Treatment of adhesions

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Initial management is based on intravenous rehydration and nasogastric decompression; occasionally , this treatment is cura tive. Although an initial conservative regimen is considered appropriate, regular assessment is mandatory to ensure that strangulation does not occur. Conservative treatment should not usually be prolonged bey ond 72 hours. When laparotomy is required, although multiple adhesions may be found, only one may be causative. If there is absolute certainty that this is the cause of the obstruction, this should be divided and the remaining adhesions can be left in situ severe angulation is present. Division of these adhesions will only cause further adhesion formation. When obstruction is caused by multiple adhesions, the adhesions should be freed by sharp dissection from the duo denojejunal junction to the caecum. Following the release of band obstruction, the constriction sites that hav e su ff ered direct compression should be carefully assessed and, if they sho w residual colour changes, invaginated with a seromuscular suture (Figure 78.15). Laparoscopic adhesiolysis may be considered in highly selected cases of small bowel obstruction. This is classed as an advanced laparoscopic procedure and should only be under taken by surgeons with advanced laparoscopic skills. Summary box 78.14 Treatment of adhesive obstruction /uni25CF /uni25CF /uni25CF /uni25CF

Initially treat conservatively provided there are no signs of strangulation; should rarely continue conservative treatment for longer than 72 hours At operation, divide only the causative adhesion(s) and limit dissection Repair serosal tears; invaginate (or resect) areas of doubtful viability Laparoscopic adhesiolysis should only be performed by surgeons with advanced laparoscopic skills

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