CONDITION

Intestinal obstruction and ileus

Intestinal obstruction and ileus stop food, fluid, and gas moving normally through the bowel.

WHAT IT IS
Blocked bowel passage or bowel muscles temporarily stopping

BODY SYSTEM
Digestive system

MAIN SYMPTOMS
Cramping pain, vomiting, bloating, not passing stool or gas

WHAT CAUSES IT
Physical blockage, surgery, illness, medicines, or chemical imbalances

HOW IT IS DIAGNOSED
Examination and abdominal imaging, usually CT

MAIN TREATMENT
Bowel rest, fluids, decompression, and sometimes surgery

CAN IT BE CURED?
Sometimes - removing blockage or reversing the ileus cause

IS IT AN EMERGENCY?
Yes - suspected obstruction needs urgent hospital assessment

LONG-TERM OUTLOOK
Most recover; scar tissue can cause repeated obstruction

Overview

An intestinal obstruction is a physical blockage that prevents the contents of the bowel from moving forward. It may affect the small bowel or large bowel and can be partial or complete.

An ileus causes a similar backup, but there is no physical object blocking the bowel. Instead, the bowel's normal squeezing movements slow greatly or stop. Ileus often develops after abdominal surgery, during a serious illness, or because of certain medicines.

Both conditions can cause pain, swelling, nausea, and vomiting. They also prevent the normal absorption of fluid and salts. A complete blockage may damage the bowel or cut off its blood supply, so suspected obstruction needs urgent medical assessment.

Ileus and mechanical obstruction are treated differently. Imaging is often needed to tell them

apart and find the cause.

Symptoms

Symptoms may begin suddenly or build over several hours or days. Their pattern can be affected by where the problem is and whether the bowel is partly or completely blocked.

Common symptoms include:

Vomiting may happen earlier when the blockage is in the small bowel. A large-bowel blockage may cause more obvious swelling and constipation before vomiting begins.

You may still pass stool or have diarrhea with a partial obstruction. Stool already beyond a complete blockage may also pass at first. Being able to pass some stool does not rule out an obstruction.

Ileus often causes steady discomfort and widespread bloating rather than strong waves of cramping. Symptoms alone cannot reliably separate ileus from a physical blockage.

Constant severe pain, rather than pain that comes and goes, can be a sign that the bowel is under strain or losing its blood supply.

- Cramping or wave-like abdominal pain
- A swollen or tight abdomen
- Nausea and vomiting
- Difficulty passing gas or stool
- Loss of appetite

Causes and risk factors

In adults, one of the most common causes of small-bowel obstruction is adhesions. These are internal bands of scar tissue that can form after abdominal or pelvic surgery. They may pull, bend, or trap part of the bowel, sometimes years after the operation.

Other physical causes include:

The causes differ by age. For example, intussusception is more common in young children, while tumors and diverticular disease are more relevant causes of large-bowel obstruction in older adults.

Ileus is common for a short time after abdominal surgery because surgery, anesthesia, pain, and inflammation can slow bowel movement. Other triggers include severe infection, major

injury, heart attack, kidney problems, and abnormal levels of body salts such as potassium.

Medicines that slow the bowel can contribute. These include opioid pain medicines and some medicines used for nausea, bladder symptoms, Parkinson's disease, or mental health conditions. Do not stop a prescribed medicine without advice, but make sure the hospital team knows what you take.

- A hernia that traps part of the bowel
- A tumor in or pressing against the bowel
- Narrowing caused by inflammation, such as Crohn's disease
- A twisted section of bowel, called a volvulus
- Severe stool impaction
- Intussusception, in which one section of bowel slides into another

Diagnosis

A clinician will ask about your symptoms, previous operations, bowel conditions, hernias, medicines, and when you last passed stool or gas. Your abdomen will be examined for swelling, tenderness, scars, and hernias.

