (days)</td>
<td>7.61</td>
<td>19.04</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Total medical costs</td>
<td>8,629.5</td>
<td>17,842</td>
<td>0.09</td>
</tr>
<tr>
<td>Survival (days)</td>
<td>96.05</td>
<td>103.31</td>
<td>0.59</td>
</tr>
</tbody>
</table>

Faster resolution of GOO Symptoms
Shorter Hospital Stay
No Difference in Survival

Meta analysis of 3 RCTs and 14 non-RCTs

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**PROS**

Surgical GJ
- Longevity of Relief
- Degree of Relief
- Lower Reintervention

**CONS**

- Major surgical procedure
- Inappropriate with Ascites
- Wound complications
What complications may arise from duodenal stent placement?

<table>
<thead>
<tr>
<th>Complication</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perforation</td>
<td>0.7%</td>
</tr>
<tr>
<td>Bleeding</td>
<td>5%</td>
</tr>
<tr>
<td>Stent Migration</td>
<td>5%</td>
</tr>
<tr>
<td>Restenosis</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Precipitation of Cholangitis

Enteral Stents GIE 2011; Piesman Am J Gastro 2009; Dormann Endoscopy 2004
What diet would be appropriate or expected after duodenal stent placement?

**Foods to Avoid**
- Fresh Vegetables and Fruit
- Foods with seeds (Oranges, Watermelon, Tomatoes)
- Fruit or Vegetable Skins
- Nuts
- Tough Meat

**Strategies to Eat**
- Take drinks during and after each meal.
- Eat only upright and stay upright for 1-2 hours afterwards

If a patient elects to undergo a palliative venting G-tube, what would the care of this be primarily?

**Could they continue to eat?**

88yo M presents with progressive abdominal distension, decreased flatus and is found with a large bowel obstruction. CT scan reveals an obstructing sigmoid mass. He is not certain if he would want to pursue aggressive chemotherapy, radiotherapy or surgery.
What are the options for the management of his large bowel obstruction?

1. Surgical Decompression
2. Surgical Resection
3. Endoscopic Palliative Colonic Stenting
When would a colonic stent vs a surgical intervention be appropriate?

Colonic stenting is appropriate for:

1. **Palliation** in patients for whom further therapy is not available or desired and who have a limited life span.

2. **Bridge** to the performance of a definitive surgical resection or diversion.

**Primary Palliative Colonic Stent Placement**

Single Tertiary Care Retrospective Review; n = 168 patients

- **Stent Patency: 145 days**
  - 88.5% patients remained patent until death

- **Complication Rate (24%)**
  - Perforation (9%)
    - MUCH higher (3x) with Bevacizumab
  - Occlusion (9%)
  - Migration (5%)
  - Erosion/Ulcer (2%)
Colonic Stent Placement as Bridge to Surgery

Meta-Analysis 10 Studies (n=451 patients)

- Technical Success: 92.6%
- LOS: 7.7 days shorter
- Inpatient mortality: ↓
- Inpatient complications: ↓
- Stoma Formation: ↓ ↓ ↓ (OR 0.02)
- Overall Survival: No Difference

Tilney Suge Endoscopy 2007

What are the situations where colonic stenting has more limited efficacy?

Extrinsic Compression

- Advanced GYN Cancer: 77% had some relief after stent placement but 33% needed surgical decompression ultimately
- Other studies have showed poorer outcomes with extrinsic disease (20% clinical success) and higher need for surgical diversion (up to 60%).
- Most of these patients have overt or subclinical carcinomatosis leading to multifocal obstruction & intestinal paresis.

Caceres Gynecol Oncol 2009; Miyayama AJR 2000

What are the complications of colonic stent placement?

<table>
<thead>
<tr>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration</td>
</tr>
<tr>
<td>Restenosis</td>
</tr>
<tr>
<td>Perforation</td>
</tr>
</tbody>
</table>

Migration Factors

- Stent diameter/angulation
- Post-operative Chemo/XRT
- Fecal Impaction
- Distal Position

Suh Surg Endoscopy 2010; Datye Minim Invasive Ther Allied Technol 2011
What recommendations are made about diet/bowel regimen in patients with a colonic stent?

