
Giver det mening
At foretage
TTP?

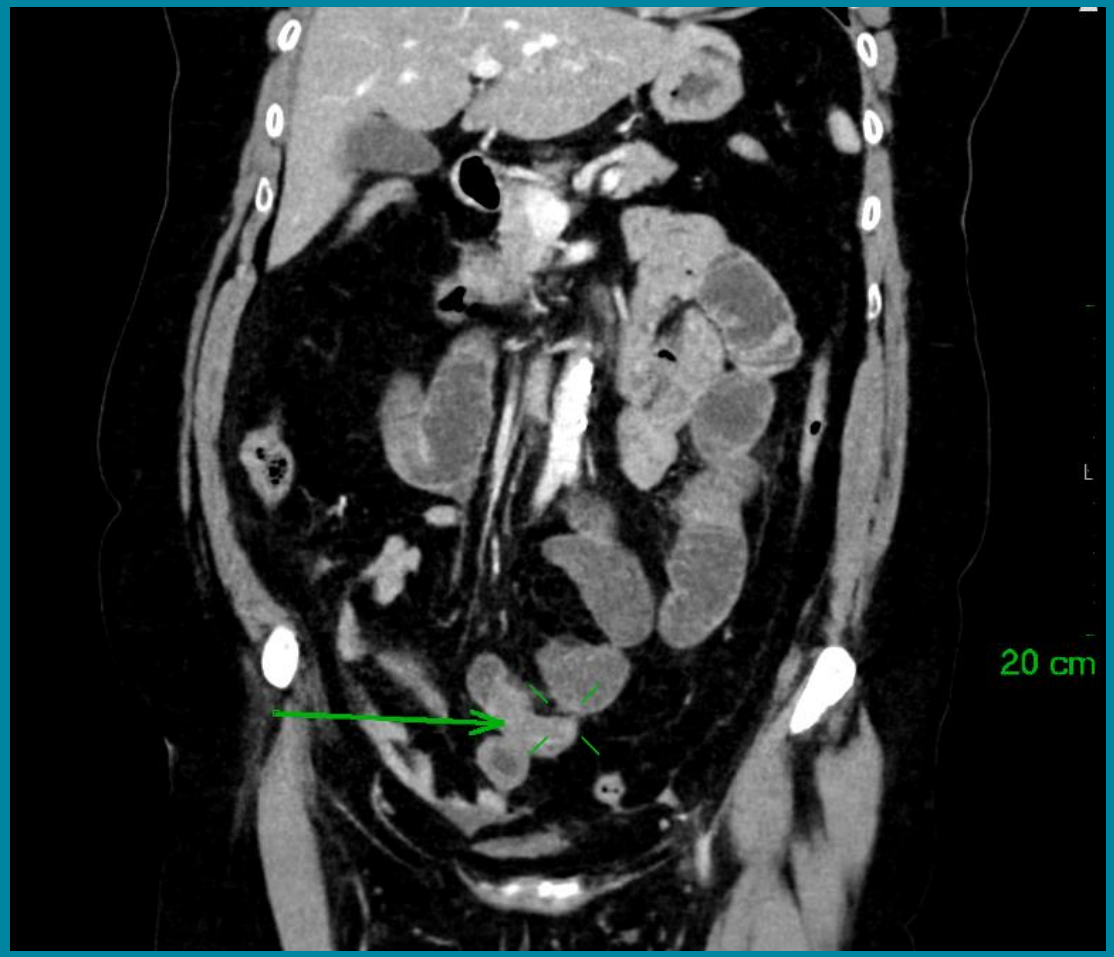
Tidligere
Hysterektomeret i 1996
Op ileus 2003

Statusnotat
Abdomen
Vågen, klar, orienteret i tid, sted og egne data. Varm og tør. Pæne farver. Normopnøisk. Ikke akut påvirket. Ikke kronisk medtaget. Fremstår moderat smerteforpint .

