ONE-PAGE CHEAT SHEET

Bowel obstruction

Drip and suck, but know when to operate

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Free surgical teaching

CAUSES

- Small bowel: **adhesions** (most), hernias, tumours, Crohn's, gallstone ileus, intussusception
- Large bowel: **colorectal cancer** (most), volvulus, diverticular stricture
- Pseudo-obstruction (Ogilvie's) and ileus are functional

FEATURES

- Colicky pain, vomiting (early in proximal SBO), distension, absolute constipation (early in LBO)
- Tinkling bowel sounds; look for scars and hernias, do a rectal exam
- **Strangulation**: constant pain, fever, tachycardia, peritonism, raised lactate

IMAGING

- X-ray rule **3-6-9**: small bowel over 3 cm, colon over 6 cm, caecum over 9 cm
- Valvulae conniventes cross the whole small bowel; haustra do not cross the colon
- **CT with IV contrast**: level, cause and signs of ischaemia or a closed loop
- Sigmoid volvulus: "coffee bean" from the pelvis

MANAGEMENT

- IV fluids, **NG tube**, catheter and fluid balance, analgesia
- Correct potassium and magnesium
- Adhesional SBO without strangulation: conservative with a **water-soluble contrast** study (contrast in the colon within 24 h predicts resolution)
- Operate for strangulation, closed loop, hernia, or failure to settle (about 48–72 h)
- Sigmoid volvulus: flexible sigmoidoscopic decompression, then consider elective resection
- Malignant LBO: resection (Hartmann's or anastomosis) or a stent as a bridge

DON'T MISS

- **Closed-loop obstruction** with a competent ileocaecal valve: caecal perforation risk (caecum over 12 cm)
- Femoral hernia in an elderly woman
- Ogilvie's: exclude a mechanical cause with CT, stop opioids, correct electrolytes; neostigmine or colonoscopic decompression

EXAM PEARLS

- Faeculent vomiting means distal obstruction
- Pneumobilia with SBO: think gallstone ileus
- Hypokalaemia prolongs ileus

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