

Acute Obstruction

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KEYWORDS

- Acute care surgery • Acute obstruction • Adhesions • Ischemia • Volvulus
- Cholangitis

KEY POINTS

- Acute gastric outlet obstruction secondary to paraesophageal hernia or gastric volvulus is a surgical emergency.
- Laparoscopic manage of small bowel obstruction secondary to adhesions has been demonstrated to be safe and potentially lower morbidity and length of stay.
- Patients with small bowel obstruction without risks of adhesions require a low threshold for early operative intervention.
- Treatment of colonic obstruction is dependent on degree (complete vs partial), anatomic location, and etiology.
- Biliary obstruction with infection (cholangitis) requires emergent drainage and is primarily treated via nonsurgical (ERCP or PTC) means.

OBSTRUCTION

Acute obstruction of the gastrointestinal or biliary tract represents a common problem for acute care surgeons and necessitates focused attention to patients' presentation, physical examination, laboratory and radiographic evaluation, and prior history. The spectrum of management options for these difficult pathologic processes ranges from conservative decompression through expeditious operative intervention depending on the anatomic location of obstruction, the nature and rapidity of symptom presentation, and the prior surgical history of patients. It is with appropriate clinical evaluation, planning, and physical examination follow-up that acute care surgeons are able to appropriately diagnose, manage, and resolve this difficult group of surgical problems and minimize the morbidity associated with each.

Presentation of Acute Esophageal Obstruction

Acute esophageal obstruction most commonly arises from foreign body impaction, either in association with a preexisting esophageal disorder or process, accidental

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ingestion, or in some cases intentional ingestion.¹ Acute foreign body impaction is a gastrointestinal emergency and can be associated with significant morbidity and even mortality due to complications, including aspiration and esophageal injury or perforation.² The most common cause of foreign body obstruction in adults is meat bolus impaction above a preexisting esophageal condition. Underlying esophageal conditions commonly include esophageal mucosal (Schatzki) rings, peptic or malignant strictures, eosinophilic esophagitis, or achalasia.^{3,4} A majority of adults are symptomatic; symptoms can occur within minutes to hours after ingestion. Acute dysphagia and inability to tolerate saliva are key symptoms in addition to retrosternal fullness, hiccups, or retching. Inability to swallow saliva typically indicates complete esophageal obstruction and requires urgent attention whereas odynophagia should elicit concerns for esophageal laceration or perforation.⁵ Respiratory symptoms, including stridor, dyspnea, or cough, can result from tracheal compression, particularly in younger patients, whereas aspiration risk is elevated in those with complete esophageal obstruction.

Diagnosis and evaluation

Clinical examination on presentation provides the primary impetus for further evaluation. Radiologic evaluation helps confirm clinical suspicion and can confirm location and associated complications. Plain films of the neck, chest, and abdominal radiographs are typically needed and may demonstrate a radiopaque foreign body. Findings of mediastinal, subdiaphragmatic, subcutaneous air, or pleural effusion all suggest complications associated with acute esophageal obstruction, including perforation.⁶ Importantly, meat impaction or other nonradiopaque foreign bodies are not visualized on plain film, and failure to localize on plain film does not preclude its presence. In those patients with a stable or controlled airway, CT imaging is superior to plain radiographs for foreign body detection, characterization (size, shape, and perforation concern), and management decision options. Contrast swallow evaluation should not be performed due to the increased risk of aspiration.

Management

Simultaneously with history and physical, airway protection and management are of the utmost importance.⁷ Those patients with respiratory symptoms and inability to tolerate secretions should be endotracheally intubated. Medical management, including glucagon administration, has been described for food bolus impaction; however, the literature remains conflicted regarding its actual benefit and caution should be used in those patients with underlying esophageal pathology, such as strictures or malignancy, resulting in an underlying fixed obstruction.^{2,8} The mainstay of treatment of acute esophageal obstruction is endoscopy evaluation and retrieval.⁹ Flexible endoscopy under conscious sedation or general anesthesia is the procedure of choice, with success rates of more than 90% in the recent literature. Rigid esophagoscopy requires general anesthesia and is preferable in younger patients and in those patients with sharp object impaction or obstruction. Blunt objects that have passed into the stomach can usually be managed conservatively. Gentle pushing of a food bolus into the stomach can be attempted. Simultaneous evaluation for strictures or esophageal pathology should be undertaken. Sharp objects require urgent attention to reduce the risk of perforation. Special attention to impacted disc or button batteries due to the risk of caustic injury and perforation is required.^{1,2,9}

Once the acute obstruction has been appropriately evaluated and definitively managed, an underlying esophageal process that led to the obstruction should be sought. This may require additional endoscopic examination, thoracic CT imaging, esophageal manometry, or fluoroscopic esophageal contrast evaluation.

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