Abdomen:
Adipøst, udspilet , Nedre midtlinje cikatrice efter hysterektomi i 1996. Diffust palpationsøm med maks i ve. side. Der kan ikke palperes i dybden hvorfor patologiske processer eller organomegali ikke kan vurderes. Uømme nyreloger. sparsomme tarmlyde.
Exploratio rectalis: Ej relevant

Paraklinik
hgb 9,1
leuko 8,3
crp 74
kalium 3,7
natrium 135
kreatinin 77
eGFR 70
laktat 1,5
LDH 280

CT-abdomen d.d viser mekanisk tyndtarms-ileus formentlig adhærence betinget med transition zone i det lille bækken.

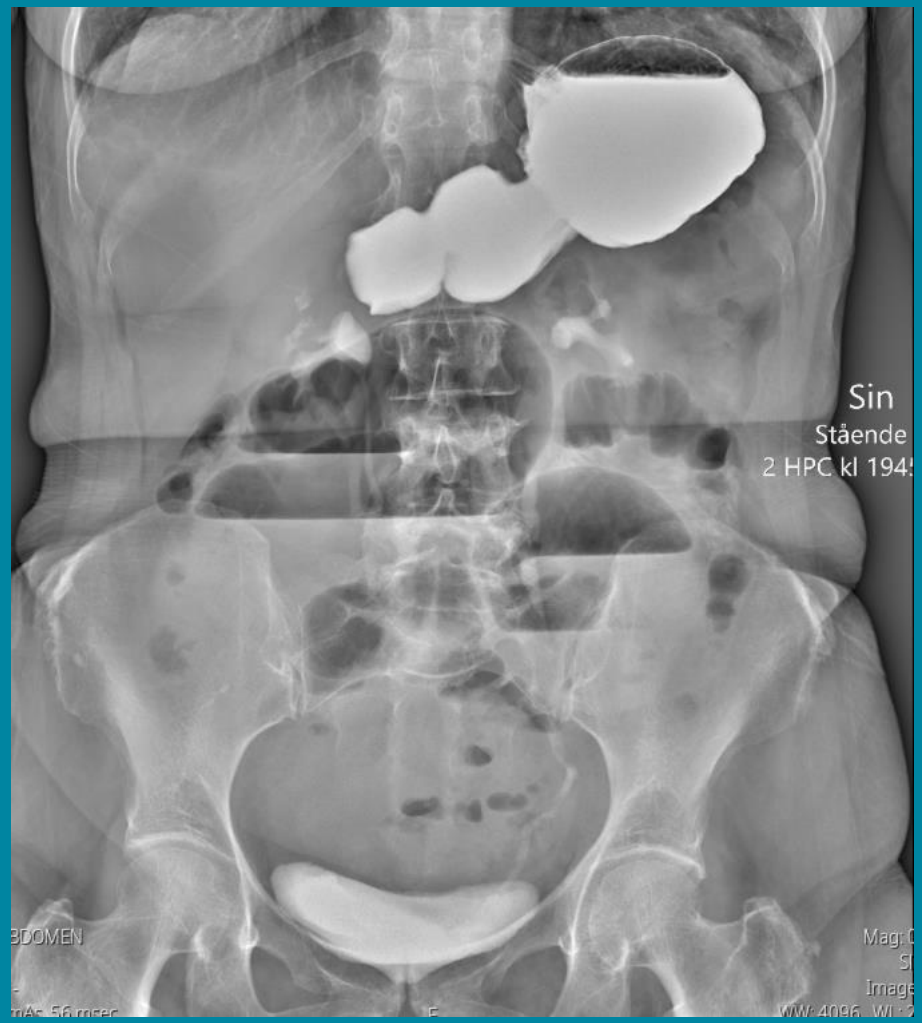


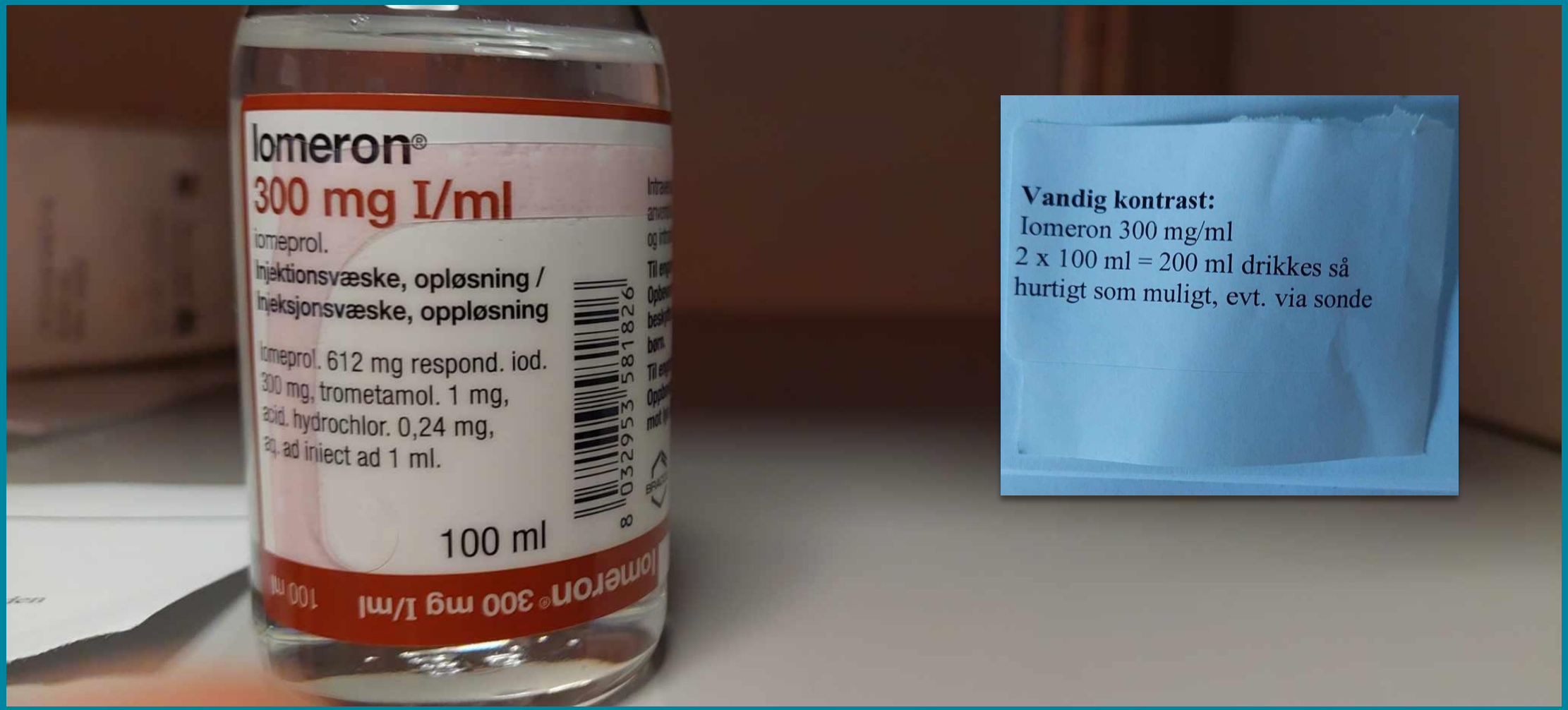
Indikation/anamnese:
Tyndtarm ileus.
Gennem de sidste 3 dage har haft intermitterende smerter, som aktuelt konstante med turvis forværring, opkastninger, manglende defækation.
Siden symptomdebut kunne ikke indtage kost, drukket næsten intet.
I 2016 fik kunstig aortaklap, følges i kardiologisk ambulatoriet her i huset, i Marevan-behandling.
I mandags og d.d. ikke taget præparatet, men i går, usikker ift. virkning der er kort efter indtagelse kastet op.
I øvrigt kronisk smertepatient efter kirurgi for fraktur af venstre håndleddet.

Abdominalt: Nedre midtlinjecikatrice efter hysterektomi for flere år siden grundet metroragi, præparatet findes ikke i Patobank.
Angiveligt også haft ileus et par gange, sidste gang både 2003 og i 2014, konservativ behandlet.

Objektivt
Smerteforpint (bedring på morfin)
Abdomen: Udspilet, palpationsøm diffust med maks. i venstre side.

CT-scanning er med dilateret stykke tyndtarm op til 4 cm, transitionszone, sammenfaldet colon.




