

Postoperative Ileus

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THE STORY IN ONE SENTENCE

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“Postoperative A stalled gut (Ileus)”

Normal anatomy — the body's job

The bowel wall is wrapped in smooth muscle that squeezes in waves (peristalsis) to push food, liquid, and gas from stomach to rectum. That squeeze is controlled by a mesh of nerves inside the bowel wall (the enteric nervous system, sometimes called the gut's own brain) and by signals from the vagus nerve (the main highway from the brainstem to the belly). The smooth muscle also needs the right balance of electrolytes — especially potassium, magnesium, and calcium — to contract smoothly. At rest, the bowel has plenty of reserve power; it can speed up or slow down depending on what you eat and how you move.

BODY'S JOB

The bowel's job is to keep everything moving downstream so that nutrients are absorbed in the small intestine and waste leaves the body through the colon and rectum. The gut's squeezing waves (Peristalsis) — the rhythmic squeeze-and-relax wave — is what prevents backup, bloating, and bacterial overgrowth. When the system works, you do not feel it; when it stops, pressure and gas build quickly.

1. Food leaves the stomach and enters the small intestine.
2. Smooth muscle in the bowel wall squeezes in coordinated waves, pushing the contents forward inch by inch.
3. Nerves in the enteric nervous system (the gut's local control panel) and the vagus nerve (the brainstem's messenger) keep the rhythm steady.
4. Electrolytes (potassium, magnesium, calcium) fuel every muscle squeeze.

5. Liquid, gas, and solid waste move through twenty-plus feet of small and large bowel and exit the body as stool and flatus (gas).

What breaks

In postoperative a stalled gut (ileus), the nerve signals that tell the bowel to squeeze are turned down or blocked, so the smooth muscle sits still even though there is no physical obstruction. Surgery triggers inflammation in the belly, anesthesia drugs suppress the enteric nervous system, opioid pain pills lock the muscle in a relaxed state, and direct handling of the bowel during the operation stuns the local nerves. The result is that the gut's squeezing waves (peristalsis) stops and the bowel becomes a floppy, quiet tube that cannot push anything forward.

CLINICAL TERM

Postoperative a stalled gut (ileus) is a transient, non-mechanical inhibition of gastrointestinal motility following surgery, caused by surgical trauma, inflammatory mediators, autonomic nervous system imbalance (reduced parasympathetic and increased sympathetic tone), opioid receptor activation in the enteric nervous system, and electrolyte derangements. The failure is in central processing (nerve signaling) and output regulation (muscle contraction), not in input handling or structural blockage.

How the body compensates

At first, the small bowel and stomach try to keep pushing against a bowel that will not move, so gas and liquid back up and stretch the walls. The body tries to protect itself by triggering nausea (to stop more food from coming in) and by shifting some fluid back into the bloodstream. Those early compensations buy a little time, but if the bowel stays quiet, the same back-pressure causes the wall to swell, bacteria to overgrow, and the risk of vomiting (with aspiration into the lungs) or tearing (perforation) to climb.

1. The stomach and upper small bowel try to push harder, but the stalled segment will not budge, so fluid and gas pool and stretch the bowel wall like a balloon.
2. Stretch receptors in the wall signal the brainstem's vomiting center (the area postrema and chemoreceptor trigger zone) to trigger nausea and the urge to vomit, which stops you from eating or drinking more and prevents even greater backup.
3. Some of the pooled fluid is reabsorbed into the bloodstream, which can temporarily lower the pressure, but it also concentrates bacteria inside the bowel and slows motility even further.

4. If the bowel does not wake up within two to three days, the wall becomes swollen (edematous) (swollen with fluid), blood flow to the tissue drops, bacteria multiply (bacterial overgrowth), and the lining can break down, raising the risk of infection (bacterial translocation into the bloodstream) or perforation (a tear that spills bowel contents into the belly).

