ADYNAMIC OBSTRUCTION Paralytic ileus

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This may be defined as a state in which there is failure of trans mission of peristaltic waves secondary to neuromuscular failure (i.e. in the myenteric [Auerbach's] and submucous [Meissner's] plexuses). The resultant stasis leads to accumulation of fluid and gas within the bowel, with associated distension, vomiting, absence of bowel sounds and absolute constipation. Varieties The following varieties are recognised: /uni25CF Postoperative : a degree of ileus usually occurs after any abdominal procedure and is self-limiting, with a variable Leopold Auerbach , 1828–1897, Professor of Neuropathology , Breslau, Germany (now Wroc ł aw , Poland), described the myenteric plexus in 1862. Georg Meissner , 1829–1905, Professor of Physiology , Göttingen, Germany , described the submucous plexus of the alimentary tract in 1852. - - - - duration of 24–72 hours. Postoperative ileus may be pro - longed in the presence of hypoproteinaemia or metabolic - abnormality .) and /uni25CF Infection : intra-abdominal sepsis may give rise to local - ised or generalised ileus. /uni25CF Reflex ileus : this may occur following fractures of the spine or ribs, retroperitoneal haemorrhage or even the ap - plication of a plaster jacket. /uni25CF Metabolic : uraemia and hypokalaemia are the most common contributory factors. Clinical features - Paralytic ileus takes on a clinical significance if, 72 hours after laparotomy: /uni25CF there has been no return of bowel sounds on auscultation; /uni25CF there has been no passage of flatus. Abdominal distension becomes more marked and tym - panitic. Colicky pain is not a feature. Distension increases pain from the abdominal wound. In the absence of gastric aspiration, e ff ortless vomiting may occur. Radiologically , the abdomen shows gas-filled loops of intestine with multiple fluid levels (if an erect film is felt necessary). Management Nasogastric tubes are not required routinely after elective - intra-abdominal surgery . Paralytic ileus is managed with the use of nasogastric suction and restriction of oral intake until bowel sounds and the passage of flatus return. Electrolyte balance must be maintained. The use of an enhanced recov - ery programme with early introduction of fluids and solids is, however, becoming increasingly popular (see Chapter 73). Specific treatment is directed towards the cause, but the follo wing general principles apply: /uni25CF If a primary cause is identified this must be treated. /uni25CF Gastrointestinal distension must be relieved by decompres - sion.

Figure 78.21 Gross functional colonic distension.

/uni25CF There is no convincing evidence for the use of prokinetic drugs to treat postoperative adynamic ileus. /uni25CF If paralytic ileus is prolonged CT scanning will demon strate any intra-abdominal sepsis or mechanical obstruc tion and therefore guide any requirement for laparotomy . The decision to take a patient back to theatre in these circumstances is always di ffi cult. The need for a laparotomy becomes increasingly likely the longer the bowel inactivity per sists, particularly if it lasts for more than 7 days or if bowel activity recommences following surgery and then ceases.

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