Iomeron®
300 mg I/ml
iomeprol.
Injektionsvæske, opløsning /
Injeksjonsvæske, oppløsning
iomeprol. 612 mg respond. iod.
300 mg, trometamol. 1 mg,
acid. hydrochlor. 0,24 mg,
aq. ad iniect ad 1 ml.
100 ml
Vandig kontrast:
Iomeron 300 mg/ml
2 x 100 ml = 200 ml drikkes så
hurtigt som muligt, evt. via sonde

Meta-analysis

Systematic review and meta-analysis of the diagnostic and therapeutic role of water-soluble contrast agent in adhesive small bowel obstruction

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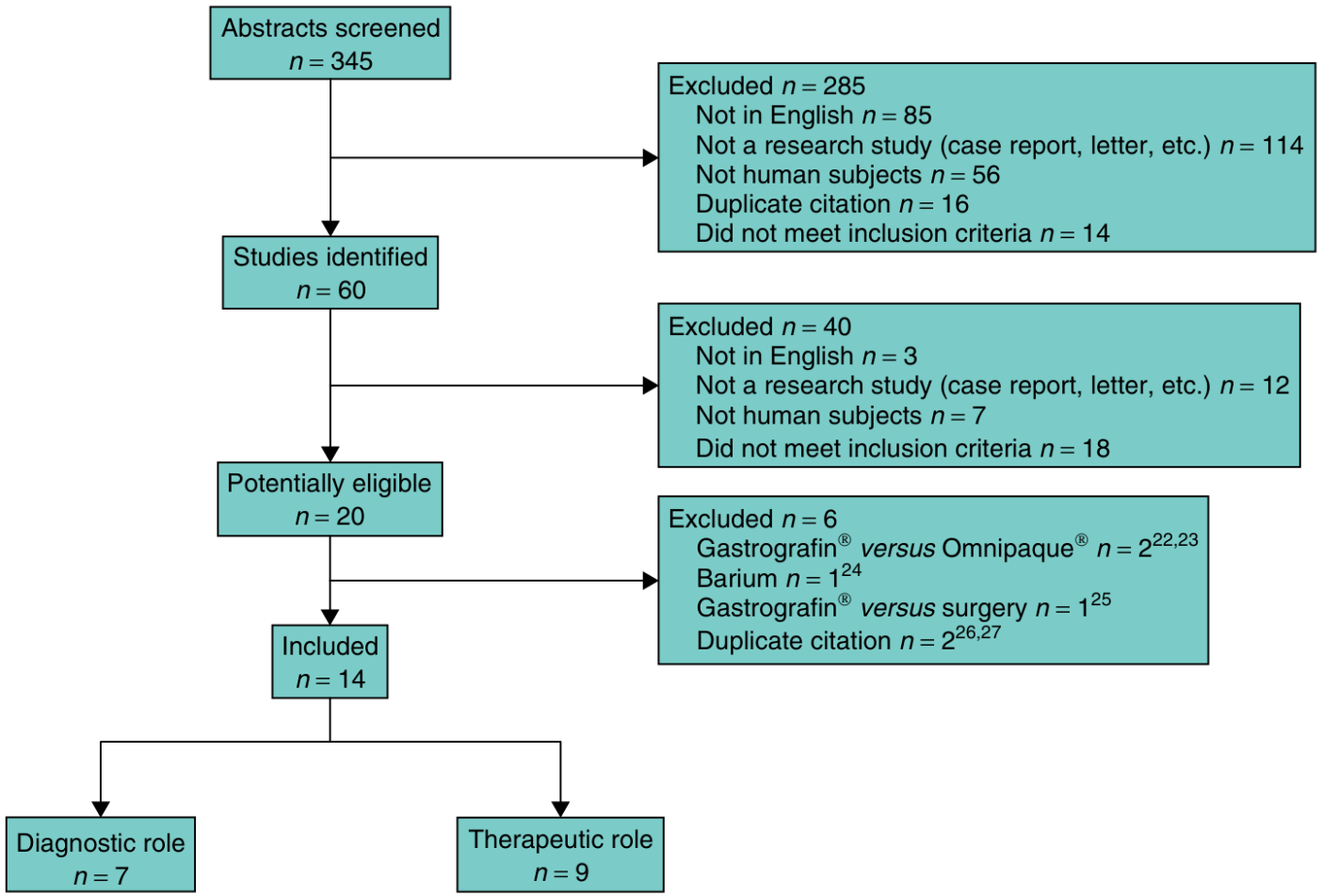