Domino effect

1. Surgery cuts tissue, and the body floods the area with inflammatory cytokines (signaling proteins such as interleukin-6 and tumor tissue death (necrosis) factor-alpha) to start healing; those same cytokines directly inhibit the enteric nervous system and suppress the vagus nerve's 'squeeze' signal. — Inflammation is part of normal wound repair, but the chemical messengers do not stay local — they spread along the bowel wall and tell the muscle to pause, which is why a stalled gut (ileus) can affect segments far from the incision.
2. Anesthesia drugs (especially inhaled agents and propofol) and opioid pain pills (morphine, hydromorphone, fentanyl) bind to receptors in the enteric nervous system and smooth muscle, locking the bowel in a relaxed, non-squeezing state. — Opioids hit mu receptors in the gut wall and block acetylcholine (the neurotransmitter that triggers muscle contraction); the more opioid you give and the longer you give it, the longer the bowel stays asleep.
3. With the gut's squeezing waves (peristalsis) turned off, gas (swallowed air and bacterial fermentation) and fluid (saliva, gastric juice, pancreatic and bile secretions) accumulate in the stomach and small bowel, stretching the walls and raising pressure inside the lumen (the hollow space). — A normal person makes one to two liters of secretions every day that must move forward; when the exit is blocked by paralyzed muscle, that fluid has nowhere to go, so it pools and the belly swells (distension).
4. Distension itself triggers a reflex (the intestino-intestinal reflex) that further shuts down the gut's squeezing waves (peristalsis) — a vicious cycle where being stretched makes the muscle even less likely to squeeze. — The bowel wall has stretch sensors; when they fire too much, the enteric nervous system responds by releasing inhibitory signals (such as nitric oxide and vasoactive intestinal peptide) that relax the muscle even more, turning a pause into true paralysis.
5. As the bowel sits still, bacteria that normally live in the colon start multiplying in the small bowel (bacterial overgrowth), producing more gas, more toxins, and more inflammation; the swollen wall also becomes leaky, and bacteria or their toxins can cross into the bloodstream (translocation). — The small bowel is usually a fast-moving stream that washes bacteria downstream; when flow stops, the stream becomes a stagnant pond, and bacteria bloom. The gut wall's barrier function depends on healthy blood flow and intact tight junctions between cells; prolonged distension cuts off blood flow and opens gaps.

6. If distension becomes severe, pressure inside the bowel can exceed the pressure in the small arteries that feed the wall (compartment syndrome of the bowel), starving the tissue of oxygen (ischemia) and raising the risk of perforation (a tear) or tissue death (necrosis) (tissue death). — The bowel wall is a living organ that needs constant blood supply; when stretch closes off the tiny arteries, the cells begin to die, and a dead or dying wall cannot hold contents in — it tears, spilling stool and bacteria into the sterile belly (peritonitis) or the bloodstream (sepsis).
7. Nausea and vomiting become severe; if the patient vomits while lying flat or with a decreased level of consciousness, stomach contents can go into the lungs (aspiration), causing aspiration pneumonia or acute respiratory distress. — The vomiting center in the brainstem is triggered by stretch signals, toxins, and electrolyte shifts; vomiting is the body's attempt to relieve pressure, but it carries the risk of choking and lung injury, especially in a post-surgical patient on opioids who may not protect their airway.
8. Early mobilization (walking within hours of surgery), minimizing opioids (using non-opioid pain control such as acetaminophen, NSAIDs, or regional nerve blocks), correcting electrolytes (replacing potassium and magnesium), and starting small sips of clear liquid as soon as safe can reset the nerve-and-muscle dialogue and restart the gut's squeezing waves (peristalsis) within 24 to 48 hours; delays or high-dose opioids lock in the a stalled gut (ileus) and force prolonged fasting, nasogastric tube drainage, and greater risk of complications. — Walking activates the parasympathetic nervous system (the vagus nerve's 'rest-and-digest' pathway) and physically jiggles the bowel, which helps break the cycle of paralysis. Opioid-sparing pain plans remove the brake on the enteric nervous system. Correcting low potassium and magnesium gives the muscle the fuel it needs to contract. The earlier these steps happen, the shorter the a stalled gut (ileus); every extra day of no oral intake and high opioid use makes the bowel harder to wake up.

Symptoms · what the patient feels, and why

- Belly bloating and feeling full: After surgery, the intestines slow down or pause their squeezing wave motion (peristalsis — the rhythmic muscle squeezes that push food along). Gas and fluid pile up inside the bowel, stretching the belly and making it feel tight and swollen.
- Nausea and vomiting: The stomach and small bowel stop pushing food forward normally. Fluid and stomach contents back up, triggering the vomiting center in the medulla (the part of the brainstem that controls the throw-up reflex) and making the person feel sick and throw up.
- No passing gas or stool: The colon stops its normal squeezing waves, so nothing moves through. Gas and stool stay stuck higher up instead of traveling to the rectum and coming out.

