Caring for the patient with an intestinal obstruction


Summary

This article aims to increase your understanding of issues associated with intestinal obstruction, including the different causes of small bowel and large bowel obstruction, the treatments available and the best nursing management of patients with this condition.

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Introduction

The large and small bowel can become obstructed for several different reasons and the treatments for each type of obstruction generally require some form of surgery. In the UK, approximately 5 per cent of all acute surgical admissions relate to small bowel obstruction (Surgical Tutor 2005a), while 15 per cent of all colorectal cancers present as intestinal obstruction (Surgical Tutor 2005b). There are many different causative factors of intestinal obstruction. It is therefore important that surgical nurses have an understanding of this wide-ranging subject and the evidence-base required to ensure that patients are cared for not only empathetically, but also safely and effectively.

Anatomy and physiology

The gastrointestinal tract (GIT) has four main functions:

- Ingestion – in the mouth.
- Digestion – begins in the stomach.
- Absorption – in the small intestine.
- Elimination – via the large colon and anus.

The GIT (Figure 1) stretches from the mouth through the oesophagus, stomach, duodenum, jejunum, ileum, caecum, ascending colon,
transverse colon, descending colon, sigmoid colon and rectum to the anus. The GIT also has associated digestive organs such as the liver, pancreas and biliary tree. The blood supply to the GIT originates from branches of the aorta and is supplied by the inferior and superior mesenteric arteries, as well as the rectal and internal iliac arteries (Brooker 1998, Clancy and McVicar 2002).

The structure of the GIT is constant throughout the gut and is made up of four layers. The outer layer – the serosa – attaches the gut to the mesentery, which ensures its blood supply. The second layer – the muscularis – is the muscular layer that ensures that food and waste are passed throughout the GIT with the movement of peristalsis. The third layer – the submucosa – attaches the muscularis to the mucosa which is the inner layer. The mucosa contains microvilli, which are extensions of the enterocytes of the gut. These are associated with the absorption of nutrients that have started to be chemically broken down in the early process of ingestion. Digestion of food begins to occur within the mouth not only through mastication of food but also through the action of salivary amylase, which begins to break down the starches in carbohydrates. The food combines with saliva to form a soft mass called a bolus, which is easy to swallow (Brooker 1998, Clancy and McVicar 2002).

From the mouth the bolus then passes through the oesophagus and into the stomach where further physical and chemical breakdown of the food occurs. The stomach churns the food and mixes it with gastric juice to form chyme. In the stomach hydrochloric acid is released, which helps to destroy bacteria. Pepsinogen is also produced which, in the optimal pH provided by hydrochloric acid, breaks down proteins to pepsin so they can be absorbed through the microvilli of the small intestine. Intrinsic factor, which is necessary for the absorption of vitamin B12, is also produced in the stomach. Here the chyme is mixed with water to further liquefy the food that has been ingested, preparing it for further chemical breakdown and absorption in the small intestine (Brooker 1998, Clancy and McVicar 2002).

The small intestine includes the duodenum, jejunum and ileum and in this part of the intestine faeces is liquid. It is not until it passes through the ileo-caecal valve at the beginning of the large bowel that water is absorbed and the faeces becomes formed. Therefore, any obstruction occurring within the small bowel can be associated with large pools of intra-abdominal fluid, which can easily be seen on plain X-ray films (Merck 2005).

The majority of nutrient absorption occurs at the distal end of the ileum through the microvilli, which allow proteins and carbohydrates to pass through the epithelial cells and into the capillaries while fats are absorbed into the milky white lacteals, which are lymphatic capillaries found in the villi of the small intestine mucosa (Tortora and Grabowski 2000). However, it is the action of peristalsis that moves the bowel contents along the GIT. Peristalsis is not a continuous movement, but occurs in response to the gastro-colic reflex when food or fluids are ingested (Brooker 1998, Clancy and McVicar 2002).
Intestinal obstruction

Intestinal obstruction can be classified into obstruction of the large and small bowel, and can be further subdivided into mechanical, vascular, neurogenic and pseudo-obstruction (Box 1) (Springhouse Publishers 1988, Surgical Tutor 2005c). Each type of obstruction is caused by narrowing of the intestinal lumen or failure of gut motility and can be either simple (where there is no interference in the blood supply), or strangulating (where the blood supply is interrupted leading to necrosis of the gut tissue) (Merck 2005). Because of the anatomy and physiology of the gut, this can cause complex problems for patients from generalised abdominal pain, vomiting and dehydration to perforation of the bowel leading to peritonitis, sepsis, surgical emergency or even death (Springhouse Publishers 1988).

