

Postoperative Ileus

A plain-English guide for you and your family

WHAT IS HAPPENING

After surgery, your bowel sometimes takes a break and stops squeezing food and liquid forward — we call that postoperative a stalled gut (ileus). It is not a blockage (nothing is stuck in the pipe); instead, the muscles in the wall of the intestine are temporarily stunned and cannot push. Surgery itself, anesthesia medicines, and strong pain pills all turn down the signal that tells the gut to move. You feel bloated, sick to your stomach, and cannot pass gas or stool. Most of the time the bowel wakes back up on its own in two to three days if you walk soon after surgery, sip small amounts of liquid, and use the lowest dose of opioid pain medicine that keeps you comfortable. Early walking is the single best way to restart the gut's rhythm. If the bowel stays quiet too long, pressure builds inside and can cause serious trouble — vomiting that goes into the lungs, tearing of the bowel wall, or infection — so the team watches closely and may put a tube through your nose into your stomach to drain fluid and lower the pressure until the bowel wakes up.

What you might feel

- Belly bloating and feeling full
- Nausea and vomiting
- No passing gas or stool
- Crampy belly pain that comes and goes
- Quiet or absent bowel sounds when the doctor listens with a stethoscope
- Loss of appetite
- Fever above 101°F (38.3°C) that starts or gets worse
- Severe, constant, sharp belly pain instead of crampy pain
- Fast heart rate (tachycardia) above 110 beats per minute at rest

Call the doctor right away if...

- 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.

What the care team will do

- Measure abdominal girth at the umbilicus (belly button level) every 4 to 8 hours and mark the measurement spot with a skin marker
- Auscultate all four abdominal quadrants for 60 seconds each shift and document bowel sound quality and frequency
- 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
- 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)
- 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
- 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
- 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
- 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

Medicines you may be given — and why

Alvimopan (Entereg)

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.

Metoclopramide (Reglan)

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.

Neostigmine

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).

Chewing gum (sham feeding)

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.

Where this information comes from

- 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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