

# Diagnostic Imaging Pathways - Bowel Obstruction (Suspected)

## Population Covered By The Guidance

This pathway provides guidance for imaging adult patients with suspected bowel obstruction, including the roles of plain abdominal radiography and more advanced imaging.

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**Date of next review: December 2021**

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## Quick User Guide

Move the mouse cursor over the **PINK** text boxes inside the flow chart to bring up a pop up box with salient points.

Clicking on the **PINK** text box will bring up the full text.

The relative radiation level (RRL) of each imaging investigation is displayed in the pop up box.

SYMBOL	RRL	EFFECTIVE DOSE RANGE
	None	0
	Minimal	< 1 millisieverts
	Low	1-5 mSv
	Medium	5-10 mSv
	High	>10 mSv

## Pathway Diagram



**SUSPECTED BOWEL OBSTRUCTION**

Date reviewed: December 2018  
 Please note that this pathway is subject to review and revision

Plain radiography (AXR)

Further imaging may not be required if the patient requires urgent surgery, or if the patient is known to have adhesive obstruction and is to be managed conservatively. Indications for further imaging include:

- Uncertainty of diagnosis of SBO
- Patient not improving with conservative treatment
- Clinical concern, e.g. For perforation or bowel ischaemia

If acute 'high grade' symptoms

CT  
 Gastrografin + repeat AXR

If non-acute 'low grade' symptoms

CT or MR enteroclysis or enterography  
 Fluoroscopic SBFT or enteroclysis

Strong suspicion of small bowel obstruction

Strong suspicion of large bowel obstruction

If signs of volvulus

CT

Surgical / Colonoscopic / Radiological detorsion

Likely obstructing lesion or suspected complicated diverticulitis

CT

Strong suspicion of paralytic ileus or pseudo-obstruction

No imaging

Or in some circumstances to exclude mechanical obstruction

CT

If uncertainty about the site of obstruction

CT ± enema contrast

## Image Gallery

*Note: These images open in a new page*

1a



### Small Bowel Obstruction

Image 1a (Plain radiograph, Supine view): Multiple dilated loops of small bowel.

1b



Image 1b (Plain radiograph, Erect view): Multiple dilated loops of small bowel with air-fluid levels and "string of pearls" sign indicating a mechanical small bowel obstruction.

2a



### Incarcerated Small Bowel Hernia

Image 2a (Plain radiograph): Multiple dilated loops of small bowel in the upper abdomen.

2b



Image 2b (Plain radiograph): Lower abdominal film showing increased density in the right obturator foramen.

2c

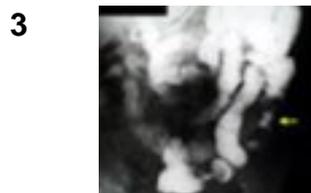


Image 2c (Computed Tomography): Coronal view of the same patient demonstrating an incarcerated small bowel. Dilated proximal loops of small bowel enter a large right inguinal hernia. The distal small bowel loop exiting the hernia is collapsed.

2d



Image 2d (Computed Tomography): Axial view showing the dilated small bowel loop in the right inguinal hernia (arrow).



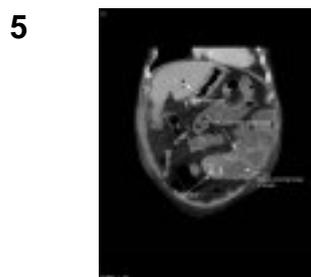
### Malignant Small Bowel Obstruction

Image 3 (Small bowel enteroclysis): Small bowel obstruction due to a serosal metastasis (arrow).



### Gallstone Ileus

Image 4 (Plain radiograph): Multiple loops of distended small bowel with air in the biliary tree (arrow).



### Gallstone Ileus

Image 5 (Computed Tomography): A large gallstone is impacted in the small bowel causing mechanical obstruction. Note air in the biliary tree.



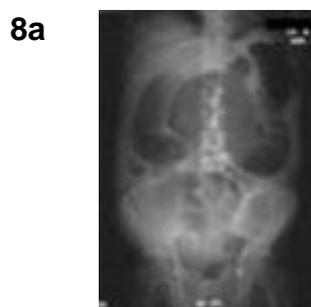
### Pneumoperitoneum

Image 6 (Plain radiograph): Perforated bowel and pneumoperitoneum. The intraabdominal gas outlines the liver edge, gallbladder and falciform ligament.



