CONDITION

Intestinal pseudo-obstruction

Intestinal pseudo-obstruction causes bowel blockage symptoms even though no physical blockage is present.

WHAT IT IS
Obstruction symptoms without a physical intestinal blockage

BODY SYSTEM
Digestive system

MAIN SYMPTOMS
Abdominal swelling, pain, nausea, vomiting

WHAT CAUSES IT
Intestinal nerve or muscle dysfunction, sometimes from another illness

HOW IT IS DIAGNOSED
CT or X-ray excluding a mechanical blockage

MAIN TREATMENT
Bowel rest, decompression, nutrition, and treating the cause

CAN IT BE CURED?
Sometimes - reversible acute causes may resolve

IS IT AN EMERGENCY?
Sometimes - severe pain, fever, or persistent vomiting

LONG-TERM OUTLOOK
Acute cases often resolve; chronic cases may relapse

Overview

Intestinal pseudo-obstruction causes symptoms that resemble a blocked bowel, but there is no object or narrowed area physically stopping the intestine. Instead, the muscles or nerves that move food, fluid, and gas through the bowel are not working normally.

The condition can affect the small intestine, colon, or both. When it begins suddenly, it is called acute pseudo-obstruction. Acute colonic pseudo-obstruction, also known as Ogilvie syndrome, mainly affects the colon and often develops during a serious illness, after surgery, or while taking certain medicines.

Chronic intestinal pseudo-obstruction lasts for months or years or keeps returning. It may be caused by another condition, an inherited problem, or an unknown change in the bowel's nerves or muscles.

Pseudo-obstruction matters because a severely enlarged bowel can interfere with eating and hydration. In uncommon but serious cases, pressure can damage the bowel wall or cause a hole called a perforation. Chronic cases can also lead to poor nutrition.

Symptoms

Symptoms may begin suddenly or build gradually. Their severity can change from day to day.

Common symptoms include:

Passing stool or gas does not rule out pseudo-obstruction. Some liquid or gas may still move through the bowel, particularly early in an episode.

Chronic pseudo-obstruction often follows a pattern of flares and quieter periods. During a flare, eating may worsen swelling, fullness, nausea, or pain. Symptoms of acute colonic pseudo-obstruction may develop over several days in someone who is in hospital, recovering from surgery, or seriously unwell.

Severe, constant pain is less typical than bloating or cramping. It needs urgent assessment because it may indicate reduced blood flow, perforation, or a different cause of bowel obstruction.

- A swollen or visibly enlarged abdomen
- Cramping, discomfort, or abdominal pain
- Nausea and vomiting
- Feeling full after eating a small amount
- Constipation or fewer bowel movements
- Difficulty passing gas
- Diarrhoea, sometimes between episodes of constipation
- Unplanned weight loss in chronic cases

Causes and risk factors

Normal digestion relies on coordinated muscle contractions called motility. These contractions push bowel contents forward. Pseudo-obstruction develops when the bowel's nerves, muscles, or control signals cannot produce effective movement.

Chronic cases may involve:

Conditions that can affect bowel movement include diabetes, Parkinson's disease, systemic sclerosis, thyroid disorders, amyloidosis, and some neurological or muscle conditions. Certain infections, cancers, immune conditions, and previous radiation treatment may also contribute.

Acute colonic pseudo-obstruction is often linked to another major stress on the body. Examples include recent surgery, severe infection, trauma, heart or lung illness, and major disturbances in body salts such as potassium.

Medicines that slow the bowel may trigger or worsen symptoms. These include opioid pain medicines and medicines with anticholinergic effects, which block nerve signals involved in bowel movement. Never stop a prescribed medicine suddenly without medical advice.

Having one of these risk factors does not mean that you will develop pseudo-obstruction.