The specific causes of intestinal obstruction are varied and relate largely to the level of the obstruction (Merck 2005). In the small bowel, the most common causes of obstruction are: adhesions caused by previous surgical intervention, where two surfaces bind together as a result of the inflammatory process; hernias causing constriction of an intestinal loop after it protrudes through the abdominal wall; Crohn’s disease; malignancies; Meckel’s diverticulum where there has been an incomplete closure of the embryo duct which leaves a protruding sac from the wall of the ileum; and intussusception where the bowel telescopes into itself (Miller et al 2000, Hallett 2003, Merck 2005, Surgical Tutor 2005a). However, in tropical countries, obstruction of the small bowel can also be associated with ascariasis – a parasitic infection that can be transmitted via the soil and which has been suggested to affect one in four of the world’s population (Costello and Keenan 2001, Crompton 2001).

In the large bowel, obstructions are usually caused by: tumours; constipation; diverticula – pocket-like protrusions through the muscularis; and volvulus characterised by a 180 degree twist of the bowel lumen, causing strangulation of the blood supply. Volvulus most frequently occurs in the sigmoid colon and the caecum (Merck 2005). Approximately 15 per cent of all large bowel obstructions are associated with colorectal cancers (Surgical Tutor 2005b). It is documented that large bowel obstructions are associated with a high mortality rate (Biondo et al 2004).

**Presenting symptoms**

The patient with small or large bowel obstruction has similar symptoms when presenting for treatment. Pain is a general feature of any patient presenting with an acute abdomen, which is the term used to describe the syndrome of sudden onset abdominal pain. However, the intensity of the pain will differ with each individual patient, as will the area of the abdomen affected. In small bowel obstruction pain is often felt around the umbilical or epigastric areas of the abdomen (Merck 2005). In the small bowel, the most common causes of obstruction are: adhesions caused by previous surgical intervention, where two surfaces bind together as

### BOX 1

**Types of intestinal obstruction**

<table>
<thead>
<tr>
<th>Type of obstruction</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical</td>
<td>Stenosis, herniation, tumours, ingestion of foreign objects, intussusception, adhesions, Hirschsprung’s disease, volvulus, constipation</td>
</tr>
<tr>
<td>Vascular</td>
<td>Embolus, telangiectasia (Osler-Weber-Rendu’s syndrome)</td>
</tr>
<tr>
<td>Neurogenic</td>
<td>Abdominal trauma, chemotherapy, electrolyte imbalance, paralytic ileus</td>
</tr>
<tr>
<td>Pseudo-obstruction</td>
<td>Abdominal malignancy, chest infection, myocardial infarction, cerebrovascular accident, renal failure, puerperium, electrolyte disturbances</td>
</tr>
</tbody>
</table>

(Ogilvie’s syndrome) (Springhouse Publishers 1988, Merck 2005, Surgical Tutor 2005a, 2005b, 2005c)
distressing. If patients with large bowel obstruction delay seeking medical intervention, absolute constipation and distension will occur which will increase pain levels (Merck 2005, Surgical Tutor 2005b).

Although vomiting is also a feature of this pathophysiology, small bowel obstruction has a tendency to cause profuse vomiting, especially if the obstruction is at a high level. This is because of the higher fluid levels associated with the small bowel as the majority of fluid is absorbed as it passes through the ileo-caecal valve (Brooker 1998). Patients with a large bowel obstruction may also experience vomiting, this is often seen at a late stage within the disease process and is often characterised by faecal vomit (Springhouse Publishers 1988).

Other generalised symptoms related to both small and large bowel obstructions include lethargy, oliguria and dehydration as fluid intake is often minimal because of nausea. In large bowel obstruction there is often marked abdominal distension, while peritonitis can indicate strangulation or perforation (Surgical Tutor 2005a, 2005b).

**Diagnosis**

Clinical examination (Figure 2) will take into account the clinical presentation of the patient while blood results can give an indication of the biochemical status. Blood samples will be taken to measure haemoglobin and the white cell count (WCC). A raised WCC can be an indicator of infection which can suggest perforation or even ensuing sepsis and possible bacterial translocation as the gut becomes so distended that the bowel contents are able to pass through its membranes (Sagar et al 1995, Bratt-Wyton 1998). Blood is also taken for urea and electrolytes, and C-reactive protein (CRP) to determine renal function and the inflammatory process. In the likelihood of surgical intervention, group and save – where a blood sample is taken to determine the patient’s blood group – and a cross-match are performed. In obstructions where the vascular supply is altered, raised serum lactate levels can be an indicator of ischaemia (Kumar et al 2003). This has been found to be a good marker in some instances where CRP levels, abdominal distension and signs of peritonitis have either been normal or within acceptable limits (Muraki et al 2003).