Blood tests do not confirm an obstruction. They help check for dehydration, infection, kidney strain, and changes in body salts. A pregnancy test may be appropriate before certain imaging or treatment.

A CT scan is often the most useful imaging test. It can show where the bowel is blocked, suggest the cause, and look for reduced blood flow, a leak, or a hole in the bowel. Abdominal X-rays may show widened loops of bowel but may not identify the cause.

In selected small-bowel obstructions, a water-soluble contrast liquid may be followed on X-rays. This can help show whether bowel contents are moving through. Endoscopy, such as colonoscopy, is used only in certain large-bowel problems and is not suitable for every obstruction.

Treatment and management

Treatment usually begins in hospital. The immediate aims are to relieve pressure, replace lost fluid, control symptoms, and decide whether an operation is needed.

Food and drink may be paused to rest the bowel. Fluids and salts are then given through a vein.

A thin tube may be passed through the nose into the stomach to drain fluid and air, especially when vomiting or swelling is significant.

Some partial small-bowel obstructions caused by adhesions improve without surgery. This requires hospital monitoring so that treatment can change quickly if pain, examination findings, blood tests, or imaging suggest bowel damage.

Surgery may be needed when there is:

During surgery, the blockage may be released or removed. Damaged bowel may need to be taken out, with the healthy ends joined together. In some situations, bowel contents are diverted through an opening in the abdomen called a stoma. A stoma may be temporary or permanent, depending on the cause and operation.

Selected large-bowel obstructions caused by cancer may be treated with a stent. This is a hollow tube placed inside the bowel to hold it open. It may relieve symptoms before planned surgery or serve as longer-term symptom treatment in some circumstances.

Ileus is treated by addressing its trigger. This may involve correcting fluid or salt problems, treating an infection, reviewing medicines, and encouraging movement after surgery when safe. Nutrition support may be needed if normal eating cannot restart for an extended period.

Do not try to treat possible obstruction with laxatives or enemas unless a healthcare professional has said they are safe. They may be unsuitable when a physical blockage is present.

- A complete or persistent blockage
- Concern about reduced blood supply to the bowel
- A trapped hernia, twist, hole, or leak
- Worsening symptoms despite non-surgical treatment
- A tumor or another cause that cannot clear by itself

Complications

A blockage can stretch the bowel and reduce its blood supply. Tissue that loses its blood supply may become damaged or develop a hole. Bowel contents can then leak into the abdomen, causing severe inflammation or infection.

Vomiting and trapped bowel fluid can lead to dehydration, abnormal salt levels, and kidney injury. Vomit may also enter the lungs.

A prolonged ileus can delay recovery, eating, and discharge after surgery. It can also contribute

to weakness or poor nutrition. Early assessment and monitoring help limit these problems.

Prevention

Not every obstruction can be prevented. Adhesions may form after necessary surgery, and there is no reliable action you can take at home to stop them developing.

When surgery is needed, surgeons may use techniques intended to limit tissue injury and adhesion formation. These measures reduce risk but cannot remove it.

Following recommended bowel cancer screening may help detect some growths before they cause a blockage. Getting a hernia assessed before it becomes trapped may also reduce the risk of an emergency.

After surgery, following advice about movement, eating, and opioid pain medicines may support bowel recovery. Do not change prescribed medicines on your own.

Living with it and what to expect

Many people recover fully after the blockage clears or its cause is treated. Recovery time reflects the cause, how unwell you became, and whether surgery was needed.

A postoperative ileus often improves as the effects of surgery, illness, and medicines settle. Bowel sounds or passing gas may return before normal appetite and bowel movements. If recovery takes longer than expected, the team may repeat tests to look for a physical blockage or another complication.

An adhesion can cause another obstruction months or years later, although recurrence is not certain. Knowing the symptoms and seeking assessment early is more useful than trying to follow a highly restricted diet indefinitely.