- Neuropathy , meaning damage or abnormal function in the bowel's nerves
- Myopathy , meaning weakness or abnormal function in the bowel's muscles
- Problems with the cells that help coordinate intestinal contractions
- An inherited change affecting nerves, muscles, or energy production
- An unknown cause, sometimes called idiopathic pseudo-obstruction

Diagnosis

Symptoms alone cannot distinguish pseudo-obstruction from a physical blockage. Medical assessment and imaging are therefore important.

An abdominal X-ray can show widened loops of intestine. A CT scan provides more detail and helps look for a tumour, twisted bowel, scar tissue, hernia, or another mechanical cause. The absence of a physical blockage, together with bowel enlargement and compatible symptoms, supports the diagnosis.

Blood tests do not confirm pseudo-obstruction. They can identify dehydration, infection, inflammation, anaemia, or abnormal levels of potassium and other body salts. Tests may also look for an underlying thyroid, immune, nerve, or muscle condition.

A colonoscopy is not routinely needed to make the diagnosis. It may be used in selected acute cases to examine or decompress the colon, or when imaging has not fully excluded another problem.

If symptoms are chronic, further testing may include:

These investigations may help show whether the main problem involves nerves or muscles. Sometimes the exact cause remains unknown even after detailed testing.

- Transit tests that measure how quickly material moves through the digestive tract
- Manometry, which measures pressure and muscle contractions inside the bowel
- Nutrition assessment and tests for vitamin or mineral deficiencies
- Genetic testing when an inherited condition is suspected
- A bowel biopsy in carefully selected cases

Treatment and management

Treatment depends on whether the condition is acute or chronic, how enlarged the bowel is, and whether there are complications. The first priority is to rule out a physical blockage or bowel damage.

For an acute episode, treatment often begins in hospital. Food and drink may be paused temporarily to rest the bowel. Fluids and body salts can be given through a vein. A tube through the nose into the stomach may remove fluid and air, while a rectal tube may help release gas from the colon.

The healthcare team will review medicines that can slow bowel movement and treat infections, electrolyte disturbances, or other triggers. Changing position and moving when medically safe may also help the colon empty.

If acute colonic pseudo-obstruction does not improve, a medicine called neostigmine may be considered. It stimulates bowel contractions but can slow the heart rate, so it is given with close monitoring. Colonoscopic decompression is another option. During this procedure, a flexible camera is passed into the colon so trapped gas can be released.

Surgery is generally reserved for a perforation, damaged bowel tissue, or severe enlargement that has not responded to other treatment.

Chronic pseudo-obstruction needs longer-term management. Care may involve gastroenterology, nutrition, pain, and other specialist services. Treatment may include:

Some people can maintain nutrition with small meals, softer foods, or liquid supplements. Others need feeding into the digestive tract or nutrition delivered through a vein. Intravenous nutrition is used when the intestine cannot absorb enough nutrients, but it requires monitoring for infection, blood clots, and liver complications.

Repeated operations can create scar tissue and may not correct an underlying motility problem. Surgery is therefore planned cautiously. Intestinal transplantation is considered only for a small group with irreversible intestinal failure and serious complications from long-term intravenous nutrition.

- Managing any underlying condition
- Reviewing medicines that reduce bowel movement
- Medicines intended to support intestinal movement or control nausea
- Treatment for bacterial overgrowth in the small intestine
- Nutrition support tailored to what the bowel can tolerate
- A venting tube or stoma in selected severe cases

Complications

Vomiting and reduced intake can cause dehydration and abnormal salt levels. Chronic difficulty eating may lead to weight loss, vitamin deficiencies, loss of muscle, and malnutrition.

Slow movement allows excess bacteria to grow in the small intestine. This is called small intestinal bacterial overgrowth. It may cause bloating, diarrhoea, and poor nutrient absorption.

Other possible complications include:

Reduced blood flow and perforation are medical emergencies, but they do not happen in every case.

- Dependence on tube feeding or intravenous nutrition
- Infections or blood clots related to intravenous feeding lines
- Bowel wall damage from severe stretching
- Reduced blood flow to the bowel
- Perforation and infection inside the abdomen

Prevention

Inherited and unexplained forms of chronic intestinal pseudo-obstruction cannot currently be prevented.