**Foods to Avoid**
- Fresh Vegetables and Fruit
- Foods with seeds (Oranges, Watermelon, Tomatoes)
- Fruit or Vegetable Skins
- Nuts
- Tough Meat

**Strategies to Eat**
- Take drinks during and after each meal.
- Eat only upright and stay upright for 1-2 hours afterwards
- Aggressive bowel regimen with Miralax daily

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39yo F with PMH serous ovarian carcinoma for the past 7 years with peritoneal carcinomatosis, malignant ascites managed with a pleurex catheter now presents with nausea/vomiting and gastric/small bowel distention on CT.

Goals of care have been discussed during her several admissions in the last year, but due to the relatively indolent nature of her disease and her young age she has been reticent to consider a primarily palliative approach to her care.

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What are the options for the management of this patient’s large/small bowel obstruction on CT?
How do we counsel patients on their nutrition through this scenario?

Malignant Biliary Obstruction

67yo M presents with painless jaundice and on CT is found with dilation of the common bile duct and pancreatic duct with an ill defined mass in the head of the pancreas.
What techniques are available for the decompression of the bile duct to palliate jaundice?

1. ERCP
2. EUS Guided Biliary Drainage
   - EUS Guided Choledocoduodenostomy
   - EUS Rendezvous ERCP
3. Percutaneous Transhepatic Cholangiography
4. Surgical Decompression
What is the difference between plastic stents, uncovered metal stents, or fully covered metal biliary stents?

Why do physicians choose one over the other?

Which is most appropriate?

Walter et al Gastro 2015

**PROS**

- Plastic Stent
  - Ease of insertion, removal, and exchange
  - Very well studied with a low side effect profile
  - Inexpensive

- Uncovered SEMS
  - Stent Failure & Occlusion at 3-4 months
  - Requirement for repeated ERCP procedures for replacement

**CONS**

- Plastic Stent
  - Stent Failure & Occlusion at 3-4 months
  - Requirement for repeated ERCP procedures for replacement

- Uncovered SEMS
  - Higher Cost than uncovered SEMS

**Diagram**

- Plastic Stent
  - Diagnosis Unknown
    - No GB
    - Malignant
      - <3 mos life expectancy
      - 6-12 mos life expectancy
      - Complex
        - Intrahepatic Stricture
  - Malignant
    - Complex
      - Malignant
        - Plastic Stent(s)
        - Uncovered SEMS
Three months have passed and the patient has undergone 3 cycles of chemotherapy and CT scan has demonstrated stable disease. He has not developed jaundice or pruritus.

When is it appropriate to change a plastic stent for a metal stent in the bile duct?

**Elective conversion of a plastic stent to a metal stent is preferable to:**

1. Minimize the likelihood of the patient developing jaundice, cholangitis, or a biliary complication while neutropenic or undergoing chemotherapy
2. Maximize the time before the development of jaundice and stent failure complications.
The patient progresses on first line chemotherapy and starts second line chemotherapy. His metal biliary stent remains in place and 9 months has passed. His oncologist picks up elevations in alkaline phosphatase on routine labwork and refers the patient to therapeutic endoscopy.

What are the indications for repeat ERCP once a metal biliary stent is placed?

- Jaundice
- Cholangitis (Fever, RUQ Pain, Jaundice, AMS)
- Symptomatic Pruritus
- Imaging demonstrating concern for stent failure

3 months pass and the patient develops jaundice and pruritus. During multidisciplinary conversation with the patient’s oncologist, there is hope that the patient may be able to benefit from a promising clinical trial.
What may cause stent dysfunction after the placement of a metal stent for malignant obstruction?

- Stent Migration
- Stone/Sludge/Debris Within/Above Stent
- Epithelial Hyperplasia
- Tumor Ingrowth
- Progression of tumor beyond the stented area

What are the options after metal stent placement to address recurrent biliary obstruction?

- Mechanical debridement/cleaning of the previously placed stent
- Balloon dilation of tumor ingrowth
- APC/Laser of Tissue/Tumor Ingrowth
- Placement of a fully covered SEMS within the uncovered SEMS
- Placement of a plastic stent through the SEMS
- Alternative biliary drainage (PTC, Choledocoduodenostomy)

The patient re-develops jaundice while on the clinical trial.
What are the recommendations on further interventions after the placement of biliary stent-through-stent?

2 months pass and the patient was unable to tolerate clinical trial and has enrolled in hospice. He calls to ask if he should have an ERCP to change the plastic stents within his metal stent.

What are the other palliative measures for non-invasive management of symptomatic jaundice?

