Management

Management

Ileus may be managed by nasogastric drainage and restriction of oral intake until there is evidence of improvement. Support - ive care such as attention to fluid and electrolyte balance and nutrition is also important, especially if ileus persists. Underlying drivers of ileus, e.g. abscess or peritonitis, should be managed on their merits. Reg rettably , despite improved knowledge of the pathophysiology , specific drugs aimed at blocking inflammation or stimulating local neuromuscular function, e.g. prokinetics, have not proved su ffi ciently e ff ective yet to be adopted for routine use. In patients with POI, if prolonged, CT scanning is the most e ff ective investigation; it will demonstrate any intra-abdominal sepsis or mechanical obstruction and therefore guide an y requirement for laparotomy . Otherwise 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 persists, particularly if it lasts for more than 7 days or if bowel activity recommences following surgery and then stops again.

Inhibitory spinal (adrenergic) re /f_l exes Acute stress response HPA axis activation releases catecholamines Mast cell Bowel activation handling Prolonged in /f_l ammatory response Figure 73.3 Pathophysiology of postoperative ileus. HPA, hypothalamic–pituitary–adrenal axis. (a) Figure 73.4 Computed tomography abdomen scout /f_i lm (a) and representative coronal image dilatation of the small intestine (ileus) secondary to a driving in /f_l ammatory focus (pelvic collection, arrow) (courtesy of Dr Arman Parsai, Barts Health NHS Trust, London, UK). Prolonged Immediate local and decrease or distant abolition of decrease or motility abolition of motility Macrophage and neutrophil migration and activation Inhibitory Increased Afferent spinal mucosal sensitisation (adrenergic) permeability re /f_l exes Bacterial translocation (b) (b) of a 22-year-old woman showing widespread

Management

The management of ACPO depends on whether complica - tions are evident or considered imminent. In patients with clinical and radiological features of caecal ischaemia or perforation, emergency surgery will be required and usually necessitates a subtotal colectomy and end ileostomy (with high levels of morbidity and mortality). The majority of patients can however follow a more stepwise approach, starting with conservative measures (Table 73.3). Clearly the underlying cause where relevant, e.g. UTI, respiratory tract infection or myocardial infarction, should also be managed in parallel. It is reasonable to wait before progressing from one stage to the next but caecal diameters of 12 /uni00A0 cm or above warrant rapid decompression to reduce perforation risk. The decision of whether to use intravenous neostigmine is di ffi cult and is usually reserved for patients in whom supportive measures and colonic decompression have failed. Treatment is tion, brady - associated with profound autonomic e ff ects (saliva cardia, bronchospasm and hypotension) as well as abdominal cramps, followed often by a massive evacuation of flatus and faeces. Cardiac monitoring and a health professional compe - tent in the

emergency administration of resuscitative drugs (especially atropine) are essential. Contraindications to the use of neostigmine include renal insu ffi ciency , recent myocardial infarct, arrhythmias and asthma. Surgery is associated with high morbidity and mortality should be reserved for those with impending perforation and e failed or perforation has occurred. when other treatments hav

(c) TABLE 73.3 Management of acute colonic pseudo- obstruction. Reversal of risk Correct /f_l uid and electrolyte imbalances factors Stop or reduce offending drugs, e.g. opioids, anticholinergics, calcium channel blockers (where possible) Empty the rectum by enemas and/or /f_l atus tube Endoscopic Colonoscopy +/– /f_l atus tube decompression Pharmacological Intravenous neostigmine unless decompression contraindicated (risk of arrhythmia and a

bronchospasm) Surgery Subtotal colectomy (usually with ileostomy) Venting stoma, e.g. caecostomy, in very un /f_i t patients a Requires high-dependency unit-level monitoring and support on hand for cardiorespiratory complications. (d) Figure 73.5 Scout /f_i lm (a) and representative coronal computed tomography image (b) of a patient with acute colonic pseudo-obstruction. The entire colon and rectum is variably distended with /f_l uid and gas. (c) Plain abdominal radio

graph (courtesy of James Hill) and (d) intraoperative photograph of the colon during sur gery for acute colonic pseudo-obstruction (courtesy of James Hill).

ACPO is a life-threatening condition in which prompt diag nosis and appropriate management can limit the occurrence of complications (e.g. ischaemia or perforation). Such complications occur in about 5–10% of patients and require emergency surgery with mortality ra tes between 30% and 60%. Recurrence is an issue in some patients with unmodi fiable risk factors, e.g. senility and neurological disease. Such patients should have chronic modification of polypharmacy to avoid o ff ending drugs and keep the rectum empty by regular enemas. Prokinetic medications, suc h as those used for chronic constipation, may have a role in such patients, although none are licensed for this indication. Management

The main lines of management are shown in Summary box 73.6 , noting that for most patients there is no cure. Surgery , with the exception of placing feeding tubes or formation of a venting stoma, is impotent for a condition that is a di ff use neuromuscular disease. Further, surgery worsens the prognosis by adding the risk of adhesions into the diagnosis and, if resections or complications occur, speeding the patient towards intestinal failure. Small bowel (or multivisceral) transplantation is an option in selected patients.

Figure 73.6 Intestinal pseudo-obstruction in a young male patient. A full-thickness biopsy was undertaken from the proximal jejunum at minilaparotomy.

Summary box 73.6 Management of intestinal pseudo-obstruction /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

(b) Figure 73.7 Two examples of myopathy: (a) hollow visceral myopathy (note the vacuolation of the smooth muscle, arrows); (b) extra muscle layer in the muscularis propria (arrows). Nutrition (enteral/parenteral) Analgesia (but try to avoid opioids) Prokinetics (generally disappointing) Antibiotics (overgrowth) Immunotherapy – speci /f_i c in /f_l ammatory cases (limited data) Psychological support, including speci /f_i c patient support groups Palliative care Surgery (very selected cases)

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