### Pneumoperitoneum

Image 7 (Plain radiograph, Lateral decubitus): Perforated bowel with pneumoperitoneum. The intraabdominal gas outlines the liver edge and chest wall.



### Large Bowel Obstruction

Image 8a (Plain radiograph): Distension of the caecum, ascending and transverse colon.

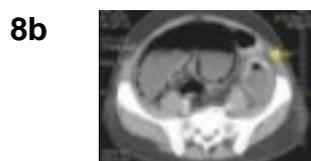


Image 8b (Computed Tomography): CT of the same patient showing marked caecal distension secondary to a constricting tumour (arrow).



### Colorectal Carcinoma



Image 9a: A right hemicolectomy showing a large, ulcerated and exophytic caecal adenocarcinoma.

9b



Image 9b (H&E, x2.5) and 9c (H&E, x10): Histological sections showing a moderately differentiated colorectal adenocarcinoma composed of malignant glands invading into the bowel wall (blue arrows). The glands are lined by cells showing marked nuclear atypia. Normal colonic mucosa is included for comparison (green arrow).

9c



10



### Caecal Volvulus

Image 10 (Plain radiograph): Markedly distended loop of large bowel from a caecal volvulus.

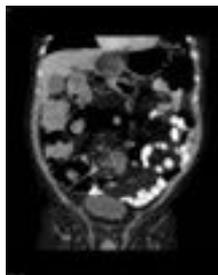
11



### Sigmoid Volvulus

Image 11 (Plain radiograph): Markedly dilated loop of large bowel. The dense white line between the limbs (arrow) points to the origin of the volvulus.

12



### Sigmoid Volvulus

Image 12 (Computed Tomography): Sigmoid volvulus with the classical "whirl" sign representing the twisted sigmoid mesentery (arrow).

## Teaching Points

- CT is generally the investigation of choice to diagnose bowel obstruction, the location, cause and complications
- Plain radiographs may miss low-grade obstruction and are rarely able to show the cause, however they are a fast, inexpensive and widely available investigation
- In low-grade small bowel obstruction or during relatively asymptomatic intervals between episodes of recurrent obstruction, the small bowel can be assessed with CT or MR enteroclysis or enterography. The small bowel is dilated with intraluminal contrast; areas of obstruction that may be missed on conventional CT are non-distendable and more easily identified

## Plain Radiography (AXR)

- Limited sensitivity and specificity for bowel obstruction, but remains widely used in the initial diagnostic evaluation due to widespread availability, low cost and ability to monitor disease progression [1](#)
- For small bowel obstruction, some studies report accuracy approaching 80-90%, [2,3](#) similar to CT, [4](#) while others reported AXR to be of little or no help; [5,6](#) one study found AXR to be misleading in 20-40% of patients [7](#)
- For large bowel obstruction, sensitivity has been reported as approximately 80% for detecting and predicting the level of large bowel obstruction [8,9](#)
- Erect AXR may be complementary to supine views but does not necessarily improve diagnostic accuracy [10](#)
- Even though AXR may be able to diagnose SBO and LBO, CT provides much more information about the site, cause and complications of SBO, so AXR is unlikely to be definitive
  - In suspected SBO patients, AXR may just prolong the evaluation period while adding radiation exposure [11,12](#)
- Except for inguinal hernias and gallstone ileus, AXR rarely identifies the cause of obstruction [13](#)
- Findings suggesting the diagnosis of small bowel obstruction include [4,13,14](#)
  - Distended loops of small bowel >3cm
  - Collapsed colon
  - Presence of >2 air fluid levels on erect AXR
  - The "string of pearls" sign resulting from the small amount of residual air compared with the large amount of retained fluid
- Limitations [1,4,15](#)
  - Unable to diagnose the cause of obstruction in most cases
  - Cannot reliably detect the presence of ischaemic complications
  - May miss early, proximal or partial/low grade obstruction
  - Difficult to differentiate between obstruction and ileus
  - In obstruction of ileocaecal region, it may be difficult to determine whether the level is in the proximal large bowel or distal ileum

