

Original Research Article

ROLE OF GASTROGRAFIN IN ADHESIVE INTESTINAL OBSTRUCTION

ABSTRACT

OBJECTIVE: To determine the role of gastrografin in adhesive intestinal obstruction.

STUDY DESIGN: This is an observational study.

SETTING: Study carried out at General Surgery Department, Liaquat University of Medical and Health Sciences Jamshoro and Shaheed Benazir Bhutto Medical College, Lyari Karachi, from January 2020 to July 2021.

MATERIAL & METHOD: Patients having clinical and radiological signs evidence of adhesive bowel obstruction over the age of 18 years were selected for the study. One hundred milliliters of gastrografin were given via nasogastric tube and its transit was followed by serial abdominal radiographs and fluoroscopy.

RESULTS: In the time of 1 and half years, we received 53 patients with adhesive intestinal obstruction. It included 54.7% (n= 29) males and 45.2% (n=24) females with a mean age of 61 years. Out of 53 patients, 46 patients had a single previous abdominal surgery. After complete examination and investigations emergency laparotomy was performed in 15% (n=8) patients. Hence, out of total 53 patients, 27 patients fit into our criteria for gastrografin meal and follow through. Fluoroscopy revealed a partial obstruction in 19 patients and complete obstruction in 8 patients. After gastrografin follow through obstruction was relieved in 17 patients within the meantime of 63 hours (range 20-78h).

CONCLUSION: In our study, gastrografin is found to be of great diagnostic and therapeutic value, with fewer adverse effects. It also reduces the need for surgery, hence decreasing the financial burden of operative treatment. In Pakistan, its use is still limited because of a lack of equipment, expertise, and radiological imaging facilities.

KEY WORDS: Gastrografin, Intestinal obstruction, Diagnostic and therapeutic.

INTRODUCTION

Small bowel obstruction is a leading cause of surgical emergency and a major cause of morbidity and mortality. Worldwide, it has been seen as a significant financial burden on the healthcare system. The most common etiology of small bowel obstruction is adhesions because of previous abdominal surgery (1). The recurrence rate of small bowel obstruction because of adhesions is very high, and it depends on the type of procedure performed. Major surgical procedures have higher chances of adhesion formation, and they obstruct after approximately 10 years of surgery (2). Yearly small bowel obstruction alone results in 30,000 deaths and affects the quality of life (3). Recently, the algorithm of management of small bowel obstruction has changed because of the advancement in imaging by abdominal computed tomography (CT) scan and laparoscopic surgery (4). Laparoscopic surgery has reduced the formation of adhesions by 25% and the adhesion severity score has been lowered by 1.7 times (5). According to a study in Europe, the cost for non-operative treatment is 7 times less than surgical treatment (6). Non-surgical treatment for small bowel obstruction comprises bowel rest and nasogastric decompression in patients without strangulation. Strangulation can be ruled out by the help of an abdominal CT scan, as ischemia only occurs in 20% of cases of small bowel obstruction (7). Gastrografin is an ionic bitter flavored contrast containing sodium diatrizoate and meglumine diatrizoate, having an osmolarity of 1900 mOsm/L. (8). Water-soluble contrast medium gastrografin has been used for small bowel obstruction recently, and its therapeutic effect has been evaluated. The efficacy of gastrografin in patients with no response to conservative treatment is being studied in various randomized controlled trials these days. If there is no sign of strangulation on the CT scan and no danger signs, then conservative treatment is used for small bowel obstruction. Conservative treatment is usually implied for 48 hours, and the patient is evaluated for clinical and radiological improvement (9). Using gastrografin is implied when there is no improvement after 48 hours to look for a degree of intestinal obstruction. Gastrografin is an oral water-soluble contrast agent administered via NG tube and its transit time to the large intestine is noted by serial abdominal radiographs. The appearance of contrast in the large intestine suggests partial obstruction and continuation of conservative treatment. Surgery is only required for cases with no clinical and radiological improvement after 48 hours and administration of gastrografin shows complete obstruction (10). The mode of action of gastrografin in intestinal obstruction is not known. The only probable explanation found is because of its high osmolality, it allows the shifting of fluid into the bowel lumen, decreasing edema and diluting bowel content for easy passage. As described above, it also aids in the need's evaluation for surgery in bowel obstruction(11). Our study aims to evaluate the diagnostic and therapeutic value of gastrografin in adhesive intestinal obstruction.

MATERIAL & METHOD:

This study was carried out at the General Surgery Department, Liaquat University of Medical and Health Sciences Jamshoro and Shaheed Benazir Bhutto Medical College, Lyari Karachi, from January 2020 to July 2021. In this study, we selected patients visiting the emergency

department and after being evaluated shifted to the department of general surgery. Patients having clinical and radiological signs evidence of adhesive bowel obstruction over the age of 18 years were selected for the study. A detailed history, especially regarding previous surgeries and physical examination, was carried out. Patients having previous abdominal malignancy, history of abdominal radiation, signs of bowel strangulation, and early postoperative obstruction were excluded from the study. Abdominal radiographs were taken, and nasogastric decompression was performed. Intravenous fluid resuscitation and conservative treatment were started in most patients. Patients having no clinical and radiological improvement with conservative management for 48 hours were given gastrografin via a nasogastric tube. One hundred milliliters of gastrografin were given via nasogastric tube and its transit was followed by serial abdominal radiographs and fluoroscopy. Gastrografin presence in the large intestine after 24 hours showed partial obstruction and conservative management was continued. Those patients with no contrast in the large intestine even after 24 hours were treated by laparotomy. Complete resolution of bowel obstruction was established when signs and symptoms of obstruction were alleviated and no bowel dilation on X-ray. In this study, we observed the percentage of patients requiring surgery after gastrografin administration, complications, and mortality with adhesive bowel obstruction. Data were collected prospectively and entered SPSS for analysis.

