Strangulated Small Bowel Obstruction

The VSCC has recently been referred a case in which a patient died whilst undergoing surgery for a strangulated femoral hernia. The presumed cause of death was aspiration of gastric content.

The diagnosis of a strangulated small bowel obstruction is usually straightforward, especially if this occurs within a hernial sac. If the obstruction is longstanding i.e, for some days, the patient will be unwell, possibly with fluid and electrolyte disturbance, especially if there are other co-morbidities. It will be necessary in this circumstance to spend some time assessing and resuscitating the patient prior to surgery. A nasogastric tube should be passed to empty the stomach prior to surgery in order to reduce the risk of aspiration during induction of anaesthesia. Passage of a urinary catheter will help in the management of fluid replacement and will decompress the bladder. Central venous pressure monitoring may be useful if obstruction has been prolonged.

Delay, however, will have to be balanced by the need to proceed forthwith because of the impending risk of perforation and peritonitis. This decision should be jointly made by the surgeon and anaesthetist.

General anaesthesia with pre-oxygenation, rapid sequence induction and endotracheal intubation is mandatory for airway protection.

VSCC Approved: April 2005

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