Diagnosis of small and large bowel obstruction is generally made through plain supine abdominal X-rays. However, there is some debate about the value of the erect film as an aid to diagnosis within this country, while in other countries the erect plain abdominal film is still used (Merck 2005, Surgical Tutor 2005a, 2005b).

In small and large bowel obstruction, X-rays can determine the level of the obstruction and display a dilated bowel. Yet in instances where the diagnosis or level of obstruction in the large bowel cannot be determined by plain films, a contrast enema may be performed (Surgical Tutor 2005b). However, there is much debate as to the best radiological method of diagnosing intestinal obstruction. While plain films are a standard and cheaper method of diagnosis, studies by Suri et al (1999) suggest that ultrasonography and computed tomography (CT) scans are more accurate in determining the level and cause of intestinal obstruction. A study by Walling (2002) identified that the use of magnetic resonance imaging (MRI) scanning was more accurate in determining the site of the obstruction. The associated cost and time implications need to be taken into consideration against the need for exact diagnosis.

**Time out 4**

Consider the symptoms you identified in Time out 3. Perhaps some of these symptoms are similar to other conditions associated with an acute abdomen? What differentiates bowel obstruction from other conditions? Take a moment to consider how it is diagnosed.

**Time out 5**

Think about the patients you have nursed with bowel obstructions. Go back to those causative factors you identified in Time out 2 and make a mental note of the outcomes of surgery for these patients and the medical treatment they received.

**FIGURE 2**

Areas of the abdomen

- Epigastric region
- Right hypochondriac region
- Right lumbar region
- Umbilical region
- Right iliac region
- Hypogastric region
- Midpoint of inguinal ligament

**NURSING STANDARD**
**Medical management**

**Small bowel obstruction** Fluid resuscitation is often necessary for patients presenting with a small bowel obstruction. Many patients can be severely dehydrated and in some instances it is necessary to give up to five litres of intravenous fluids to restore hydration adequately and achieve a satisfactory urine output >0.5ml/kg/hr (Adam and Osbourne 1997, Surgical Tutor 2005a). This assists in the preparation of the patient for surgical intervention as patients who undergo surgery when dehydrated have a greater mortality rate (Biondo et al 2004, Surgical Tutor 2005a).

Surgeons and anaesthetists prefer the patient to be haemodynamically stable and, if necessary, will delay surgery. However, it should be noted that it is sometimes necessary for surgical intervention at an earlier stage, especially where peritonitis and sepsis occur (Merck 2005, Surgical Tutor 2005a). A study by Fevang et al (2002) found that the majority of patients with a partial small bowel obstruction could be managed conservatively; the exceptions are those with clinical signs of an interrupted vascular supply. Conservative treatment is considered acceptable where adhesions are thought to be the cause of the obstruction, and will include fluid resuscitation, nil-by-mouth status, nasogastric tube to reduce the incidence of vomiting, appropriate pain relief and antiemetics (Fevang et al 2002, Ryan et al 2004). However, for many patients whose symptoms do not resolve, surgery is necessary to divide the adhesions (Hallett 2003).

Although the exact surgical procedure depends on the cause, many patients with a small bowel obstruction will undergo a small bowel resection and anastomosis, with the exception of those patients presenting with a simple Meckel’s diverticulum. Here the diverticulum is excised while the bowel is left on its mesentry (McLatchie and Leaper 2001).

Although open surgery is the traditional method of dealing with small bowel obstructions, Suter et al (2000) suggested that laparoscopic surgery is a viable alternative as 60 per cent of cases chosen for laparoscopic surgery are successful. This has implications for the healthcare system as laparoscopic surgery decreases the length of stay in hospital as normal diet and mobility are resumed faster and discharge occurs earlier (Suter et al 2000).