RESULTS:

In the time of 1 and half years, we received 53 patients with adhesive intestinal obstruction. It included 54.7% (n= 29) males and 45.2% (n=24) females with a mean age of 61 years. Out of 53 patients, 46 patients had single previous abdominal surgery. Most of the patients had cholecystectomy, colorectal and gynecological surgeries done. In our study group, only 7 patients had a history of over one abdominal surgery, while no one had a previous history of intestinal obstruction. Patients were first encountered at the emergency department and then shifted to the surgical unit for further management. The meantime duration from entering the emergency to admission at the surgical unit was found to be 35 hours.

After complete examination and investigations, emergency laparotomy was performed in 15% (n=8) patients due to risk for strangulation, whereas the remaining 45(84.90%) patients were managed conservatively by nasogastric compression. There was clinical and radiological improvement found in 18(40%) patients within 48 hours of admission, so conservative management was continued in these patients (Table No.1). Hence out of total 53 patients, 27(60%) patients fit into our criteria for gastrografin meal and follow through. Fluoroscopy revealed partial obstruction in 19(70.37%) patients and complete obstruction in 8(29.62%) patients (Chart No.1). After gastrografin follow through obstruction was relieved in 17 patients within a mean time of 63 hours (range 20-78h). Laparotomy was performed in 10 patients who showed persistent obstruction after gastrografin meal and follow through.

The difference in patients responding to conservative treatment and operative treatment was found in a volume of nasogastric output. Patients with unsuccessful conservative treatment had

comparatively higher nasogastric output than patients with conservative management ($p= 0.001$). There were no differences because of variables like age, gender, and duration of symptoms.

DISCUSSION:

There is no specific standard protocol for adhesive small bowel obstruction management, and it is encountered frequently. The duration of conservative treatment is controversial, especially in patients with no signs and symptoms of strangulation. Hence, it depends on the case scenario whether or not to continue the conservative management (12). Cox et al. in their study reported that approximately 69% of adhesive obstructions are relieved by conservative management within a time interval of 48 hours. Based on such studies, it is recommended to at least continue conservative treatment for 48 hours. Recently, the use of gastrografin has been considered in the management of adhesive intestinal obstruction for diagnostic and therapeutic purposes. Gastrografin has an osmolarity of 1900mOsm/L which is six times the osmolarity of the blood, allowing shifting of fluid from the intracellular compartment to the bowel lumen increasing pressure on the obstructive site (13). It also makes the contents of the bowel dilute and decreases bowel wall edema, favoring the relief of obstruction and increasing intestinal motility (14). The appearance of contrast medium in the colon within 24 hours of administration signifies partial obstruction and delay in operative treatment can be done. Various studies have shown that 98% of cases of partial obstruction can be relieved by conservative treatment. Failure of gastrografin to reach the colon shows complete obstruction, which requires surgery in 80% of the cases. (15). A retrospective study in 2020 also concluded that gastrografin has a major therapeutic role in relieving adhesive small intestinal obstruction and refractory constipation. Compared to a CT scan, it is more effective and has a higher diagnostic value (82.5% vs 92.3%) (16). The UK national audit recommends the use of gastrografin after 48 hours of conservative treatment and operative treatment after 24 hours of gastrografin administration and no improvement (17). In our study, 62.96% of partial obstructions were relieved by gastrografin meal and follow-through in a mean duration of 63 hours. Adverse effects of this contrast medium and mortality is rare when administered correctly. Aspiration pneumonia is a complication due to gastrografin administration but it can be eliminated by gastric decompression prior. Dehydration can also occur in individuals because of the shifting of fluid into the bowel lumen if intravenous rehydration is not continued simultaneously (18). Some rare complications like gastritis,

hemorrhage into the GI tract, pneumonitis, pulmonary edema have also been reported but their chances are less than 1% (19).

CONCLUSION:

In our study gastrografin is found to be of great diagnostic and therapeutic value with fewer adverse effects. It also reduces the need for surgery, hence decreasing the financial burden of operative treatment. In Pakistan its use is still limited due to lack of equipment, expertise, and radiological imaging facility.

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Table No.1
Demographic Variable
N=53

Variable	No. Patients	Percentage
Gender		
• Male	29	54.7%
• Female	24	45.2%
Management		
• Emergency laparotomy	8	22.22%
• Conservatively	45	38.88%
Conservatively Management N=45		
• Improvement found	18	40%
• For gastrografin	27	60%

Chart No.1
GASTROGRAFIN RESULT
N=27

