

Ileus

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THE STORY IN ONE SENTENCE

The bowel's muscle waves stop — food, gas, and fluid pile up inside, even though there is no blockage.

“A stalled gut (Ileus) means the bowel quits squeezing but is not blocked. Find what turned off the motor and let the belly drain.”

Normal anatomy — the body's job

The bowel is a long tube wrapped in smooth muscle that squeezes in waves (peristalsis) to push food, fluid, and waste from the stomach to the anus. The gut's nervous system (the enteric nervous system, a network of nerves in the bowel wall) fires signals every few seconds, telling the muscle to squeeze in coordinated waves. This keeps everything moving forward, like a hand squeezing toothpaste. Normal gut muscle tone, balanced body salts (especially potassium and magnesium), and steady nerve signals all work together to keep the waves going.

BODY'S JOB

The bowel's job is to move food, soak up water and nutrients, and push waste out. The muscle squeezes, the nerves fire, and everything flows in one direction. If the squeezing stops, the whole pipeline backs up.

1. Food and fluid enter the stomach, then move into the small bowel (duodenum, jejunum, ileum).
2. Smooth muscle in the bowel wall squeezes in waves (peristalsis), pushing the contents forward a few inches at a time.
3. The enteric nervous system (nerves embedded in the bowel wall) fires signals that trigger each squeeze wave — it works automatically, like a heartbeat.
4. Potassium and magnesium (electrolytes) keep the muscle cells able to contract; without them, the muscle cannot squeeze hard.

5. The contents move into the colon (large bowel), where water is absorbed and stool forms.
6. Gas and stool exit through the rectum and anus when the final waves push them out.

What breaks

The bowel's nerve signals or muscle power turn off, so the squeezing waves stop. Nothing is physically blocking the tube — the motor just quits running.

CLINICAL TERM

A stalled gut (Ileus) is functional bowel obstruction: the enteric nervous system stops firing coordinated peristaltic signals, or the smooth muscle cannot respond, so the bowel becomes paralyzed and dilates with trapped gas and fluid. No mechanical obstruction is present.

How the body compensates

The body cannot restart the bowel on its own — it needs the upstream cause fixed. Meanwhile, it tries to protect the belly from bursting by making you throw up (releasing pressure upward) and shifting fluid into the bowel wall and belly cavity. Vital signs may look okay at first, but the belly keeps swelling and the patient feels worse. The real danger is missing a mechanical blockage or perforation hidden underneath.

1. {'what': 'The body cannot fix a paralyzed bowel by itself.', 'how': 'Compensation is limited. The enteric nervous system will not restart until the drug (opioid) is reduced, the electrolytes are replaced, the inflammation calms, or the patient starts moving. The body just waits.'}
2. {'what': 'Vomiting releases pressure upward.', 'how': 'When gas and fluid pile up and stretch the stomach and upper bowel, the brain's vomiting center triggers reverse the gut's squeezing waves (peristalsis) (backward squeezing waves) to push the contents out through the mouth. This relieves some pressure but does not solve the problem.'}
3. {'what': 'Fluid shifts into the bowel wall and belly cavity.', 'how': 'Stretched bowel walls become leaky. Fluid seeps out of the blood vessels into the bowel wall (causing swelling (edema)) and into the abdominal cavity (causing fluid buildup in the belly (ascites)). This can lead to dehydration and low blood pressure, because fluid is leaving the bloodstream.'}
4. {'what': 'Vital signs may stay normal at first, hiding how sick the patient really is.', 'how': 'The heart rate may be only slightly fast, and blood pressure may hold steady for hours or even a day, because the body is compensating by squeezing blood vessels and releasing stress hormones. This is the dangerous middle — the team may think the patient is stable when they are actually on a downhill slope.'}

5. {'what': 'The belly keeps swelling, and the patient feels worse (more pain, more nausea, more bloating).', 'how': 'Every hour without treatment, more gas and fluid accumulate. The bowel stretches further, pulling on the mesentery (the tissue that holds the bowel in place) and causing deep, crampy pain.'}
6. {'what': 'The crash point: the bowel stretches so much it tears (perforation), or a hidden mechanical blockage (adhesion, hernia, tumor) is missed.', 'how': 'If the belly is not decompressed (drained with a tube) and the cause is not fixed, the bowel wall can lose its blood supply (ischemia) and die, or a small tear can open and spill bowel contents into the belly (peritonitis, sepsis). A real blockage can hide behind a stalled gut (ileus) — the X-ray and exam may look similar.'}