As any operation on the small bowel carries with it a risk of forming adhesions, the risk of readmission with a small bowel obstruction is increased (Ryan et al 2004). Gutt et al (2004) showed that there is a reduced risk of forming adhesions after laparoscopic surgery. Schindler (2004) suggests that treatment with a gonadotropin-releasing hormone agonist can reduce the inflammation in the post-operative period which can lead to adhesions. However, for this to be effective, patients need to receive treatment for two to three months pre- and post-operatively, which would not be possible with emergency surgery. Shafik (2002) identifies the possibility of using liquid paraffin to reduce the risk of adhesions following a small-scale experimental study on rats. There were no associated complications found with the use of liquid paraffin in this study.

**Large bowel obstruction** As with obstruction of the small bowel, fluid resuscitation is essential to ensure the patient is haemodynamically stable, with the administration of pre-operative prophylactic antibiotics to help prevent peritonitis after surgery. As many large bowel obstructions are caused by tumours, medical staff should discuss the possibility of colostomy formation before surgery and in some instances, where possible, patients should be marked for an appropriate stoma site (Hallett 2003).

The surgical intervention for large bowel obstruction depends on the level and cause of the obstruction. In cases of perforation or bleeding caused by the presence of a diverticulum in the large bowel, resection and anastomosis will be sufficient. However, for malignant obstructions that affect the caecum and ascending colon, a right hemicolecotomy is performed: an extended right hemicolectomy can be used for malignancies affecting the transverse colon, while a left hemicolecotomy is used for malignancies of the left colon or severe diverticulitis (McLatchie and Leaper 2001).

If a colostomy is performed because of obstruction there are two options for the surgeon:

- A loop or defunctioning colostomy where a loop of the bowel is used as the stoma and the remaining gut stays in situ – this acts as a temporary measure when it is not possible to resect and anastomose distally.

- If there is a distal perforation or sepsis, a Hartmann’s procedure can be performed. This is where the colon is resected and anastomosed and a temporary or permanent colostomy created using the remaining bowel. This is primarily a palliative measure for cancer but can be used in an emergency situation for obstruction or perforation, or where the viability of the anastomosis is doubtful because of a possible impaired blood supply (McLatchie and Leaper 2001).
There are disadvantages with both of these procedures. Patients may find the defunctioning or loop colostomy difficult to manage as it is high on the right side of the abdominal wall. With the Hartmann’s procedure 40 per cent of stomas will remain in situ because of the poor viability of the bowel (Surgical Tutor 2005b).

Endoluminal stenting – where a metal tube is placed in the bowel at the level of the blockage to keep the lumen open – has proved to be useful in palliative instances for patients with a large bowel obstruction (Seymour et al 2002). In addition, endoluminal stents may be beneficial for the relief of large bowel obstruction before surgical intervention (Cole et al 2000). This means the medical team is able to optimise the patient nutritionally and haemodynamically before surgery, thus reducing the risk of associated mortality (Cole et al 2000). The risk of peritonitis and wound infection is also reduced as the bowel can be prepared effectively. This method therefore may lead to reduced costs (Ramesh et al 1999, Cole et al 2000).

While it would seem a logical course of action to administer enemas or suppositories to patients with bowel obstructions, this is absolutely contraindicated because of a risk of perforation (Reid et al 2001). Laxatives are avoided for the same reason.

Patient care

When nursing a patient with a bowel obstruction, a full assessment of his or her needs is required, not only taking into account the patient’s physical and safety needs, but also dealing with any potential psychological needs that the patient may be experiencing. All patients react differently to the psychological aspects of being acutely ill, but when caring for patients with bowel obstructions nurses need to be aware of the added potential for psychological problems associated with altered body image pre- and post-operatively.

Caring for this group of patients takes a great deal of nursing skill, not only in the technical aspects of pre- and post-operative care but also in being empathic towards the needs of the patient. Using a holistic model of care can provide the patient with a good experience of recovery.

The important factors to consider when caring for patients with a bowel obstruction are the presentation of symptoms and the potential outcome of surgery such as: vital signs; pain; dehydration and fluid and electrolyte balance; nausea and vomiting; and altered body image.