When pseudo-obstruction is related to another condition, managing that condition may reduce episodes. A medication review can identify drugs that slow the bowel, but prescribed medicines should only be changed with professional guidance.

After an acute episode, follow the plan given for activity, food, fluids, and follow-up. There is no proven home remedy, supplement, or special diet that prevents all future episodes.

Living with it and what to expect

Acute pseudo-obstruction often improves once the trigger is treated and normal bowel movement returns. Recovery may take several days or longer, especially when it occurs alongside a serious illness. Some people have another episode if the underlying risk remains.

Chronic pseudo-obstruction usually has a less predictable course. Symptoms may remain fairly steady or alternate between manageable periods and flares. The underlying nerve or muscle problem may persist even when symptoms temporarily improve.

Many people continue daily activities between episodes, although meals, travel, work, and social plans may need adjustment. Regular follow-up usually focuses on weight, hydration, blood tests, nutrition, bowel function, and the safety of medicines or feeding support.

Keeping a brief record of symptoms, meals, vomiting, bowel movements, and weight can help identify changes. Restrictive diets can worsen malnutrition, so major food exclusions are best planned with a dietitian familiar with intestinal motility conditions.

Emotional strain is also common when symptoms are unpredictable. Support for sleep, mental health, work, and family life can be part of long-term care without suggesting that the symptoms are psychological.

When to get medical help

Seek emergency medical care for:

These symptoms may indicate perforation, reduced bowel blood flow, infection, or another form of obstruction.

Contact your usual healthcare service promptly if swelling or vomiting is increasing, you are passing much less urine, or you cannot maintain food and fluid intake. New symptoms should be assessed rather than assumed to be another pseudo-obstruction episode.

Routine follow-up is appropriate for gradual weight loss, more frequent flares, changes in bowel habits, increasing difficulty eating, or possible medicine side effects. People using tube feeding or intravenous nutrition need the monitoring schedule arranged by their care team.

- Severe or rapidly worsening abdominal pain
- A hard, very tender, or rapidly enlarging abdomen
- Repeated vomiting with an inability to keep fluids down
- Vomit containing blood or material that looks like coffee grounds

- Fever, fainting, confusion, or marked weakness with abdominal swelling
- Bloody or black stools
- Chest pain, breathing difficulty, or signs of severe dehydration

Common questions

Is intestinal pseudo-obstruction the same as a blocked bowel?

No. The symptoms can be very similar, but pseudo-obstruction has no physical object or narrowed area blocking the intestine. Imaging is needed because the two cannot be safely distinguished from symptoms alone.

Can I still have bowel movements with pseudo-obstruction?

Yes. Some people continue to pass stool or gas, particularly if the bowel is only partly affected. Diarrhoea can also occur. A bowel movement does not rule out the condition.

Does intestinal pseudo-obstruction go away?

An acute episode may resolve when its trigger is corrected. Chronic pseudo-obstruction may continue or return because the underlying nerve or muscle problem remains. Treatment aims to control symptoms, maintain nutrition, and prevent complications.

Is intestinal pseudo-obstruction just severe constipation?

No. Constipation may be one symptom, but pseudo-obstruction involves ineffective movement and enlargement of the intestine. Taking more laxatives without assessment may not solve the problem and could delay care for an acute episode.

What can I eat with chronic pseudo-obstruction?

There is no single diet for everyone. Smaller meals, softer foods, or liquids may be easier for some people, while high-fibre foods may worsen swelling in others. Nutrition advice should account for symptoms, weight, absorption, and any feeding support.

Will I need surgery?

Most cases are managed without major surgery. Procedures may be needed to decompress the bowel, provide nutrition, or treat a perforation or damaged section of intestine. Surgery does not reliably correct a widespread nerve or muscle problem.

Sources

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