- Suppressive Antibiotics
- Palliation of Jaundice
  - Cholestyramine
  - Ursodiol
- Palliation of Pruritus
  - Zoloft
  - Atarax
When would you ever consider an ERCP in a patient who is on hospice?

Tips for Tubes
- Dressing over the external bumper
- Silver nitrate to excess granulation tissue
- External bolster able to push in or out 1 cm
- Keep tube entrance perpendicular to the abdominal wall
- Tube clogs increase 10 fold with checking gastric residuals
- Cranberry juice and carbonated beverages are inferior to water for flushing
- For tube clog – water works in a third, pancreatic enzymes reopen another 50%; remainder try mechanical devices or replace
- Replacement of a internal bumper type PEG in 1-2 years, balloon-type more frequent

Declogging Protocol
- Aspirated out any remaining liquid
- Instill 10 mL warm water with light pressure back and forth
- Clamp 15 minutes then try to aspirate or flush with water
  - If unsuccessful:
    - Crush a NaBicarb 650 mg tablet and dissolve in 10 mL water
    - Open a Creon 12000 capsule and dissolve in the Water/NaBicarb solution
    - Instill in tube and clamp for 15 minutes then draw back
Chronic idiopathic constipation:
- 50% of people age > 65
- 74% elderly in nursing homes

Opiate induced bowel dysfunction in >80% of patients who regularly use opiates

Constipation is a common problem in palliative care – range of 18 to 90%

Causes are often multifactorial relating to poor dietary intake, physical inactivity, underlying disease and treatment related.

Almost 50% of patients report ineffective relief in frequency and accompanying symptoms of constipation even with treatment.

### Standard Constipation Therapies

<table>
<thead>
<tr>
<th>Type</th>
<th>Agents</th>
<th>Dose</th>
<th>Mechanism</th>
<th>Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk-adding laxatives (Fiber)</td>
<td>Methylcellulose, Psyllium, Polycarbophil</td>
<td>4 g/day, 10-20 g/day</td>
<td>↓ colon transit time, ↑ stool volume, ↓ intra-colonic pressure, favor colonic bacterial growth</td>
<td>Bloating, flatulence; Avoid if intestinal obstruction</td>
</tr>
<tr>
<td>Osmotic</td>
<td>Lactulose, Polyethylene Glycol, Sorbitol</td>
<td>15-60 mL, 17 g (daily-TID), 15-60 mL</td>
<td>Osmotic water retention, dilution of feces, increased fecal volume and peristalsis</td>
<td>Bloating, cramping, flatulence, distinct taste</td>
</tr>
<tr>
<td>Emollients and lubricants</td>
<td>Mineral oil, Docusates</td>
<td>15-30 mL, 50-360 mg</td>
<td>Lubricant and stool softener, stimulant of water secretion</td>
<td>Nausea, vomiting, cramping, rectal urgency</td>
</tr>
<tr>
<td>Contact, or Stimulants</td>
<td>Bisacodyl, Anthraquinoines (Sennosides), Senna, Cascara, Castor oil</td>
<td>10-20 mg, 8-25 mg, 15-60 mg, 5 mL</td>
<td>Water secretion via damage to enterocytes, stimulation of cAMP, colonic motility stimulation</td>
<td>Excessive water and electrolyte loss, dehydration, cramps, melanosis coli</td>
</tr>
<tr>
<td>Enemas</td>
<td>Water, Sodium Phosphate</td>
<td>240-1000 mL, 120 mL</td>
<td>Soften, lavage, distension</td>
<td>Trauma to mucosa, Incontinence</td>
</tr>
<tr>
<td>Suppositories</td>
<td>Glycerine Bisacodyl</td>
<td>4 g, 5-15 mg</td>
<td>Glycerine is mixed stimulant and osmotic laxative</td>
<td>Anal irritation</td>
</tr>
</tbody>
</table>
Clinical Pearls of Standard Regimens

- Exclude impaction and fissure when starting oral regimens
- In head-to-head trials polyethylene glycol (PEG) was better tolerated with less abdominal pain and higher efficacy than lactulose.
- No difference between Lactulose and Senna head-to-head
- "Libby's Miralax Mini-Clean Out"—1/2 bottle of PEG dissolved in 32 ounces of Gatorade can work wonders.
- Docusate not helpful—no benefit to Senna/Docusate vs Senna alone and more altered stool consistency with Docusate.