## Computed Tomography (CT) in Evaluation of Small Bowel Obstruction (SBO)

- Preferred imaging modality for the diagnosis of bowel obstruction [1,15-17](#)
- In moderate or high grade obstruction, CT is normally performed with intravenous contrast but intraluminal contrast is not required
- 90-96% sensitivity for detection of acute high-grade obstruction, with specificity 96-100% [4,18-22](#)
- A number of CT findings are associated with the need for surgery [23](#)
- Useful in
  - Confirming or excluding small bowel obstruction (versus pseudo-obstruction) [4,18,19,24](#)
  - Defining the degree and site of obstruction, including the presence of closed loop obstruction [4,24-28](#)
  - Identifying the cause of small bowel obstruction (73-95% sensitivity) [4,19,21,22,25,27,29](#)
  - Confirming or excluding the diagnosis of ischaemia (approximately 60-90% sensitivity and up to 100% specificity) [24,28-33](#) or perforation
  - Ability to depict other causes of an acute abdomen
- Limitations
  - Lower sensitivity (approximately 50%) for the detection and location of low-grade small

bowel obstruction [4,20,22](#) – CT or MR enteroclysis or enterography may be advantageous in this situation

- Exposure to ionising radiation
- Iodinated contrast may be contraindicated with renal impairment or allergies, however SBO can still be assessed without contrast [34](#)

## CT Enterography and Enteroclysis

- Can be performed In low grade small bowel obstruction or during relatively asymptomatic intervals between episodes of recurrent obstruction
- Enteroclysis is performed by intubating the small bowel and infusing contrast material, essentially bypassing the stomach [13](#)
- By distending the small bowel, fixed or narrowed areas can be identified
- Enteroclysis can be an adjunct to CT; compared with CT, has high reliability for diagnosing or ruling out low-grade and intermittent obstructions [35](#)
- Can also detect multiple levels of obstruction [35](#)
- Main disadvantages are that enteroclysis is time consuming and uncomfortable for patients
- In enterography, patients ingest a large amount of fluid that fills the stomach and small bowel; the volume is limited by patient tolerance [36](#)
  - In enterography, patients ingest a large amount of fluid that fills the stomach and small bowel; the volume is limited by patient tolerance [36](#)
  - Although enteroclysis achieves better small bowel distension, it is not clearly superior to enterography [37](#)
- Enterography may be preferred if expertise to insert a nasojejunal tube is not available

## MR Enterography and Enteroclysis

- Can be performed in low grade small bowel obstruction or during relatively asymptomatic intervals between episodes of recurrent obstruction
- Enteroclysis is performed by intubating the small bowel and infusing contrast material, essentially bypassing the stomach [13,38](#)
- By distending the small bowel, fixed or narrowed areas can be identified, including low-grade obstructions
- Can also demonstrate extraluminal features [38](#)
- Unlike fluoroscopy or CT enteroclysis, there is no exposure to ionising radiation. This is advantageous in younger patients with Crohn's Disease who require repeat imaging and may have recurrent presentations of obstruction
- Disadvantages:
  - Patient discomfort
  - Time-consuming
  - Longer acquisition time than CT can result in peristalsis motion artefacts; breath holding required to minimise respiration artefact
  - MRI is contraindicated in the presence of some ferromagnetic prostheses
  - Cost
  - Limited availability
  - Although MRI does not use ionising radiation, there is exposure during fluoroscopic insertion of the nasojejunal tube [39](#)
- In enterography, patients ingest a large amount of fluid that fills the stomach and small bowel; the

volume is limited by patient tolerance [38](#)

- Enteroclysis achieves better luminal distension, particularly at the level of the jejunum, [38](#) however there is no significant difference in terms of detection of clinically significant findings. [40,41](#) Limited studies comparing MR enterography and enteroclysis have focused on Crohn's disease; there is little research investigating the accuracy in other causes of small bowel obstruction