Fig. 1 Study outline. Studies by Biondo and colleagues[7] and Farid and co-workers[8] were analysed in both diagnostic and therapeutic roles

Diagnostic role of water-soluble contrast agent

Seven studies with a total of 508 patients were included[3–9]. The presence of WSCA in the colon predicted resolution of SBO with 96 (95 per cent c.i. 95 to 97) per cent sensitivity and 98 (94 to 99) per cent specificity. PPV and NPV were 99 (98 to 100) and 90 (85 to 95) per cent respectively. The positive and negative likelihood ratios were 40·14 (13·12 to 112·80) and 0·04 (0·02 to 0·07) respectively (*Table 2*). There were no differences in sensitivity, specificity, PPV, NPV, and positive and negative likelihood ratios where the timing of radiography was 4–8 h or 24 h (*Table 3*).

Therapeutic role of water-soluble contrast agent

Resolution of small bowel obstruction without surgery

All nine studies with a total of 765 patients examined the impact of WSCA on the resolution of adhesive SBO[7,8,10–16]. One study was excluded from meta-analysis because of a protocol violation[14]; seven patients who had persistent signs of SBO after 48 h of conservative treatment were not operated on, contrary to the study protocol. A significant reduction in the need for surgery was observed with the administration of WSCA compared with conventional treatment: 76 (20·8 per cent) of 366 *versus* 106 (29·6 per cent) of 358 (pooled OR 0·62, 95 per cent c.i. 0·44 to 0·88; $P = 0·007$). The test for heterogeneity indicated that the studies were amenable to pooling ($P = 0·34$) (*Fig. 2*). The 95 per cent c.i. of the pooled OR was outside the zone of clinical indifference, thus establishing that WSCA had a significant effect with respect to this outcome measure.

Reference	Proportion needing surgery		Weight (%)	Odds ratio
	WSCA	Control		
Assalia *et al.*[16]	7 of 59	10 of 48	11·8	0·51 (0·18, 1·47)
Feigin *et al.*[12]	3 of 25	4 of 25	4·3	0·72 (0·14, 3·59)
Fevang *et al.*[13]	17 of 48	15 of 50	11·5	1·28 (0·55, 2·98)
Biondo *et al.*[7]	5 of 44	8 of 46	8·4	0·61 (0·18, 2·03)
Lee *et al.*[15]	25 of 75	29 of 75	23·4	0·79 (0·41, 1·55)
Burge *et al.*[10]	4 of 22	4 of 21	4·1	0·94 (0·20, 4·39)
Di Saverio *et al.*[11]	7 of 38	17 of 38	16·8	0·28 (0·10, 0·79)
Farid *et al.*[8]	8 of 55	19 of 55	19·7	0·32 (0·13, 0·82)
Total	75 of 366	106 of 358	100·0	0·62 (0·44, 0·88)

Heterogeneity: $\chi^2 = 7{\cdot}93$, 7 d.f., $P = 0{\cdot}34$; $I^2 = 12\%$
Test for overall effect: $Z = 2{\cdot}68$, $P = 0{\cdot}007$

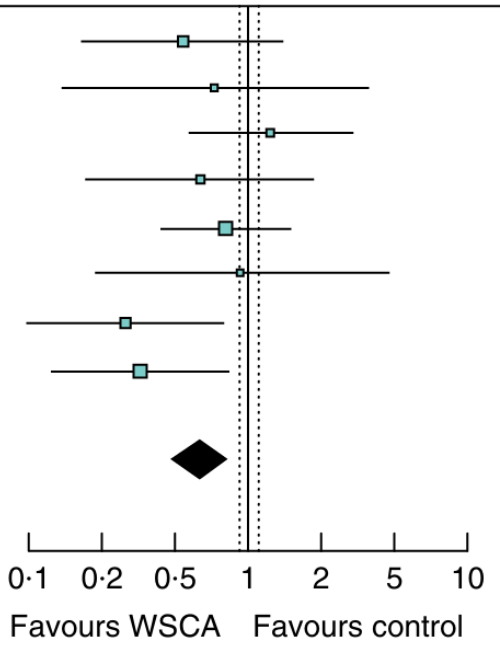

Fig. 2 Effect of water-soluble contrast agent (WSCA) on the need for surgery in patients with adhesive small bowel obstruction. Odds ratios are shown with 95 per cent confidence intervals. Dotted lines indicate the zone of clinical indifference