Domino effect

1. The enteric nervous system (nerves in the bowel wall) stops firing coordinated peristaltic signals, or the smooth muscle cannot respond. — Surgery stress, opioid drugs, low potassium or magnesium, severe illness, or nearby inflammation all quiet the nerve signals or weaken the muscle. The bowel's automatic squeezing waves pause or stop entirely.
2. Food, fluid, and gas stop moving forward and pile up inside the stomach and bowel. — Without the gut's squeezing waves (peristalsis), nothing pushes the contents downstream. The bowel becomes a stagnant pool instead of a flowing river.
3. The belly swells visibly (distension). — Trapped gas stretches the bowel loops like balloons. You can see and feel the tight, bloated belly. The patient feels full, crampy, and uncomfortable.
4. The patient throws up (nausea and vomiting). — The stomach and upper bowel fill up with backed-up fluid and food. The brain's vomiting center triggers reverse waves to empty the stomach upward, because there is nowhere else for the contents to go.
5. No gas or stool comes out (obstipation). — The paralyzed bowel cannot squeeze hard enough to push anything to the rectum. The last bit of stool or gas that was already near the exit may pass at first, but then nothing.
6. Bowel sounds become very quiet or absent (silent abdomen). — The gut's squeezing waves (Peristalsis) makes the gurgling sounds you hear through a stethoscope. No squeezing waves means no noise. A silent belly is a red flag — either a stalled gut (ileus) or a complete blockage.
7. Fluid leaks out of stretched bowel walls into the belly cavity and bowel wall itself (third-spacing). — The bowel walls stretch and become leaky. Plasma seeps out of blood vessels, causing bowel-wall swelling (edema) and free fluid in the abdomen. The patient becomes dehydrated even though their belly is full of fluid.

8. If the cause is not fixed, the bowel can tear (perforate), lose blood supply (ischemia), or a hidden mechanical obstruction can be missed, leading to sepsis or death. — Extreme stretching crushes the tiny blood vessels in the bowel wall, starving the tissue of oxygen. Dead bowel can perforate, spilling bacteria into the belly. A real blockage (adhesion, hernia, tumor) may be hiding under the a stalled gut (ileus) picture, and treating it like simple a stalled gut delays life-saving surgery.

Symptoms · what the patient feels, and why

- The belly is bloated and feels tight: The intestines stop squeezing food and gas along (like a conveyor belt that stops moving), so everything piles up inside and stretches the gut walls, making the belly swell.
- No bowel movements or gas comes out: Because the gut muscles aren't pushing anything along, stool and gas stay trapped inside instead of moving toward the exit.
- Belly pain that is crampy or achy: The stretched, swollen gut walls send pain signals; sometimes the gut tries to squeeze but can't move anything, which feels like a cramp.
- Nausea and vomiting: When the gut is full and nothing moves forward, the body tries to empty the stomach the other way—by throwing up.
- No appetite or feeling full very quickly: The backed-up gut signals the brain that there's no room for more food, so hunger shuts off.
- Belly sounds are very quiet or silent when the doctor listens: Normally the gut makes gurgling noises as it squeezes; in a stalled gut (ileus) the muscles are still, so the belly is unusually quiet.
- Fever: If bacteria start to overgrow in the stagnant gut or if the gut wall gets inflamed or infected, the body raises its temperature to fight back.
- Severe, sharp belly pain that keeps getting worse: This can mean the gut wall is tearing, dying from lack of blood, or leaking—emergencies that need surgery right away.

Focused exam

- Belly is swollen, tight, and tender when you press on it: In a stalled gut (ileus), the bowel stops squeezing food and gas forward, so everything piles up inside. The belly stretches like a balloon, and the pressure makes it hurt when you touch it. The tightness tells you the bowel is full and stuck.
- Bowel sounds are very quiet or completely silent: Healthy bowel makes gurgling sounds every few seconds because the muscles squeeze in waves. In a stalled gut (ileus), those squeezing waves stop, so the belly goes quiet. Silence means the bowel is paralyzed and not moving anything forward.

