



Patient Report

Intestinal Obstructions

A Report by
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Note: This report from a patient view is a little more grisly than usual. I'll apologize in advance and warn away the squeamish.

I assume that most of our members are familiar with small bowel obstruction due to polyps. List members have given many reports of polyps causing blockage and/or intussusception. But, in the general population, surgical adhesions are a far more common cause of small bowel obstruction. Because many list members have had abdominal surgery (laparotomy), we are at risk for obstruction from both polyps and surgical adhesions.

According to Dr. Harold Ellis et. al¹:

“After laparotomy, almost 95% of patients are shown to have adhesions at subsequent surgery. Adhesions are internal "scars" that form after trauma through complex processes, involving injured tissues and the peritoneum. For most patients, adhesion formation has little effect. Some patients however have clinical consequences.

“Intestinal obstruction is the most severe consequence of adhesions. 30-41% of patients who require abdominal reoperation have adhesion-related intestinal obstruction. For small-bowel obstruction, the proportion rises to 65-75%. The clinical consequences are not confined to the gut; adhesions are a leading cause of secondary infertility in women and can cause significant abdominal and pelvic pain.”

Dr. Ellis studied adhesions for over 40 years and reported in a textbook chapter on intestinal obstruction²:

“A RATIONAL APPROACH TOWARD ADHESIONS. It is my belief that the surgeon's attitude toward intraabdominal adhesions must change. These have been considered as things to be avoided or prevented at all costs, to be destroyed and divided wherever and whenever encountered. Undoubtedly intestinal obstruction from adhesions is a relatively common surgical emergency as already noted, but this must be put against that nearly all patients who have undergone a major laparotomy have adhesions, which in the very great majority of instances are, and remain, completely symptomless.

“...Indeed, in many cases, adhesions may well have been protective or even lifesaving to the patient, preventing leakage of suture lines, protecting devascularised damaged intestine, and walling off inflammatory collections.”

The author goes on to describe techniques he uses to reduce unnecessary adhesion formation during surgery. As a patient, I am grateful that surgeons work to encourage good adhesions while discouraging bad adhesions. Here are the symptoms of intestinal obstruction: “...colicky abdominal pain, nausea, vomiting, abdominal distention, and a failure to pass flatus & feces. These symptoms may vary with the site and duration of the obstruction.”³

If you or a family member with PJS are experiencing these symptoms, they may be due to polyps causing an obstruction and/or intussusception or to post-surgical adhesions. It is important to visit a physician for a physical examination and possibly a radiological exam. Obstruction can be life threatening. I don't mean to scare anyone, but believe it is important to keep informed about all aspects of our health care.

Please remember I am a patient, not a doctor. These quotes and references are meant to help us understand adhesions. It is my hope that one day we will all have knowledgeable physicians who watch out for us. But I know from experience, those physicians are difficult to find. Until then, it is important to be self-informed about PJS related issues.

¹Ellis, Harold et al. *Adhesion-related hospital readmissions after abdominal and pelvic surgery: a retrospective cohort study*. Lancet 1999; 353: 1476-80.

²*Maingot's Abdominal Operations*. Volume 1, Ninth Edition, 1989.

³*Sabiston Textbook of Surgery: the Biological Basis of Modern Surgical Practice*. Sixteenth Edition, 2001.

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