- 4, 8 og 24 timer
- Inkomplet tyndtarmsileus hvis kontrast i colon
- Komplet tyndtarmsileus hvis ingen kontrast i colon

Study characteristics

Studies examining the diagnostic role of WSCA employed 50–100 ml Gastrografin®[3–8] or 40 ml Urografin® (Schering)[9]. Abdominal plain radiographs were obtained after 4 h[3–5], 8 h[9] or 24 h[6–8]. Patients were considered to have partial SBO if the contrast reached the colon; if not, they were considered to have complete SBO. The decision whether or not to operate was based on the radiological findings.

- Kontrast i colon mellem 4-24 timer så vil ileustilstanden ophæves uden operation hos 99% af patienterne
- Meget accurat prediktor
- Cut off, 8 timer

SBO. If the contrast reaches the colon within 4–24 h after administration, obstruction will resolve without operation in 99 per cent of patients. On the other hand, if contrast does not reach the colon, the obstruction is unlikely to resolve without operation in 90 per cent of patients. The pooled sensitivity and specificity approached 100 per cent, indicating that WSCA is a very accurate predictor of non-operative resolution. Regarding the optimal cut-off for contrast reaching the colon, there appears to be no advantage in waiting longer than 8 h as the sensitivity, specificity, PPV and NPV were similar at 4–8 h and 24 h, although these were only two false negatives among 196 patients who had a 24-h delay, compared with 12 of 312 patients with a delay of 4–8 h.

- Ingen tegn på strangulation god evidens for at undlade operation
- God predictor for ikke kirurgisk behandling

For patients presenting with SBO without signs of strangulation, there is good evidence to support non-operative management. Level I data have shown that conservative treatment can be successful in up to 90 per cent of patients without peritonitis[16]. Less clear, however, is the way to predict between progression to strangulation or resolution of SBO. Several studies have investigated the diagnostic role of WSCA[3–9].

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- Begrænsninger
- Kun 3 RCT og ingen dobbelblinde

This review had some significant limitations. Seven studies[3–9] were included in the analysis of the diagnostic role of WSCA, only three of which were RCTs[4,7,8]. None was described as double blinded and none had a diagnostic standard against which WSCA could be evaluated. The eventual patient outcome (need for surgery and findings at laparotomy or non-operative resolution) was regarded as the standard against which the accuracy of WSCA as a diagnostic tool was evaluated.

- Diagnostiks
- terapeutisk

The results of this meta-analysis support both the diagnostic and therapeutic use of water-soluble contrast in patients with adhesive SBO. The presence of contrast in the colon within 4–24 h is predictive of resolution of obstruction. For patients undergoing non-operative management, water-soluble contrast decreased the need for surgery and reduced the length of hospital stay.

sumed by several authors,[3,14,34,39] high osmolarity, approximately 6 times that of extracellular fluid, increases the pressure gradient across an obstructive site, promotes shifting of fluid into the bowel lumen, decreases bowel edema, and enhances bowel motility leading to the resolution. The