- No gas or stool passed for 24 hours or more: Gas should pass several times a day. When it stops completely, it means the bowel is not pushing anything out. This is the clearest sign that a stalled gut (ileus) is happening—the exit is blocked because nothing inside is moving.
- Vomiting, especially green, yellow, or brown fluid: When the bowel is paralyzed, food and fluid back up and come out as vomit. The color tells you how far back the backup goes—green or brown bile means the small bowel is stuck and fluid is flowing the wrong way.
- Patient just had belly surgery, is on strong opioid pain medicines, or has been very sick in the ICU: These are the upstream causes that paralyze the bowel. Surgery makes the bowel sleepy for days. Opioids slow the nerve signals that tell the bowel to squeeze. Severe illness drains the minerals the bowel needs to move. Knowing this helps you expect a stalled gut (ileus) and catch it early.
- X-ray or CT scan shows swollen loops of bowel filled with air and fluid, but no twist, blockage, or tumor: In a stalled gut (ileus), the bowel looks puffy and full on imaging, but there is no physical thing blocking it—no kink, no scar, no tumor. The bowel just stopped squeezing on its own. This picture rules out a mechanical obstruction and confirms the bowel is paralyzed, not trapped.

Diagnostics · every test answers a question

- Basic metabolic panel (BMP) with potassium and magnesium → Are the minerals that power bowel muscle contractions dangerously low?
- Complete blood count (CBC) → Is there infection or bleeding that could be causing or worsening the a stalled gut (ileus)?
- Serum lactate → Is the bowel getting enough blood, or is part of it dying?
- Abdominal X-ray (kidney-ureter-bladder or KUB view) → Are the bowel loops full of air and fluid, and is there a clear point of blockage?
- CT scan of the abdomen and pelvis with IV contrast → Is there a physical cause blocking the bowel—a twist, scar, tumor, abscess, or leak—or is the bowel just paralyzed on its own?
- Serum lipase or amylase → Is the pancreas inflamed and triggering the a stalled gut (ileus)?

Treatment logic

- NPO (nothing by mouth) and place a nasogastric (NG) tube if the patient is vomiting or the belly is very swollen → Stops new food and fluid from piling up in a paralyzed bowel. The NG tube sucks out what is already backed up, dropping the pressure inside and giving the bowel a chance to rest and wake up.

- Replace low potassium and magnesium through IV fluids → Potassium and magnesium are the spark plugs for muscle contractions in the bowel wall. Bringing them back to normal (potassium 3.5–5.0 mEq/L, magnesium 1.7–2.2 mg/dL) lets the nerve signals restart the squeezing waves that push food forward.
- Cut down opioid pain medicines; switch to non-opioid pain control like acetaminophen, NSAIDs, ice packs, or nerve blocks → Opioids bind to receptors in the bowel wall and block the nerve signals that trigger squeezing. Lowering the dose or switching to other pain relief removes the brake and lets the bowel start moving again.
- Treat the root cause: IV antibiotics for infection, drain an abscess, or go back to surgery if there is a leak or complication → Infection and inflammation release signals (like cytokines) that tell the bowel to stop moving. Treating the infection or fixing the surgical problem shuts off those signals and lets the bowel wake up naturally over a few days.
- Get the patient moving: sit up in bed, stand, and walk as soon as it is safe → Movement and gravity stimulate the vagus nerve (the main nerve that controls bowel squeezing) and naturally restart the waves. Early walking after surgery is proven to shorten a stalled gut (ileus) and get the bowel moving faster.
- Give alvimopan (Entereg) if the patient just had bowel surgery, or metoclopramide (Reglan) to boost bowel squeezing → Alvimopan blocks opioid receptors in the gut wall (but not in the brain, so pain relief stays) and lets squeezing restart. Metoclopramide boosts acetylcholine (the nerve chemical that tells the bowel to squeeze). Both speed up return of bowel function.

Medications

NPO (nothing by mouth) + nasogastric decompression · Supportive measure (bowel rest)

When the bowel stops moving, food and liquid pile up and can cause vomiting or unsafe swelling. Stopping all food and drink by mouth (NPO) lets the bowel rest so it is not asked to push anything along while it recovers. If the stomach fills with fluid and air, a thin tube is gently passed through the nose into the stomach (nasogastric tube) to drain the backup. This prevents vomiting and makes the patient more comfortable while the bowel wakes up.

