

Emergency General Surgery Practice Management Guidelines: Small Bowel Obstruction

I. Background: Small bowel obstruction remains one of the more common reasons for Emergency General Surgery consultation. Protocolized management has been shown to shorten length of hospital stay and time to operative management.

II. Guideline:

A. Initial Evaluation with Concern for Bowel Obstruction

- a. Labs
 - i. CBC
 - ii. BMP
 - iii. Lactate
- b. Imaging
 - i. CT Abdomen/Pelvis with IV Contrast
- c. Surgical Evaluation
 - i. Emergency General Surgery Consultation
 - ii. If due to gastrointestinal malignancy (known or suspected), consult Surgical Oncology
 - iii. If Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis), consult Colorectal Surgery
 - iv. If due to gynecologic malignancy, consult Gynecologic Oncology
- d. Admission
 - i. Patients with bowel obstruction should preferably be admitted to a surgical service

B. Indications for Urgent Exploration

- a. Suspected Ischemia
 - i. Peritonitis on physical examination
 - ii. Concerning laboratory values
 1. Leukocytosis
 2. Lactic Acidosis
 - iii. Concerning CT findings
 1. Closed-loop obstruction
 2. Internal Hernia
 3. Pneumatosis Intestinalis
 4. Mesenteric Edema
- b. Incarcerated Hernia
- c. Strongly consider exploration in those without prior abdominal surgery

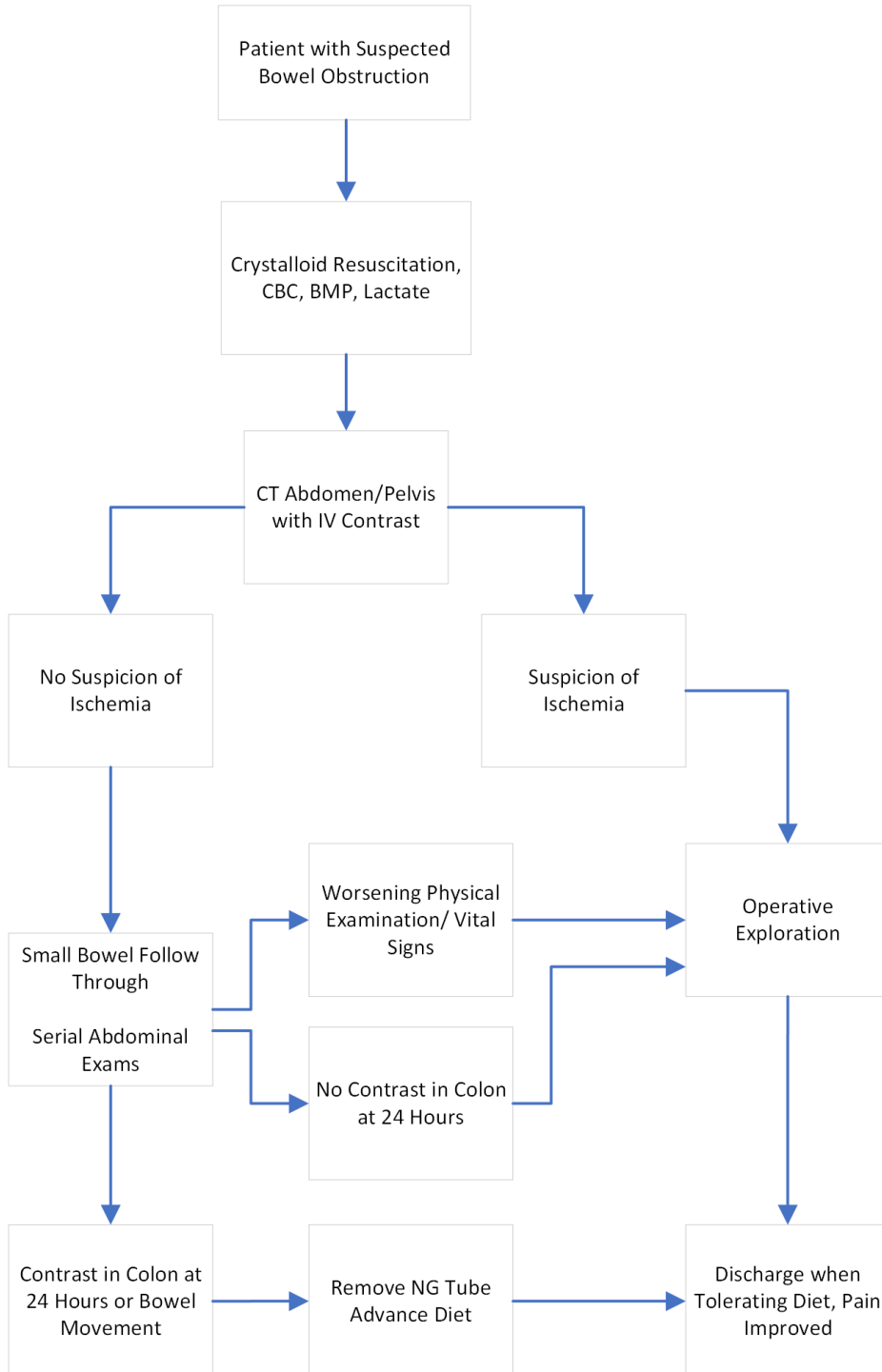
C. Nonoperative Management – Small Bowel Follow Through

- a. Nasogastric Decompression for 2 hours
- b. Abdominal X-ray to confirm gastric tube placement
- c. Orders
 - i. "Xray Small Bowel Nonfluoro"
 - ii. iohexol (OMNIPAQUE) 300 mg/mL 300 mL
 - iii. X-rays at 0, 2, 8, 24 hours
- d. If contrast in the colon OR bowel movement within 24 hours, passed small bowel follow through
- e. If no contrast in the colon and no bowel movement within 24 hours, consider exploration

D. Criteria for Discharge

- a. Tolerating diet without nausea/vomiting
- b. Bowel function
- c. Resolution of pain

E. Flowchart



III. References

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December 18, 2023