- Crampy belly pain that comes and goes: The bowel tries to squeeze against a section that is not moving. These failed squeezes cause waves of cramping pain as the intestine stretches — like trying to push toothpaste through a tube with a kink in it.
- Quiet or absent bowel sounds when the doctor listens with a stethoscope: Normally, the gut's squeezing waves (peristalsis) makes rumbling and gurgling sounds as gas and liquid slosh through the bowel. When the intestines pause after surgery, those sounds fade or disappear completely — the gut goes silent.
- Loss of appetite: The gut-brain connection (vagus nerve signals running between the intestines and brainstem, plus gut hormones like GLP-1 and PYY) tells the brain that the bowel is full and not moving. The brain then turns off hunger until the bowel wakes up again.
- Fever above 101°F (38.3°C) that starts or gets worse: A new or climbing fever may mean bacteria are leaking through the bowel wall (bacterial translocation) or that a serious complication like an abscess (pocket of pus) or anastomotic leak (surgical connection breaking open and spilling bowel contents) is forming. The immune system raises body temperature to fight infection.
- Severe, constant, sharp belly pain instead of crampy pain: Steady, sharp pain that does not come in waves suggests the peritoneum (the thin lining covering the intestines and inside of the belly) is inflamed by leaked bowel contents, blood, or pus. This can mean perforation (a hole in the bowel), starved blood flow (ischemia) (dying bowel tissue from poor blood flow), or internal bleeding.
- Fast heart rate (tachycardia) above 110 beats per minute at rest: The heart speeds up to make up for low blood volume (from fluid shifts into the belly or bleeding), infection spreading in the blood (sepsis), or severe pain. It is the body's alarm that something serious may be happening.

Focused exam

- Abdominal distension and tympany on percussion: A tight, drum-like belly filled with gas tells you the bowel is stretched and not moving contents forward; severe distension can squeeze blood vessels in the bowel wall and cut off oxygen, and it may mean you need to place a tube to drain the backed-up gas and fluid.
- Bowel sounds (hypoactive or absent): A healthy gut makes rumbles and gurgles every few seconds as muscles squeeze food along; quiet or silent bowel sounds mean the nerve signals that drive those squeezes are turned off, which is the core problem in a stalled gut (ileus).

- **Tenderness and guarding:** Mild tenderness is expected after surgery, but sharp pain with guarding (the belly muscles tighten when you press) raises the red flag for peritonitis (infection in the belly lining), a hole in the bowel, or an abscess—problems that need urgent imaging and may need another operation.
- **Vital signs:** fever, a fast heart rate (tachycardia), low blood pressure (hypotension): A fast heart rate or mild fever can come from pain and stress, but fever above 38.5°C (101.3°F) or a heart rate over 110 beats per minute that does not drop after pain medicine suggests infection, sepsis (the body's dangerous overreaction to infection), or another serious problem beyond routine a stalled gut (ileus).
- **Passage of flatus or stool:** Passing gas or stool proves the gut is waking up and moving things all the way through; if a patient has not passed gas by 3 to 5 days after surgery, it signals prolonged a stalled gut (ileus) and you should check pain medicine dose, potassium and magnesium levels, and consider imaging to rule out a blockage.
- **Surgical wound and drain output:** A new bulge or fluid leaking from the cut, or cloudy, foul-smelling fluid from a drain, can signal an anastomotic leak (the stitched bowel connection is leaking), an abscess (pocket of pus), or a wound infection—all of which make a stalled gut (ileus) worse and may need surgery to fix the source.

Diagnostics · every test answers a question

- **Complete blood count (CBC) with differential** → Is there a rising white blood cell count that suggests infection, abscess, or a leaking bowel connection instead of simple a stalled gut (ileus)?
- **Basic metabolic panel (BMP):** sodium, potassium, chloride, bicarbonate, BUN, creatinine, glucose → Are low electrolytes—especially potassium or magnesium—paralyzing the bowel muscle and prolonging the a stalled gut (ileus)?
- **Abdominal X-ray** (supine and upright or lateral decubitus) → Is there dilated bowel with air-fluid levels that confirms a stalled gut (ileus), and is there free air under the diaphragm that signals a hole in the bowel?
- **CT abdomen and pelvis with IV contrast** → Is there a mechanical blockage (scar tissue, hernia, narrowed area), abscess, leaking bowel connection, or dying bowel tissue that needs surgery rather than just watchful waiting?
- **Serum lactate** → Is the bowel dying from lack of blood flow, or is the patient becoming septic from a hidden infection?
- **Magnesium level** → Is low magnesium adding to the a stalled gut (ileus), especially in patients who have not eaten or who received diuretics (water pills)?