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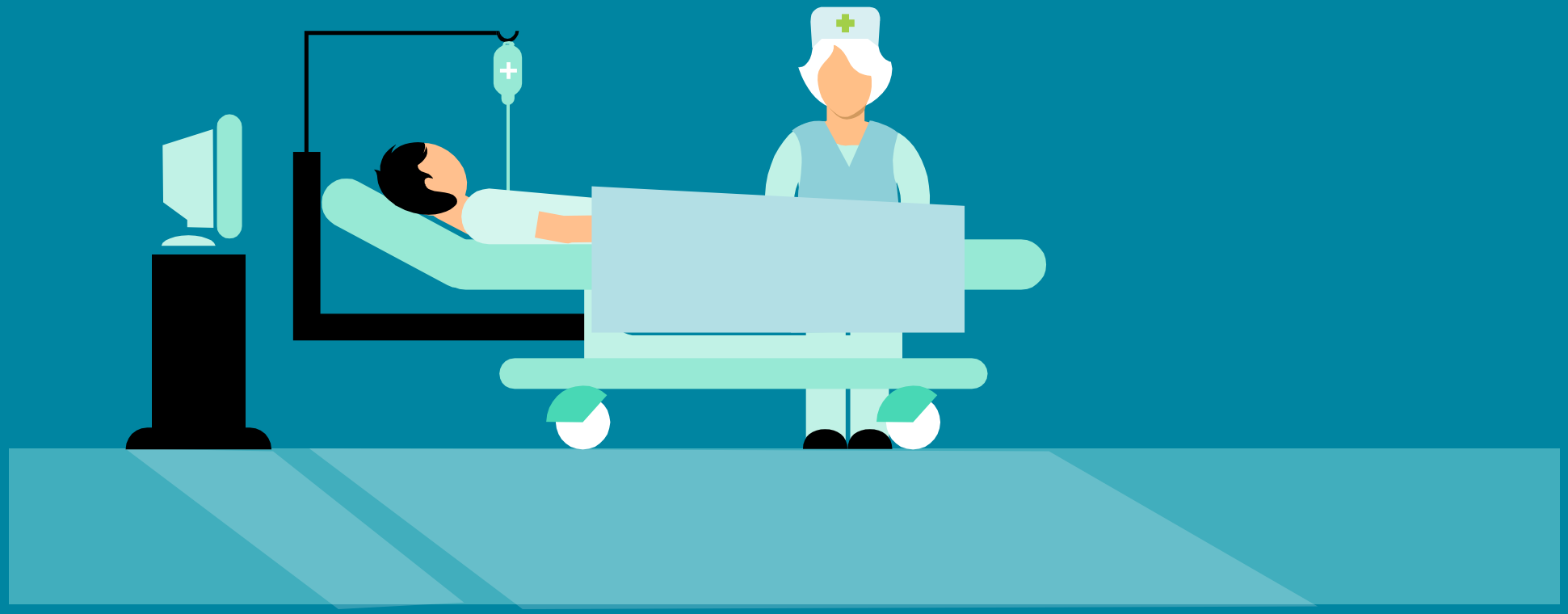
Tak – spørgsmål?



Non-strangulated adhesive small bowel obstruction: CT findings
predicting outcome of conservative treatment