## Fluoroscopic Small Bowel Follow Through (SBFT) and Enteroclysis

- SBFT and enteroclysis have been generally replaced by cross-sectional imaging, including CT and MR [17,40,42](#) however water-soluble contrast agents are still used for diagnostic, prognostic and therapeutic purposes. [Read more here](#)
- Can be performed in low grade small bowel obstruction or during relatively asymptomatic intervals between episodes of recurrent obstruction
- SBFT involves ingestion of 500-600mL of oral contrast, followed by intermittent fluoroscopy of the small bowel every 15 to 30 minutes until contrast reaches the right colon
- In fluoroscopic enteroclysis, the small bowel is intubated and contrast is gradually infused to distend the small bowel
- A dedicated small bowel follow through examination may be appropriate in suspected low grade small bowel obstruction if enteroclysis is unavailable [43](#)
- Findings in small bowel obstruction include [18](#)
  - Failure of contrast to reach the colon within 4 hours
  - Dilatation of loops of small bowel
  - Delayed transit time of the barium to a point of transition in the caliber of the bowel lumen
  - With complete obstruction, no barium will be visualised past the point of obstruction in delayed images taken 24 hours after administration of contrast
  - With partial obstruction, barium will pass the obstructed portion into collapsed bowel loops
- Advantages [18](#)
  - Does not require nasointestinal intubation
  - Compared to enteroclysis, SBFT is easier to perform and does not require additional expertise
- Limitations [18,42,43](#)
  - Time required for contrast to reach the obstruction
  - Dilution of barium in high-grade obstruction because of excess residual intraluminal fluid resulting in non-uniform small bowel filling [19](#)
  - Partially obstructing lesions may not be visualised due to limitations in assessment of intestinal distensibility and fixation of small bowel loops
  - Inability of the patient to drink sufficient quantities of barium
  - Contraindicated in complete obstruction with suspected bowel ischaemia
  - Does not demonstrate extramural disease
  - Higher radiation dose compared with other modalities

## Gastrografin + Repeat AXR

- Multiple studies have shown the diagnostic and prognostic value of water-soluble contrast agents such as gastrografin in the work-up of SBO
- Oral contrast is administered followed by delayed imaging, usually AXR, but contrast can also be visualised on CT
- The presence of contrast in the colon predicts the resolution of obstruction without surgery with

- 92-96% sensitivity and 93-98% specificity [44-46](#)
  - AXR should be taken at least 4-24h from administration of contrast [44-46](#)
- There is also mixed evidence about whether water-soluble contrast has a therapeutic effect in reducing the need for surgery. [44-48](#) Some surgeons may administer gastrografin for therapeutic purposes as well as diagnostic [49](#)

## Computed Tomography (CT) in Evaluation of Large Bowel Obstruction (LBO)

- Imaging modality of choice for the diagnosis and cause of LBO [50](#)
- Reported sensitivity of 91-96% and specificity of 91-93% for LBO [51,52](#)
- As in SBO, CT is useful for identifying a transition point in LBO, as well as depicting intraluminal, mural and extramural causes of obstruction [50](#)
  - The most common cause of LBO is carcinoma of the colon [50,53](#)
- Intravenous contrast should be used if possible; oral and rectal contrast are not routinely indicated
- Supplementary CT acquisitions (e.g. prone or decubitus scans) may be performed to distinguish real versus pseudo transition points in the colon seen on supine scans. These may be acquired using low-dose protocols [51](#)
- Limitations
  - Some appearances may mimic LBO such as spasm at the splenic flexure, [51](#) or isolated distension of hepatic flexure and ascending colon in pancreatitis. [54](#) Supplementary acquisitions in different positions can help to distinguish these
  - Partially obstructing lesions may not be well demonstrated, especially right-sided colonic tumors [50,51](#)
  - Exposure to ionising radiation and intravenous contrast
- Contrast enema has been largely replaced by CT [50](#)
- If the diagnosis of LBO is uncertain, rectal contrast can aid in localisation of the lesion [50,55](#)
- CT colonography is useful to diagnose colorectal malignancy, particularly if colonoscopy is incomplete due to being unable to bypass strictures [56](#) but is not indicated in the acute setting
  - Bowel preparation is required before the colon is insufflated with air, so CT colonography is not generally appropriate in acute LBO

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References are graded from Level I to V according to the Oxford Centre for Evidence-Based Medicine, Levels of Evidence. [Download the document](#)

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