Treatment logic

- NPO (nothing by mouth) + nasogastric tube decompression if vomiting or severe distension → Stops new food and liquid from piling up in a gut that cannot push things forward; the nasogastric (NG) tube (a flexible tube passed through the nose into the stomach) drains backed-up stomach fluid and gas so pressure inside the bowel falls, nausea drops, and the intestinal wall can rest and recover its nerve signals.
- Early mobilization: sitting in chair and walking within hours of surgery if blood pressure and pain allow → Movement and upright posture wake up the parasympathetic nervous system (the vagus nerve running from the brainstem) and trigger the gut's own pacemaker cells (interstitial cells of Cajal in the bowel wall) to fire; gravity helps gas and stool move downward through the colon.
- Minimize opioids; use non-opioid analgesia (acetaminophen, NSAIDs if kidneys allow, regional nerve blocks or epidural without high-dose opioids) and taper opioid dose as soon as pain control permits → Opioids bind to mu-opioid receptors on neurons in the myenteric plexus (the nerve network embedded in the bowel wall) and slam the brakes on the gut's squeezing waves (peristalsis) (the squeezing waves); reducing opioid dose removes the chemical handcuffs so acetylcholine (the nerve messenger that drives muscle contraction) can work again.
- Correct electrolytes: replete potassium to > 4.0 mEq/L and magnesium to > 2.0 mg/dL → Potassium and magnesium are the main ions that control the voltage inside smooth muscle cells; normal levels restore the electrical signals so the muscle can contract and relax in coordinated waves (peristalsis).
- IV fluids to maintain euvolemia (normal fluid balance); avoid both dehydration and fluid overload → Enough hydration keeps blood pressure stable so the gut gets enough oxygen and nutrients; balanced crystalloid (lactated Ringer's or normal saline) prevents the electrolyte shifts that worsen a stalled gut (ileus).
- Encourage oral intake (sips of water, then clear liquids, then soft diet) as soon as nausea allows and bowel sounds return; feed the gut to wake it up → Eating triggers the release of gastrointestinal hormones (gastrin, cholecystokinin, motilin from cells in the stomach and small bowel lining) and stimulates stretch receptors in the bowel wall that jumpstart coordinated contractions and move the gut back into its normal rhythm.
- Consider alvimopan (12 mg PO twice daily starting before surgery and continued up to 7 days) in patients undergoing bowel resection → Alvimopan is a peripheral mu-opioid receptor antagonist (it blocks opioid effects in the gut wall without reversing pain control in the brain), allowing the bowel to move even when the patient needs systemic opioids for pain.

Medications

Alvimopan (Entereg) · Peripheral mu-opioid receptor antagonist

Alvimopan blocks opioid pain medicines from locking onto receptors in the gut wall (not in the brain), so the bowel can wake up and move again even while pain is controlled. It stays in the intestines and cannot cross into the brain.

1. After surgery, opioid pain medicines (morphine, hydromorphone, oxycodone) lock onto mu-opioid receptors in the gut wall and tell the intestine to freeze and stop moving.
2. Alvimopan sits on those same gut receptors and blocks the opioid from attaching there.
3. Because alvimopan stays in the gut and does not enter the brain, pain relief from the opioid continues while the bowel is freed to squeeze again.
4. The bowel's natural wave-like pushes (peristalsis) restart, moving gas and stool forward.
5. Time to first bowel movement and time to leave the hospital both get shorter.

SAFETY WATCH

Approved only for short-term hospital use (maximum 15 doses). Long-term use may raise the risk of heart attack based on animal studies. · Do NOT use in patients who have taken opioids every day for more than 7 days before surgery. The drug works less well and safety is not proven in these patients. · Watch for stomach pain, nausea, or bloating. Rarely, severe cramping can happen if given when there is a true mechanical blockage. · Not FDA-approved for outpatient use. Hospitals must join a special monitoring program (EASE program) to prescribe it.