Vital signs

Patients with bowel obstruction are likely to exhibit signs of hypovolaemic shock as it becomes increasingly difficult to maintain homeostasis because of dehydration caused by nausea and vomiting and the shift of fluid into the bowel. Not all patients become septic as a result of obstruction. Many are treated early enough to avoid it but it can happen as a result of paralytic ileus and sepsis. Nurses need to monitor vital signs closely and respond appropriately to changes in the following (Hicks-Keen and Swearingen 1997, Collins 2000, Jevon and Ewens 2002, Anderson 2003):

- Temperature – this can denote deterioration or aggravation of the inflammatory process leading to sepsis. This can be as a result of perforation of the bowel.
- Pulse – tachycardia in this instance can be linked to the compensatory mechanism associated with hypovolaemia as the heart attempts to circulate the lower blood volume and is also associated with sepsis.
- Respiration – this is increased as the heart and lungs work together to oxygenate the small volume of circulating blood and remove excess carbon dioxide from the blood. Acidosis may develop.
- Blood pressure – there will be hypotension related to the low circulatory volume.
- Oxygen saturation – to monitor the amount of oxygen binding to the haem. Oxygen therapy is usually necessary to ensure adequate oxygenation and tissue perfusion.
- Urine output – to ensure renal perfusion is maintained. As hypovolaemia occurs, blood is diverted to the essential organs to ensure their continued perfusion. Blood pressure is linked to this and increasing the circulatory volume by adequate infusions of fluid will assist in improving blood pressure and will also perfuse the kidneys and encourage urine output.
Learning zone: surgical nursing

- Increasing abdominal distension and pain – this can be a sign of peritonitis and perforation of the bowel demonstrating a deteriorating clinical condition.

For patients with a suspected bowel obstruction, the use of modified early warning system charts can be useful in rapidly recognising the deterioration of a patient’s condition (Subbe et al 2001).

Pain It is essential that good pain management is achieved to enable the patient to be prepared for surgery. The psychological implications of poorly treated pre-operative pain causes increased anxiety in patients, which makes pain difficult to manage in the post-operative period (Kitcatt 2003). It has long been documented that information reduces anxiety (Haywood 1975, Byshee 1988). Although adults expect to have some degree of pain associated with surgical intervention, intramuscular analgesia can be effective in the pre-operative period. However, there are peaks and troughs associated with this method of pain relief and prescriptions should reflect this and be written as regular analgesia to enable full effectiveness (Trounce and Gould 2000, Young 2000).

While intramuscular analgesia is easy to administer it can also have a psychological effect on patients in pain as they see the nurse’s intervention and expect pain to reduce as a result (Ballantyne et al 1993, Rawal 1998). However, it should also be noted that the effectiveness of this method can be reduced if the patient is hypovolaemic through dehydration. Hypovolaemia is known to cause an insufficiency in perfusion to the muscles, diminishing the ability of the analgesia to diffuse easily into the blood across the capillary membrane (Anderson 2003, Kitcatt 2003). A bolus effect can occur when adequate circulatory volume is achieved effectively giving the patient a bolus of the drug.

Several different preparations can be used to help treat pain during the pre-operative period. Opiates such as morphine are common preparations but it should be noted that morphine increases nausea and vomiting as it stimulates the chemoreceptor trigger zone in the brain (Jolley 2001). It is therefore important to use regular antiemetics. Morphine also has the advantage of slowing down gut motility (Trounce and Gould 2000, Jolley 2001). Hyoscine butylbromide can be useful in controlling the colicky, spasmodic-type pain associated with bowel obstruction as it encourages the smooth muscle to relax (Trounce and Gould 2000). Other preparations such as octreotide can also reduce the amount of fluid that enters the gut in bowel obstruction, thus helping to relieve some of the pain associated with abdominal distension (Caprio et al 2004).

Pain relief within the post-operative period is equally important. Poor analgesia has been shown to cause complications such as atelectasis, deep vein thrombosis and pressure ulcers as patients find it difficult to breathe deeply or mobilise because of the associated increase in pain levels that these activities cause (Kitcatt 2003). In the post-operative period patient-controlled analgesia or epidurals can be more useful in controlling pain than intramuscular analgesia because of the hypovolaemic effects that surgery can cause (Torrance and Serginson 2000).

Dehydration and fluid and electrolyte balance Correcting and maintaining fluid and electrolyte balance in patients with bowel obstruction is essential before surgery as it improves the patient’s outcome (Biondo et al 2004). During bowel obstruction, especially small bowel obstruction, fluid levels can quickly rise within the gut. This is because reduced peristalsis causes the bowel to dilate and rapidly lose its function of absorbing water and minerals, which in turn affects fluid and electrolyte balance (Torrance and Serginson 2000).

Hourly monitoring of fluid balance is an essential part of nursing care because diminished absorption of fluid can affect haemodynamic stability quickly and hypovolaemia can occur rapidly. Therefore, fluid replacement regimens should be started promptly to replace the losses from extracellular and intracellular spaces (Moore 2004).

