ED QUICK QUIZ
WHAT IS THE DIAGNOSIS?

BACKGROUND

A 50 year old man attends ED due to abdominal pain & vomiting

He describes generalised colicky abdominal pain that has been increasing over the past 72 hours. He states that he initially had multiple soft stools but has not moved his bowels in the past 48 hours and has been vomiting. His only PMHx is of an appendicectomy & umbilical hernia awaiting repair. He has NKDA & doesn’t take regular medications.

O/E he appears to be in a great deal of pain.

RR 20 SpO2 99% HR 12 BP 100/65 Temp 37.1

Chest is clear & HS I+II+ 0

His abdomen appears distended and is generally tender; he has no signs of peritonism. He has tinkling bowel sounds.

He has a reducible umbilical hernia

You organise an abdominal x-ray:

QUESTIONS

What does his x-ray show?

What is the initial management?

Would anything make you reconsider this management?
ANSWERS & DISCUSSION

1. Small Bowel Obstruction

SBO has multiple causes, in the developed world up to 75% of SBO cases are caused by adhesions following laparotomy, the most commonly associated operations being appendicectomy, followed by hernias. SBO may be simple or strangulated. Strangulation may result from a loop of bowel twisting on an adhesion or incarceration of a hernia, resulting in interruption of arterial supply and tissue ischaemia. **Strangulation is a surgical emergency.**

**Ileus** is a similar but distinct condition, which refers only to failure of peristalsis, not mechanical obstruction; it may involve any part of the GI tract. It is a common complication of abdominal surgery, especially when the bowel is handled by the surgeon. Other causes include any condition causing peritonitis and medications such as opiates and antimuscarinics.

2. Gastric decompression (‘Drip & Suck’)

The patient is kept hydrated by IV fluids while they have a large bore NG tube inserted to decompress the bowel. The patient should be nil by mouth during this process. This conservative management is usually trialled for up to 72 hours and 75% of SBOs will resolve themselves.

3. Haemodynamically unstable patient or irreducible hernia

The presence of haemodynamic instability, elevated lactate or an irreducible hernia should raise the suspicion of strangulation. The patient should be aggressively resuscitated and discussed with the on-call surgical registrar with a view to getting a CT to identify the position of the strangulated obstruction and operative management.