1. All oral intake is stopped so no new food or liquid enters the stomach.
2. If vomiting or severe bloating occurs, a nasogastric tube is placed to suck out fluid and gas.
3. The bowel is no longer stretched by incoming material, and pressure inside drops.
4. Smooth muscle in the bowel wall can recover coordinated contractions without being overloaded.

SAFETY WATCH

Monitor for correct tube placement (confirm with X-ray) to avoid putting the tube into the lung by mistake. · Watch fluid balance closely; patients lose fluid through the tube and need IV replacement to avoid dehydration. · Check electrolytes daily because stomach fluid contains sodium, potassium, and chloride that must be replaced. · Remove the tube as soon as bowel sounds return and the patient can pass gas or stool, to avoid irritation and infection.

Potassium chloride (IV) · Electrolyte replacement

Smooth muscle in the bowel wall needs potassium (an electrically charged mineral) to contract properly. When potassium drops too low (often from vomiting, diarrhea, or diuretics), the muscle cannot fire its electrical signals, and the bowel stops moving. Giving potassium through an IV restores the normal level in the blood and muscle cells, allowing the bowel to squeeze and push again.

1. Potassium chloride is infused slowly through an IV line into the bloodstream.
2. Potassium enters smooth muscle cells in the bowel wall.
3. The cell membrane can now create the electrical charge needed to trigger muscle contraction.
4. Coordinated squeeze-and-push waves (peristalsis) restart, and the bowel begins to move.

SAFETY WATCH

Give slowly (no faster than 10 to 20 mEq per hour) because rapid infusion can stop the heart. · Never give as a direct IV push; always dilute and infuse through a pump. · Monitor potassium level daily; too much potassium (hyperkalemia) can cause dangerous heart rhythms. · Watch the IV site for pain or redness; potassium is irritating to veins and can cause phlebitis.

Magnesium sulfate (IV) · Electrolyte replacement

Magnesium (another electrically charged mineral) helps smooth muscle in the bowel relax between contractions and also helps cells use potassium correctly. When magnesium is too low (often alongside low potassium), the bowel muscle cannot contract or relax in a coordinated way, and a stalled gut (ileus) develops. Giving magnesium through an IV restores the balance, allowing the bowel to work again.

1. Magnesium sulfate is infused slowly through an IV line.
2. Magnesium enters smooth muscle cells and acts as a helper for many enzymes.
3. The cell can now properly use ATP (the energy molecule) and potassium.

4. Smooth muscle regains its ability to contract and relax in rhythm, and bowel motility returns.

SAFETY WATCH

Give slowly (typical rate 1 to 2 grams over 1 hour) because rapid infusion can drop blood pressure or slow breathing. · Monitor magnesium level; too much magnesium can weaken muscles, cause confusion, or slow the heart. · Watch for flushing, warmth, or sweating during infusion (common and harmless, but tell the patient to expect it). · Use with caution in kidney disease because damaged kidneys cannot clear extra magnesium.

Opioid dose reduction or rotation · Opioid stewardship (harm reduction)

Opioid pain drugs (morphine, oxycodone, hydromorphone, fentanyl) plug into receptors in the bowel wall (mu-opioid receptors) that normally help coordinate the squeeze-and-push rhythm. When opioids fill these receptors, the bowel muscle becomes paralyzed and stops moving. Lowering the opioid dose or switching to a different pain method (nerve blocks, acetaminophen, lidocaine patches, ice) frees up the receptors so the bowel can wake up.

1. The pain team lowers the opioid dose or switches to non-opioid pain control (regional anesthesia, NSAIDs if safe, acetaminophen).
2. Fewer opioid molecules are attached to mu-receptors in the bowel.
3. The enteric nervous system (the bowel's own nerve network) can now send normal squeeze-and-push signals.
4. The gut's squeezing waves (Peristalsis) restarts, and the bowel begins to move.

SAFETY WATCH

Never stop opioids suddenly in a patient who has been taking them for weeks or longer; taper slowly to avoid withdrawal (sweating, shaking, severe pain). · Monitor pain scores closely and adjust non-opioid methods to keep pain controlled. · Watch for return of bowel sounds and passage of gas or stool as a sign of recovery. · Coordinate with the surgical or pain team to create a multimodal pain plan.

Alvimopan (Entereg) · Peripherally acting mu-opioid receptor antagonist (PAMORA)

Alvimopan is a blocker that sits on the mu-opioid receptors in the bowel wall and prevents opioid pain drugs from plugging into them. It works **ONLY** in the bowel (it does not cross into the brain), so it restores bowel movement without taking away pain relief. It is given around

the time of major bowel surgery to prevent or shorten a stalled gut (ileus) caused by surgery and post-operative opioids.