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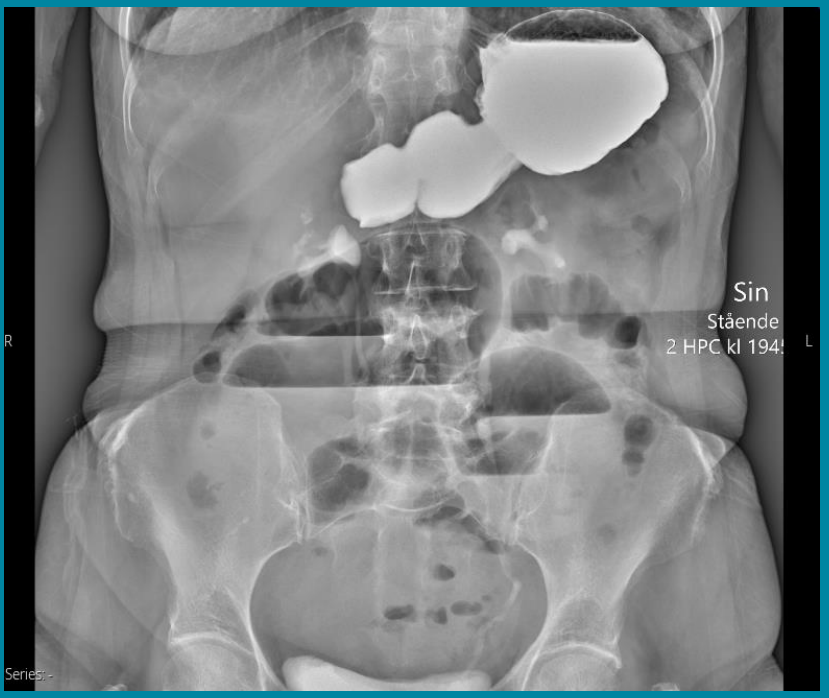
Conclusions: The lack of small bowel feces sign, focal, diffuse mesenteric haziness, and moderate amount of mesenteric fluid are independent CT findings predicting the failure of conservative treatment in patients with non-strangulated adhesive SBO. The combination of all CT findings suggests the need for surgery; absence of two or all CT findings should suggest an attempt for conservative treatment.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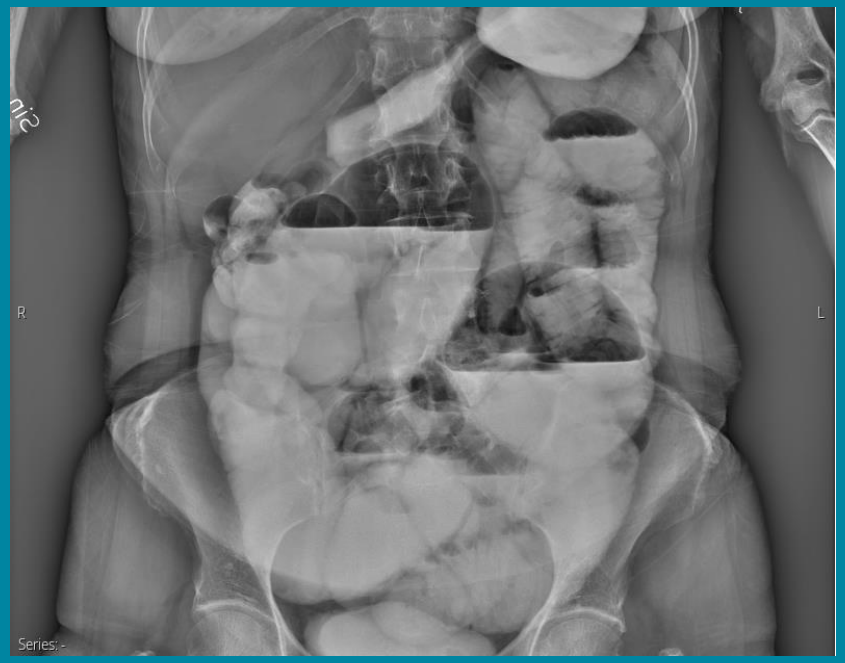
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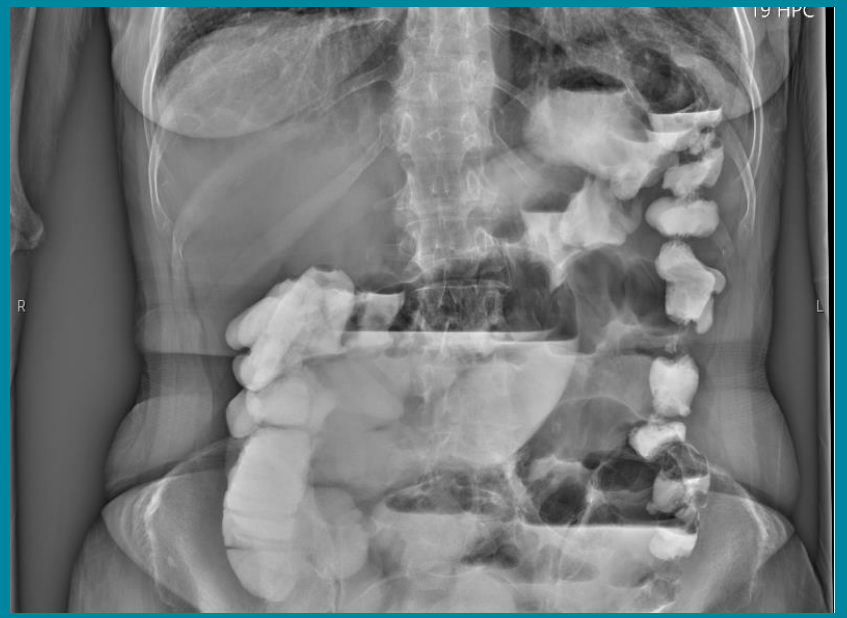
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Kirurgisk Uddannelse Holbæk