Metoclopramide (Reglan) · Prokinetic agent and dopamine D2 receptor antagonist

Metoclopramide speeds up stomach and upper-intestine emptying by blocking dopamine receptors that normally slow the gut and by boosting acetylcholine (the chemical messenger that tells gut muscles to squeeze). It also calms nausea by blocking dopamine in the brain's vomit center.

1. After surgery, dopamine receptors in the stomach wall signal the gut to stay relaxed. Inflammation also lowers acetylcholine release.
2. Metoclopramide blocks those dopamine D2 receptors and raises acetylcholine levels in the gut wall.
3. With dopamine blocked and acetylcholine higher, the stomach and upper intestine squeeze harder and in rhythm.

4. Food and fluid move from the stomach into the small bowel faster, cutting bloating and nausea.
5. At the same time, blocking dopamine in the CTZ stops the brain from sending the vomit signal.

SAFETY WATCH

Can cause drowsiness, restlessness, or anxiety. · Rarely causes serious movement side effects: acute dystonia (sudden muscle spasms of the face, neck, or eyes), akathisia (severe inner restlessness that makes you feel like you must keep moving), or tardive dyskinesia (involuntary tongue and face movements that may be permanent). Risk goes up with doses above 30 mg per day or use longer than 12 weeks. · Do NOT use in patients with seizure disorders (lowers the seizure threshold), Parkinson disease (blocks dopamine and worsens tremor and stiffness), or suspected bowel perforation or obstruction (forcing squeezing against a blockage can tear the bowel). · Use carefully in older adults (higher risk of movement side effects).

Neostigmine · Acetylcholinesterase inhibitor

Neostigmine stops the enzyme (acetylcholinesterase) that breaks down acetylcholine, so acetylcholine builds up at the nerve endings in the gut wall. More acetylcholine means stronger, faster muscle squeezes that push gas and stool forward. It is used when the colon has stopped moving and is dangerously swollen (acute colonic pseudo-obstruction or Ogilvie syndrome).

1. After surgery or in very sick patients, the colon can blow up huge without a mechanical blockage because nerve signals are weak and acetylcholine is broken down too fast.
2. Neostigmine blocks acetylcholinesterase (the enzyme that chews up acetylcholine).
3. Acetylcholine piles up at the nerve-muscle junctions in the colon wall.
4. The extra acetylcholine tells the colon muscles to squeeze hard and in rhythm.
5. Gas and stool begin moving. The dangerously stretched colon deflates, lowering the risk of perforation (tearing through the wall).

SAFETY WATCH

Can cause severe slowing of the heart (bradycardia) and drop in blood pressure. Always give with continuous heart monitoring and have atropine ready at the bedside to reverse these effects. · May trigger severe cramping, sweating, too much saliva, and diarrhea (cholinergic crisis). · Can worsen asthma or COPD by causing bronchospasm (airway tightening). · Absolutely do NOT give if mechanical obstruction is suspected. Forcing the bowel to squeeze against a blockage can cause bowel perforation. · Do NOT use in patients with recent heart attack, very slow heart rate, or bladder obstruction.

Chewing gum (sham feeding) · Non-pharmacologic intervention (cephalic-vagal stimulation)

Chewing gum tricks the brain into thinking food is coming. The act of chewing turns on the vagus nerve (the main nerve that controls gut movement), which then signals the stomach and intestines to start their normal squeezing rhythm even though no food actually goes into the stomach.

1. After surgery, the gut's nerve signals are shut down by inflammation, anesthesia drugs, and opioid pain medicines.
2. Chewing (even without swallowing food) turns on sensors in the mouth and jaw that send signals up to the brainstem.
3. The brainstem sends signals down the vagus nerve to the gut.
4. The vagus nerve releases acetylcholine along the gut wall, telling the muscles to squeeze in waves.
5. The gut's squeezing waves (Peristalsis) (the wave-like pushes) restarts earlier. Patients pass gas and have a bowel movement sooner.

SAFETY WATCH

Very safe with almost no side effects. · Do NOT use if the patient is not allowed anything by mouth (NPO) for a medical reason (for example, planned return to surgery or high risk of breathing food or liquid into the lungs). · Sugar-free gum is better to avoid spiking blood sugar, especially in patients with diabetes. · Typical plan: chew gum for 30 minutes three times a day starting the day of or day after surgery.

