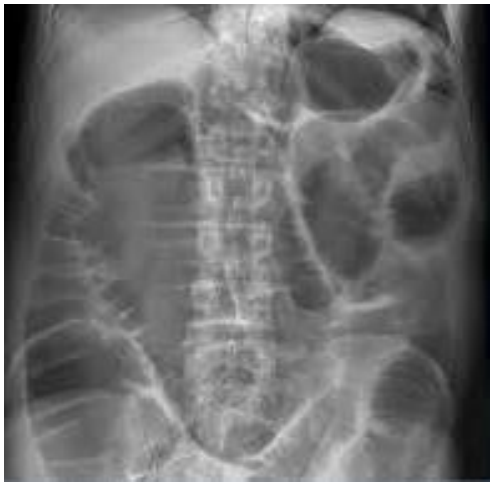
Paralytic Ileus



- Adynamic intestinal obstruction
- There is failure of transmission of peristaltic waves secondary to neuromuscular failure(the myenteric and submucous 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

Postoperative

Degree of ileus usually occurs after any abdominal procedure and is self-limiting, with a variable duration of 24–72 hours.

Infection → Intra-abdominal sepsis may give rise to localised or generalised ileus.

Reflex ileus → This may occur following fractures of the spine or ribs, retroperitoneal haemorrhage or even the application of a plaster jacket.

Metabolic

Uraemia and hypokalaemia are the most common contributory factors.

Causes

- Post operative
- Infective-Appendicitis
- Uraemia
- Hypokalaemia
- Gastroenteritis
- Pancreatitis
- Spinal injury
- Retroperitoneal haemorrhage
- Plaster jacket
- Narcotic and psychiatric medications

Clinical features

- Constipation- absolute
- No bowel sounds
- Marked abdominal distension (tympanitic)
- Vomiting
- Tachycardia. (Pain is not a feature)

Paralytic ileus takes on a clinical significance if, 72 hours after laparotomy:

- There has been no return of bowel sounds on auscultation.
- There has been no passage of flatus.

Investigation

- X-Ray- gas-filled loops of intestine with multiple fluid levels.

Treatment

- If a primary cause is identified this must be treated.
- Gastrointestinal distension must be relieved by decompression.
- Close attention to fluid and electrolyte balance is essential.

- There is no convincing evidence for the use of prokinetic
- The need for a laparotomy becomes increasingly likely the longer the bowel inactivity persists, particularly if it lasts for more than seven days.