Lubiprostone (Amitiza)

- A Cl channel activator that works by increasing intestinal fluid secretions and speeding up fecal transit.
- Bypasses antisecretory effects of opiates
- Drug interaction with Methadone: May diminish the therapeutic effect of Lubiprostone
- Small study showed edge to Senna vs Lubiprostone for more complete bowel movements and less abdominal pain.

Linaclotide (Linzess)

- GC-C agonist; cGMP increases chloride and bicarbonate secretion into the intestinal lumen with decreased GI transit time.
- Increased extracellular cGMP may decrease visceral pain by reducing pain-sensing nerve activity.
- Dose 30 min before AM meal—fatty breakfast may trigger diarrhea
- I usually start at 145mg daily and either increase or decrease dose based on response
- Minimal systemic absorption and no drug interactions
Plecanitide (Trulance)

• GC-C agonist, but activity is in small intestine (more selective than Linaclotide, less potent)
• Linaclotide 15% diarrhea vs. 5% with Plecanitide
• Take anytime, with no required relationship to meals.
• No drug interactions

Methylnaltrexone (Relistor)

• Works fast! (Up to 80% of patients with a bowel movement within 4 hours of administration)
• Contraindicated in known or suspected GI obstruction
• Increased risk for perforation in Ogilvie’s, PUD, infiltrative GI malignancy, Crohn’s disease
• May precipitate opiate withdrawal
• OIC with non-cancer pain
  - Oral: 450 mg daily
  - SQ: 12 mg daily
• OIC with advanced illness
  - SQ: 8 – 12 mg every other day as needed
• Stop other laxatives before use, resume in 3 days if needed.

Naloxegol (Movantik)

• Dose OIC 25 mg daily, reduce to 12.5 mg daily if abdominal pain or other symptoms
• ESRD dosing – begin with 12.5 mg and increase to 25 mg if not effective
• Avoid in liver failure
• Important drug interactions including Clarithromycin, Ketoconazole, Diltiazem, Verapamil
• Stop other laxatives when beginning the drug and add them back if suboptimal response after 3 days
## Costs of Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senna 8.6 mg (100)</td>
<td>$1.44</td>
</tr>
<tr>
<td>Bisacodyl 5 mg (24)</td>
<td>$5.17</td>
</tr>
<tr>
<td>Suppository 10 mg (12)</td>
<td>$1.38</td>
</tr>
<tr>
<td>Sodium Phosphate (Fleet) enema</td>
<td>$1.93</td>
</tr>
<tr>
<td>7-19 g/118 mL (133 mL)</td>
<td></td>
</tr>
<tr>
<td>Polyethylene Glycol 3350 (Miralax)</td>
<td>$20.00</td>
</tr>
<tr>
<td>Lactulose 10 g/5 mL (473 mL)</td>
<td>$36.50</td>
</tr>
<tr>
<td>(kristalose) packets 10 g (30)</td>
<td>$253.29</td>
</tr>
<tr>
<td>Naloxegol (Movantik) 25 mg (30)</td>
<td>$376.74</td>
</tr>
<tr>
<td>Methyl Dustin (Relistor) 8 mg/0.4 mL (0.4 mL)</td>
<td>$120.00</td>
</tr>
<tr>
<td>150 mg (90); $1800.00</td>
<td></td>
</tr>
<tr>
<td>Lubiprostone (Amitiza) 8 or 24 mcg (60)</td>
<td>$420.11</td>
</tr>
<tr>
<td>Linaclootide (Linzess) 72, 145 or 290 mcg (30)</td>
<td>$424.18</td>
</tr>
<tr>
<td>Plecanitide (Trulance) 3 mg (30)</td>
<td>$424.17</td>
</tr>
</tbody>
</table>

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## Constipation

- **Yes**
  - Feecal Impaction
  - Manuual disimpaction
  - Enema
  - Chronic regimen to prevent recurrence
- **No**
  - Address med list
  - Increase mobility
  - Fluids and Fiber
  - Attention to toileting behavior

## Effective?

- **Yes**
  - Continue regimen
- **No**
  - Switch stimulant or osmotic laxative
  - Consider combination therapy

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## Parting thoughts: The Rainbow of Bowel Movements

- The bad colors: Red (if blood), Black, Pale, Silver
- All others are fine, including Green
Questions?