The rate of infusions should be determined according to the patient’s fluid requirements which can be assessed from central venous pressure measurement, urine output or from the interpretation of blood results (Fanning 2000). However, not all patients will require central venous pressure monitoring and urine output can provide a valuable indication of fluid balance in patients who would be expected to have a general healthy renal function (Anderson 2003). When optimising fluid balance, the minimum urine output should be >0.5ml/kg/hr to ensure perfusion of the renal system (Adam and Osbourne 1997).

In the dehydrated patient, this will be seen as concentrated urine as the pituitary gland releases antidiuretic hormone in an attempt to preserve fluid levels and restore homeostasis through reabsorption of water in the renal tubules (Clancy and McVicar 2002, Carroll 2003).

Although the interpretation of blood results provides a more accurate analysis of fluid and electrolyte balance, the accurate measurement of input and output provides an ongoing evaluation of fluid balance. When caring for patients with bowel obstruction, blood results provide the basis of the fluid replacement regimen. Therefore, it is useful for nurses to consider the interpretation of blood results as a multi-professional team role and not just the role of medical staff – in the majority of cases nurses will have access to blood
results first. As a simple method of determining the hydration levels of a patient, nurses need to be able to identify the normal range for urea and electrolyte results and then consider the physiological aspects to hypovolaemia.

In hypovolaemia the normal circulatory volume is reduced, which leads to the blood being more concentrated in terms of the measurement of its products. Therefore, interpretation of blood results in relation to fluid balance can show that when a patient’s urea and electrolyte results are raised, and when read in conjunction with the haematocrit, the blood is concentrated and the patient is hypovolaemic or dehydrated (Heitz and Horne 2001). **Nausea and vomiting** As the gut distends, the stomach and pancreas continue to produce their digestive juices. Inserting a nasogastric tube helps to decompress the stomach and reduce the risk of a faecal vomit which can be extremely distressing for the patient (Torrance and Serginson 2000). Faecal vomits occur because of the build-up of bowel contents as the lumen of the gut stops functioning. As the contents cannot pass beyond the obstruction, they take the path of least resistance and exit via the mouth (Springhouse Publishers 1988). Regular aspiration of the nasogastric tube can assist in reducing the risk of this occurring.

The experience of nausea and vomiting can be compounded by the fact that many patients with bowel obstructions are given opiates as a method of pain relief. Opiates act on the chemoreceptor trigger zone to cause nausea and vomiting as they act centrally on the chemoreceptor trigger zone and the vomiting centre. Opiates act on the vomiting centre via the chemoreceptor trigger zone to cause nausea and antiemetics act on the chemoreceptor trigger zone and/or vomiting centre to block the neurotransmitters (Trounce and Gould 2000).

**References**


**Time out 8**

Think about patients you have nursed who you feel may have experienced alteration in their perceived body image. How did they react to this change? Consider the behaviour they exhibited. Why do you think they responded in this way? Identify how you can help patients to cope with this difficult experience.
learning zone surgical nursing

Altered body image  Perceptions of altered body image and responses to illness and surgery will differ between individuals. For some patients the experience of having a nasogastric tube in situ can be distressing, while others are alarmed at the concept of scars or the formation of a stoma. It is the nurse’s role, by developing a therapeutic relationship and using good communication skills, to help patients and families come to terms with perceived changes in body image.

Patients who experience these difficulties may exhibit different types of behaviour. Wright (1986) suggests that where motivation is poor patients may become passive in their care. In addition patients may: be in denial of the problem and refuse to acknowledge the change in their body; continually seek reassurance that they are acceptable to others; isolate themselves because of fears of rejection; and exhibit hostility and anger associated with loss – this is often directed against doctors and nurses.

Good communication with patients’ families is important. The nurse needs to identify the patient’s own coping strategies and arrange counselling to help patients come to terms with their loss. Self-help groups can also be useful for patients who have had stomas formed as they can help them to realise that it is possible for them to lead a normal active life following such surgery.

Conclusion

Nursing patients with bowel obstructions can be complex, and ranges from caring for patients in the pre-operative phase of their hospital admission to counselling in the post-operative period. Nurses need to be vigilant and observe for the signs of a deteriorating condition, recognising the signs and symptoms quickly while ensuring that patients are cared for empathetically. Patients need to receive adequate explanations of changes in their condition in order to help prevent anxiety. It should also be remembered that good communication skills will help prevent further anxiety in family members.

References continued