Red flags

- Fever above 101°F, especially if it starts after post-op day 3 or keeps climbing — may mean infection, abscess, or bowel leak.

- Severe, constant, sharp belly pain instead of crampy waves — suggests peritonitis, perforation, or dying bowel tissue.
- Fast heart rate over 110, low blood pressure, or confusion — signs the body is losing the fight against infection or bleeding.
- Belly becomes hard, rigid, and very tender to touch — classic for a perforated bowel spilling contents into the abdomen.
- Vomiting fecal-smelling or dark brown material — means a complete bowel blockage is backing contents all the way up from the colon.

Nursing priorities

1. Measure abdominal girth at the umbilicus (belly button level) every 4 to 8 hours and mark the measurement spot with a skin marker — Serial girth measurements detect progressive distension (belly swelling) before it becomes severe; increasing girth over 3 cm signals worsening a stalled gut (ileus) or obstruction requiring escalation and possible decompression (relieving pressure)
2. Auscultate all four abdominal quadrants for 60 seconds each shift and document bowel sound quality and frequency — Absent bowel sounds confirm a stalled gut (ileus); high-pitched tinkling sounds suggest mechanical obstruction; return of normal bowel sounds (5 to 30 per minute) predicts resolution and readiness to resume diet
3. Keep patient NPO (nothing by mouth) and maintain IV fluid replacement with isotonic crystalloid (normal saline or lactated Ringer's) at rate ordered, typically 100 to 150 mL per hour — NPO prevents vomiting and aspiration risk; gut sequesters (traps) 3 to 7 liters of fluid in a stalled gut (ileus) causing hypovolemia (low blood volume); adequate IV hydration maintains organ blood flow (perfusion) (blood flow) and helps restore gut motility
4. Mobilize patient to chair within 6 hours post-surgery and assist with walking at least 3 times per 12-hour shift if hemodynamically stable (systolic BP over 90, heart rate under 120) — Early ambulation (walking) reduces a stalled gut (ileus) duration by 1 to 2 days through mechanical stimulation of gut and reduced inflammatory cytokines (immune chemicals); bedrest prolongs a stalled gut and increases venous thromboembolism (blood clot) risk
5. Collaborate with provider to minimize opioid use; administer scheduled non-opioid analgesia (acetaminophen 1 gram every 6 hours, ketorolac 15 to 30 mg every 6 hours if kidneys normal) and use opioids only for breakthrough pain — Opioids bind to mu receptors in gut wall causing prolonged a stalled gut (ileus); multimodal analgesia (multiple pain medicine types) reduces opioid requirement by 30 to 50 percent and shortens time to first bowel movement by 12 to 24 hours

6. Check basic metabolic panel (blood chemistry) daily and replace potassium to keep level above 4.0 mEq per liter and magnesium above 2.0 mg per deciliter — Low potassium (Hypokalemia) (low potassium) and low magnesium (hypomagnesemia) (low magnesium) directly impair smooth muscle contraction in gut wall; vomiting and NG suction (stomach tube drainage) cause large electrolyte losses that prolong a stalled gut (ileus) if not corrected
7. Monitor for and immediately report fever over 38.3°C (101°F), worsening abdominal pain, rigid abdomen on examining by touch (palpation) (pressing belly), or a fast heart rate (tachycardia) over 120 despite fluids — These signs suggest perforation (hole in bowel) or anastomotic leak (surgical connection breakdown) with peritonitis (belly infection); mortality (death) increases from 6 percent to over 30 percent if recognition and surgery are delayed beyond 24 hours
8. Place nasogastric tube to low intermittent suction (60 to 80 mmHg) if patient has persistent vomiting or abdominal girth increases more than 3 cm despite NPO status — NG decompression (removing stomach contents through tube) relieves pressure, prevents aspiration pneumonia (lung infection from breathing in vomit), and may shorten a stalled gut (ileus) duration by reducing bowel distension that inhibits motility

Sources

- Enhanced Recovery After Surgery (ERAS) Society guidelines
- American College of Surgeons (ACS) clinical practice statements
- UpToDate clinical reference
- Cochrane systematic reviews on postoperative ileus prevention and management

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