

Small Bowel Obstruction

A plain-English guide for you and your family

WHAT IS HAPPENING

The small bowel (the long tube between your stomach and large intestine) normally moves food along in waves, absorbs water and nutrients, and keeps everything flowing downstream. When a blockage happens, the most common culprits are adhesions (sticky scar tissue from old surgery that kinks the bowel like a garden hose), a hernia (a loop of bowel poking through a weak spot in the muscle wall and getting stuck), a tumor (growth pressing on or inside the tube), intussusception (one part of the bowel telescoping into the next, like a sock turning inside out), a stricture from inflammatory bowel disease (a scarred, narrowed ring from chronic inflammation), or gallstone a stalled gut (ileus) (a large gallstone that has broken through into the bowel and plugged it). Once the tube is blocked, food and fluid pile up behind it, stretching the bowel and triggering waves of crampy pain as the intestine tries to push past the blockage. The backed-up fluid has nowhere to go, so your belly swells and you start vomiting—first stomach acid, then green bile, and finally brown liquid that smells like stool. You cannot pass gas or have a bowel movement because nothing can get through. These symptoms are not the disease itself; they are the body's alarm system and its attempts to relieve pressure and keep blood flowing until the blockage clears on its own or surgery fixes it. If the twisted loop cuts off its own blood supply (strangulation), the bowel tissue starts to die within hours, and emergency surgery is the only answer.

What you might feel

- Crampy belly pain that comes and goes in waves
- Belly swelling (distention) and a tight, drum-like feel
- Throwing up, often green or yellow-brown and foul-smelling
- No bowel movements and no passing of gas
- High-pitched, tinkling bowel sounds early on, then silence later
- Severe, constant belly pain (not crampy waves anymore)
- Fever and fast heart rate
- Severe tenderness in one spot, with guarding or rebound pain

Call the doctor right away if...

- Severe, constant belly pain instead of crampy waves—suggests strangulation (blood supply cut off) or dead bowel
- Fever, fast heart rate, or signs of shock (low blood pressure, confusion, cold skin)—suggests infection, perforation, or dying tissue
- Severe tenderness in one spot with guarding or rebound pain—suggests peritonitis from a perforated or dead loop of bowel
- Bloody stool or vomit—suggests bleeding from damaged bowel wall or starved blood flow (ischemia)
- Sudden silence of bowel sounds after they were active—suggests the bowel has stopped working (ileus) or has perforated

What the care team will do

- Place two large-bore IV catheters (18-gauge or larger) and start isotonic fluid resuscitation with normal saline or lactated Ringer solution at the ordered rate, usually 125 to 250 mL per hour initially
- Keep the patient NPO (nothing by mouth), remove all food and water from the bedside, and explain that eating or drinking will cause more vomiting and worsen the blockage
- Insert or maintain a nasogastric tube (NG tube) on low intermittent suction and measure output every 4 hours, reporting if output is greater than 200 mL per hour or if the patient vomits with the tube in place
- Monitor vital signs every 2 to 4 hours, watching for fever above 100.4°F (38°C), heart rate above 110, blood pressure drop, or decreased urine output below 30 mL per hour, and notify the provider immediately if any occur
- Assess the abdomen every 4 hours for bowel sounds, firmness, increasing distension (swelling), and tenderness, and immediately report if the belly becomes rigid, silent, or if rebound tenderness develops
- Track and document all fluid output including NG tube drainage, urine, vomit, and any stool, and monitor lab results for potassium, sodium, chloride, and lactate levels
- Give prescribed pain medication promptly, using the pain scale every 2 to 4 hours, but immediately tell the provider if pain suddenly worsens or becomes constant instead of crampy
- Position the patient with the head of the bed elevated at least 30 degrees and encourage turning side to side every 2 hours if not contraindicated by surgical plans

Medicines you may be given — and why

NPO (nothing by mouth) with IV fluids and electrolyte replacement

When the bowel is blocked, swallowed food and liquid pile up above the blockage and can't move forward. The body also pushes fluids into the swollen, backed-up bowel, which pulls water and salts (sodium, potassium, chloride) out of the bloodstream. Stopping all food and drink by mouth lets the bowel rest. An IV drip puts clean fluid and the missing salts directly into the veins to keep blood volume up, blood pressure steady, and cells working normally.

Nasogastric (NG) tube decompression

A blocked small bowel fills with swallowed air, saliva, stomach acid, and backed-up digestive juice. The pressure stretches the bowel wall, causes pain, and triggers vomiting. A thin plastic tube is passed through the nose, down the esophagus, and into the stomach. Suction gently pulls the fluid and gas out, lowering the pressure. This eases pain, stops vomiting, and reduces the risk that the patient will breathe vomit into the lungs (aspiration).

Opioid analgesics (morphine, hydromorphone, fentanyl)

A blocked bowel stretches and the walls cramp hard trying to push contents forward, causing severe colicky pain (waves of cramping). Opioids are strong pain relievers that lock onto mu-opioid receptors in the spinal cord and brain. This blocks pain signals traveling from the bowel to the brain and raises the brain's pain threshold, so the patient feels much less discomfort.

Gastrografin (diatrizoate meglumine and diatrizoate sodium oral solution)

Gastrografin is a thick, salty liquid contrast dye. When given through the NG tube or by mouth, it does two jobs. First, it is hyperosmolar—much saltier than body fluid—so it pulls water from the bowel wall and bloodstream into the bowel lumen by osmosis, like pouring salt on a slug. This extra fluid softens and lubricates the blockage and may flush it forward. Second, Gastrografin shows up bright white on X-rays and CT scans, letting doctors track whether it passes through the bowel in 24 hours. If it reaches the colon, the partial obstruction will likely resolve without surgery. If it does not pass, surgery is usually needed.

Antibiotics (broad-spectrum: cefoxitin, cefotetan, piperacillin-tazobactam, or meropenem)

If the bowel is strangled (blood supply cut off) or perforated (hole in the wall), bacteria from inside the gut spill into the normally sterile abdominal cavity, causing peritonitis (infection of the belly lining) and sepsis (body-wide infection). These broad-spectrum antibiotics kill both aerobic bacteria (like *E. coli*, which need oxygen) and anaerobic bacteria (like *Bacteroides*, which live without oxygen) by blocking cell-wall building. Without a cell wall, bacteria burst and die, stopping the infection from spreading.

Where this information comes from

- EAST Practice Management Guidelines for Small Bowel Obstruction (2012)
- American College of Surgeons
- World Journal of Emergency Surgery consensus guidelines
- UpToDate Clinical Guidelines

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