After treatment, food is usually restarted in stages. Some people are temporarily advised to eat smaller meals or use a lower-fiber diet, particularly if the bowel remains narrowed. There is no single long-term obstruction diet suitable for everyone.

Your underlying condition may need separate follow-up. This may include care for Crohn's disease, cancer, a hernia, or a condition affecting bowel movement. After an operation, follow-up may also cover wound healing, stoma care, nutrition, and return to usual activities.

When to get medical help

Seek urgent assessment if you develop abdominal swelling or pain with repeated vomiting, or if you cannot pass stool or gas. This is especially important if you have had abdominal surgery, have a hernia, or have previously had an obstruction.

Go to an emergency department promptly for:

Call emergency services if there is fainting, confusion, breathing difficulty, cold or clammy skin, or severe weakness. These can be signs of shock or serious infection.

Routine follow-up is appropriate after discharge if symptoms are steadily improving but you need advice about diet, medicines, bowel habits, wound care, or return to work. New or worsening pain, swelling, or vomiting should not wait for a routine appointment.

- Severe or constant abdominal pain
- A very tender, firm, or rapidly swelling abdomen
- Persistent vomiting or inability to keep fluids down
- Fever with worsening abdominal symptoms
- Blood in vomit or stool
- Very little urine, marked weakness, or dizziness

Common questions

Can I still poop if I have a bowel obstruction?

Yes. With a partial obstruction, liquid stool may still pass around the narrowed area. You may also pass stool that was already beyond a complete blockage. This means stool or diarrhea cannot rule out an obstruction.

Can a bowel obstruction clear on its own?

Some partial obstructions, especially those caused by adhesions, clear with bowel rest, intravenous fluids, and close hospital monitoring. Complete obstructions and blockages that threaten the bowel's blood supply usually need a procedure or surgery. It is not safe to wait at home to see whether suspected obstruction clears.

How long does an ileus last?

A short period of slow bowel activity is common after abdominal surgery and may improve over several days. The timing is different for each person and operation. Ongoing or worsening symptoms need reassessment because a mechanical blockage, infection, medicine effect, or chemical imbalance may be involved.

How is obstruction different from constipation?

Constipation usually means infrequent, hard, or difficult-to-pass stool. An obstruction physically prevents bowel contents from moving normally. Obstruction is more likely to cause marked swelling, repeated vomiting, cramping pain, or inability to pass gas, but the conditions can overlap. Symptoms alone may not show which one is present.

Will I need surgery?

Not everyone does. The decision is based on the cause, whether the blockage is partial or complete, imaging findings, and whether there are signs of bowel damage. Ileus is usually managed without surgery unless another surgical problem is found.

What can I eat after an obstruction or ileus?

Food is often restarted gradually once nausea, swelling, and bowel function improve. The plan may begin with liquids before moving toward normal food. Some people need temporary changes in meal size or fiber. Follow the discharge plan for your specific cause rather than starting a restrictive diet without guidance.

Sources

- Di Saverio S, Coccolini F, Galati M, et al. "Bologna Guidelines for Diagnosis and Management of Adhesive Small Bowel Obstruction: 2017 Update." World Journal of Emergency Surgery . 2018;13:24.
- Maung AA, Johnson DC, Piper GL, et al. "Evaluation and Management of Small-Bowel Obstruction: An Eastern Association for the Surgery of Trauma Practice Management Guideline." Journal of Trauma and Acute Care Surgery . 2012;73(5 Suppl 4):S362-S369.
- American College of Radiology. ACR Appropriateness Criteria: Suspected Small-Bowel Obstruction . 2019.
- National Institute of Diabetes and Digestive and Kidney Diseases. Intestinal Pseudo-obstruction .
- Venara A, Neunlist M, Slim K, et al. "Postoperative Ileus: Pathophysiology, Incidence, and Prevention." Journal of Visceral Surgery . 2016;153(6):439-446.
- Merck Manual Professional Edition. Intestinal Obstruction and Ileus .