1. Alvimopan is given by mouth starting just before or within hours after bowel surgery.
2. The drug travels to the bowel and attaches to mu-opioid receptors there.
3. Opioid pain drugs (given for post-op pain) are blocked from these bowel receptors.
4. The enteric nervous system can send normal squeeze-and-push signals, and the bowel recovers faster.

SAFETY WATCH

Only use in the hospital for patients having bowel surgery; it is NOT for outpatient or long-term use. · Do NOT give to patients who have taken opioids daily for more than 7 consecutive days before surgery (higher risk of heart attack or death). · Maximum 15 doses; stop as soon as the patient is discharged. · Watch for heart attack symptoms (chest pain, shortness of breath) in high-risk patients, though this is rare.

Metoclopramide (Reglan) · Prokinetic (dopamine antagonist)

Metoclopramide blocks dopamine receptors in the stomach and upper small bowel. Dopamine normally slows stomach emptying; blocking it speeds up the squeeze-and-push of the stomach and upper gut. It also blocks dopamine in the brain's vomiting center, so it reduces nausea. It is sometimes used for mild a stalled gut (ileus) or delayed stomach emptying, though evidence for true a stalled gut is weak.

1. Metoclopramide is given by mouth or IV.
2. It travels to the stomach and blocks dopamine receptors there.
3. Without dopamine's braking effect, the stomach squeezes more forcefully and empties faster.
4. It also blocks dopamine in the brain's vomiting center, reducing nausea.

SAFETY WATCH

Do NOT use for more than 12 weeks; long-term use can cause tardive dyskinesia (permanent uncontrolled movements of the face and tongue). · Watch for restlessness, drowsiness, or involuntary muscle movements (dystonia, especially in young patients). · Avoid in patients with Parkinson disease (can worsen symptoms) or seizure disorder (can lower seizure threshold). · Do NOT use if there is suspected bowel obstruction (can cause perforation).

Neostigmine (IV, monitored setting only) · Acetylcholinesterase inhibitor (indirect cholinergic agonist)

Neostigmine stops the enzyme (acetylcholinesterase) that breaks down acetylcholine, a nerve signal that tells the bowel to squeeze. By blocking this enzyme, acetylcholine builds up at the nerve-muscle connection in the bowel wall, and the bowel contracts more strongly. It is used as a last resort for severe colonic a stalled gut (ileus) (acute colonic pseudo-obstruction, Ogilvie syndrome) when the colon is dangerously swollen and other treatments have failed.

1. Neostigmine is given by slow IV push in a monitored setting (telemetry or ICU) with atropine at the bedside.
2. The drug blocks acetylcholinesterase throughout the body.
3. Acetylcholine accumulates at nerve endings in the colon.
4. The colon contracts powerfully, and the patient often passes a large volume of stool and gas within minutes to hours.

SAFETY WATCH

ONLY give in a monitored setting with continuous heart monitoring; can cause severe slow heart rate (bradycardia) or heart block. · Have atropine drawn up and ready at the bedside to reverse a slow heart rate (bradycardia) immediately if it occurs. · Watch for excessive sweating, drooling, abdominal cramping, and diarrhea (cholinergic overdose). · Do NOT use if there is suspected bowel perforation, recent bowel surgery, or known mechanical obstruction (can cause rupture). · Contraindicated in asthma or COPD (can cause bronchospasm).

Early mobilization (walking) · Non-pharmacologic intervention

Movement and walking stimulate the enteric nervous system (the bowel's own nerve network) through gentle jostling and increased blood flow. Walking also reduces inflammation, lowers stress hormones (cortisol), and shifts the body out of the paralyzed state that follows surgery or critical illness. Even short walks (to the chair, down the hall) help the bowel wake up faster.

1. The patient gets out of bed and walks (or at least sits upright) as soon as it is safe after surgery or during illness.
2. Movement stimulates stretch receptors in the bowel wall and activates the enteric nervous system.
3. Gravity and posture help gas and stool move downward through the bowel.
4. The parasympathetic nervous system (which controls bowel squeeze-and-push) becomes more active, and the gut's squeezing waves (peristalsis) restarts.

