

Sbo

A plain-English guide for you and your family

WHAT IS HAPPENING

Normally the small bowel — the long, coiled tube between your stomach and your colon — squeezes food, water, and waste forward in smooth waves (like toothpaste through a tube). Along the way it soaks up water and nutrients your body needs, and gas moves through and gets absorbed. When something blocks that tube — most often a scar from old belly surgery, or a hernia (when a loop of bowel pokes through a hole in the muscle wall), or a tumor, or the bowel twisting on itself — nothing can pass. The loop above the block swells up like a balloon. Your body tries to empty backward, so you vomit. You lose water and salt, so you get dehydrated and your blood chemistry goes off. If the block also twists the bowel or traps it in a tight hernia, the blood vessels get pinched and the tissue starts to die from lack of oxygen. Dead bowel can break open and spill bacteria into your belly, which is life-threatening. Every symptom — the belly pain, the vomiting, the bloating — is your body's alarm system trying to fix the problem or warn you. Recognizing the block early and getting it unblocked (sometimes with surgery) stops the dominoes from falling all the way to infection and shock.

What you might feel

- Crampy belly pain that comes and goes in waves
- Throwing up — early (green or yellow) if the block is high in the small bowel, late (brown, foul-smelling) if the block is lower down
- Belly bloating and swelling
- No poop and no passing gas
- Loud, high-pitched bowel sounds early on (hyperactive bowel sounds)
- Quiet or silent belly sounds later (hypoactive or absent bowel sounds)
- History of past belly surgery (especially adhesions from old cuts or infections)
- Fever and constant, severe belly pain (not crampy)

Call the doctor right away if...

- Fever above 100.4°F (38°C) with steady, severe belly pain — warns that the bowel may be losing blood flow or tearing
- Fast heart rate (tachycardia over 100 beats per minute) or low blood pressure — signs the body is losing fluid fast or going into shock
- Belly is rigid, very tender to touch, or shows guarding (muscles tighten to protect) — suggests the bowel may have torn and spilled contents into the belly (peritonitis)
- Vomit or belly pain that smells like feces — late sign of a low, complete blockage or dead bowel
- No urine output or very dark urine — the body is dangerously low on fluid

What the care team will do

- Make the patient NPO and insert or maintain nasogastric tube on low continuous suction, measuring and recording output every 4 hours
- Start large-bore IV access and give isotonic crystalloid fluids (normal saline or lactated Ringer solution) at the rate ordered, monitoring urine output hourly
- Monitor vital signs every 1 to 2 hours, watching for a fast heart rate (tachycardia) (fast heart rate above 100), fever above 100.4 Fahrenheit, or low blood pressure below 90 systolic
- Assess abdomen every 2 to 4 hours for worsening distension (swelling), location and quality of pain, bowel sounds, and peritoneal signs like rigidity (board-hard belly) or rebound tenderness (pain when you release pressure)
- Check and replace electrolytes—especially potassium, sodium, and chloride—based on lab results every 6 to 12 hours
- Measure and document intake (IV fluids) and output (urine, NG tube drainage, vomit) every shift, calculating fluid balance
- Keep patient comfortable with IV pain medicine, repositioning, and mouth care every 2 hours, since NPO and NG suction cause dry cracked lips and thirst
- Prepare patient for imaging (CT scan with IV contrast or Gastrografin study) or surgery by ensuring informed consent is signed, removing jewelry, confirming allergy history, and keeping IV access patent

Medicines you may be given — and why

NPO (nothing by mouth) + nasogastric tube decompression

The bowel is blocked, so food and liquid can't move forward and start to pile up above the blockage like cars behind a highway crash. That buildup stretches the bowel wall, causes pain, triggers vomiting, and raises the pressure so high that blood can't feed the tissue anymore. Stopping all food and drink by mouth (NPO) removes new arrivals. Placing a flexible tube through the nose down into the stomach (nasogastric tube) then sucks out the backed-up fluid and swallowed air, dropping the pressure and letting the bowel wall rest and recover blood flow.

Intravenous crystalloid fluids (normal saline or lactated Ringer's)

When the bowel is blocked, the body loses large amounts of water and salt into the backed-up intestine and through vomiting. Blood volume drops, the kidneys get less flow, and cells can't maintain the right balance of sodium, potassium, and chloride. Giving salt water directly into a vein (IV crystalloid) replaces what was lost, refills the blood vessels, restores pressure so organs get fed, and keeps the heart rhythm steady.

Gastrografin (diatrizoate meglumine and diatrizoate sodium oral solution)

Gastrografin is a thick, salty liquid that shows up bright white on X-rays and CT scans. When a patient with a partial small-bowel obstruction (some fluid can still squeeze past) drinks it, the contrast does two jobs: it maps where the blockage is and—because it is hyperosmolar (much saltier than body fluid)—it pulls extra water from the bloodstream into the bowel lumen through osmosis, like sprinkling salt on a slug. That extra water softens and lubricates the contents, sometimes flushing the obstruction through. Studies show Gastrografin can shorten time to resolution and reduce the need for surgery in adhesive small-bowel obstruction.

Antibiotic therapy (e.g. cefoxitin, piperacillin-tazobactam, or ceftriaxone + metronidazole)

When a bowel obstruction causes the intestinal wall to stretch and lose blood flow (ischemia), bacteria that normally live peacefully inside the gut can cross the damaged barrier and invade the bloodstream or abdominal cavity, causing infection (bacterial translocation). If the bowel has already torn (perforation) or twisted so tightly that tissue dies (strangulation), bowel contents spill and seed the abdomen with a mix of aerobic (oxygen-loving) and anaerobic (oxygen-hating) bacteria. Broad-spectrum antibiotics kill both types by breaking down their cell walls (beta-lactams) or blocking their ability to make proteins and DNA (metronidazole for anaerobes), preventing sepsis and abdominal abscess.

Where this information comes from

- American College of Surgeons
- Eastern Association for the Surgery of Trauma (EAST) 2018 SBO guideline
- World Journal of Emergency Surgery 2017 consensus
- UpToDate clinical reference

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