SAFETY WATCH

Check with the surgical or ICU team before mobilizing a patient with drains, lines, or fresh incisions. · Watch for dizziness or low blood pressure when first standing (common after surgery or bed rest). · Use a walker or assistant if the patient is weak or unsteady. · Start with sitting at the edge of the bed, then progress to standing, then short walks; do not rush.

Gum chewing (sham feeding) · Non-pharmacologic intervention

Chewing gum tricks the brain and gut into thinking food is coming (called sham feeding). This activates the vagus nerve (the main nerve from the brain to the bowel), which releases acetylcholine in the bowel wall and starts the squeeze-and-push rhythm even though no food is actually swallowed. Small studies show it may shorten a stalled gut (ileus) after surgery, especially colorectal surgery.

1. The patient chews sugar-free gum for 15 to 30 minutes, three times a day, starting the day after surgery.
2. Chewing activates the vagus nerve, which sends signals to the bowel.
3. The vagus nerve releases acetylcholine at nerve endings in the bowel wall.
4. Smooth muscle in the bowel begins to contract in a coordinated way, and bowel function returns faster.

SAFETY WATCH

Use sugar-free gum to avoid raising blood sugar. · Make sure the patient is alert and can protect their airway (not at risk of choking). · Stop if the patient feels nauseated or bloated. · Do not use if the surgical team has not yet allowed oral intake.

Red flags

- Fever above 100.4°F (38°C) — may mean infection or a leak in the gut
- Severe, sharp belly pain that keeps getting worse — may mean the gut is tearing or dying
- Vomiting material that looks like poop or is dark green — means a very high blockage or the gut is working backward
- Signs of shock: fast heartbeat, very low blood pressure, confusion, or cold, clammy skin — means the body is failing and needs emergency care

Nursing priorities

1. Keep patient NPO (nothing by mouth) and place or maintain nasogastric tube if patient is vomiting — The paralyzed bowel cannot move food or fluid forward so contents back up into the stomach; vomiting can go into the lungs (aspiration) and cause pneumonia or death; NG tube drains stomach and prevents aspiration
2. Check potassium and magnesium lab values and give IV replacements as ordered — Potassium and magnesium make bowel muscle cells contract; when levels are low the bowel muscle cannot squeeze and a stalled gut (ileus) continues; correcting electrolytes allows the bowel to start moving again
3. Monitor abdomen every 4 hours: measure girth at belly button, listen for bowel sounds, check for firmness and tenderness — A belly that keeps getting bigger or becomes hard and very tender suggests perforation (a hole in the bowel) or dead bowel tissue (necrosis) which needs emergency surgery; return of bowel sounds means a stalled gut (ileus) is resolving
4. Work with provider to reduce opioid pain medicine; give non-opioid options like scheduled acetaminophen, NSAIDs if allowed, ice packs, or assist with regional nerve blocks — Opioids bind to receptors on bowel muscle and directly stop the gut's squeezing waves (peristalsis) (the squeezing waves that move stool); reducing opioids allows the bowel to wake up faster while still controlling pain with other methods
5. Get patient out of bed: sit in chair for meals if allowed, stand at bedside, walk in hallway at least 3 times per day — Gravity and body movement stimulate the vagus nerve which controls bowel contractions; walking increases blood flow to intestines and speeds return of normal bowel function
6. Watch for infection signs: fever over 100.4°F, increased heart rate, new or worsening belly pain, high white blood cell count — Infection or abscess inside the abdomen releases inflammatory chemicals (cytokines) that paralyze the bowel; untreated infection can lead to sepsis (body-wide infection) and death; early detection allows antibiotic treatment or surgical drainage
7. Track fluid balance: measure all intake and all output (urine, NG tube drainage, drains); give IV fluids as ordered — The paralyzed bowel leaks fluid into the belly (third-spacing) causing dehydration and worsening electrolyte problems; adequate IV fluids maintain blood pressure and kidney function while allowing safe electrolyte replacement
8. Document time of first flatus (gas) and first bowel movement; report to provider when these occur — Return of flatus means the bowel is starting to move again; this guides the provider to start clear liquids and advance diet; bowel movement confirms a stalled gut (ileus) is resolved and normal gut function has returned

Sources

- American Society of Colon and Rectal Surgeons (ASCRS) postoperative ileus guideline
- UpToDate clinical reference
- American College of Gastroenterology (ACG)
- Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

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