# Lessons for Learning
# Bowel Obstruction – Clinical Management and Safety

## Purpose

The Clinical Excellence Commission (CEC) Serious Incident Review (SIR) Sub-committees consist of multidisciplinary clinicians who review serious incidents to identify key learnings, emerging risks, and patient safety issues with broader implications. One of their key roles is to recommend actions to mitigate potential patient safety risks.

## What reviews are telling us: System-level challenges in identifying and managing bowel obstructions

The Clinical Management SIR Sub-committee has identified recurring themes in adults involving **delayed recognition, escalation, and management of bowel obstruction.** This is a time-critical condition where early intervention can significantly impact patient outcomes. This resource has been developed to support clinicians and healthcare services by sharing learnings, case insights, and practical strategies to strengthen clinical responses and promote system improvements. Serious incident reviews have identified the following recurring risks:

**Recognition and escalation delays**: Clinical deterioration may not be recognised early in bowel obstruction, especially when signs such as pain, distension, and constipation are attributed to other causes or are observed over multiple days.

**Competing diagnostic focus**: When bowel obstruction coexists with other conditions, it may receive lower priority in clinical decision-making, delaying essential interventions.

**Red flags:** Bowel obstruction in patients with no previous history of abdominal surgery almost never resolves without surgical intervention.

**Imaging interpretation and communication**: Patients with suspected bowel obstruction should have an abdomen pelvis CT as part of the diagnostic workup and to inform management. Imaging suggestive of obstruction is not always escalated for senior clinician review when symptoms persist. Delays in acting on reports or missing radiology addendum (update or additional note) are known contributors to adverse outcomes.

**Early warning signs and escalation:** Vital signs and symptoms that don't align with the expected trajectory of illness or patient family concerns they are getting worse should be escalated. Follow the appropriate response instructions and escalate as per local Clinical Emergency Response System (CERS).

**Clinical handover and team situational awareness**: Inconsistent communication during ward rounds and between shifts can lead to incomplete understanding of patients' expected trajectory of illness or risk of deterioration.

### Key messages for safer practice

**Escalate early when bowel obstruction is suspected and symptoms persist**
**Use structured review points in non-operative management**
**Review imaging findings with senior clinicians**
**Escalate based on the whole picture, not just clinical observations**
**Plan early surgical involvement and transfer if needed**

## Case 1: Dual pathologies – Missed obstruction progression

A patient with severe abdominal pain, distension, and constipation had CT findings of gallbladder perforation and large bowel obstruction. Clinical focus remained on gallbladder management while pain and constipation persisted. The patient deteriorated with hypotension and tachycardia over several days, required emergency surgery for bowel perforation, and died from sepsis and multi-organ failure.

**Discussion: Co-existing conditions can mask the progression of bowel obstruction. Persistent pain, distension, or constipation despite treatment should prompt diagnostic reconsideration, senior clinician review, and escalation.**

***Co-existing conditions can mask the progression of bowel obstruction.***

## Case 2: Known hernia – Delay in surgical escalation

An elderly patient with a known hernia and CT-confirmed small bowel obstruction was initially for non-operative management. Despite worsening pain, vomiting, and rising lactate, surgery was delayed, and the patient deteriorated with systemic inflammatory response. After surgery, the patient died from aspiration-related complications and sepsis.

**Discussion: Non-operative management of obstruction should include clear criteria and timeframes for review. Clinical deterioration and worsening biochemical markers should trigger senior clinician review and escalation to surgical teams to avoid missed intervention windows.**

***Non-operative management must have clear review points and criteria for escalation.***

## Case 3: Missed volvulus on initial imaging

A frail, elderly patient was discharged after presenting with abdominal discomfort, with CT interpreted as faecal loading. The patient re-presented with severe distension and hypotension two days later. Repeat imaging confirmed sigmoid volvulus with bowel ischaemia. Surgery was not pursued due to frailty, and the patient died under comfort care.

**Discussion: Subtle or evolving obstructions may be missed on initial imaging. Persistent or worsening symptoms require senior clinician review and consideration of repeat imaging; there should be clear systems for reviewing radiology addenda.**

***Persistent symptoms warrant repeat imaging and senior review.***

## Case 4: Missed small bowel obstruction in post-gastric bypass patient

A patient with a history of Roux-en-Y gastric bypass presented with abdominal pain, vomiting, and distension. Initially for non-operative management, but deterioration occurred over several days. At laparotomy, a closed-loop small bowel obstruction with necrotic bowel was found.

**Discussion: Altered anatomy post-bariatric surgery can mask or mislead clinical assessment. In this case, the lack of early surgical review delayed definitive care, leading to bowel necrosis.**

***Maintain a high index of suspicion in patients with prior gastric bypass.***

## Reflective prompts for teams and services

Consider these prompts during clinical governance meetings, Safety Huddles, Morbidity and Mortality Meetings, and local quality improvement planning:

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| **How are patients, families and carers supported to raise concerns if they are worried they are getting worse?** | Educate families about REACH and ensure visible signage and regular proactive communication. |
| **Are a patient's signs, symptoms, medical history or red flags suggestive of bowel obstruction?** | Signs and symptoms of bowel obstruction can be attributable to other causes. Be aware of cognitive biases when assessing patients to reduce risk of diagnostic error. |
| **Are bowel function, pain progression, and escalation decisions clearly documented and acted on?** | Audit documentation for bowel sounds, pain escalation, and rationale for surgical consults. |
| **Do multidisciplinary teams use structured approaches to manage complex or deteriorating patients?** | Activate MDT reviews early for complex obstruction cases, involving surgery, nursing, dietetics, radiology, and anaesthetics as required. |
| **Are clinical deterioration protocols and escalation systems being applied consistently?** | Ensure to escalate in line with local CERS. |
| **How do local systems support learning from incidents and aligning care with patient goals?** | Use M&M or QI forums to reflect on obstruction cases and ensure goals of care and advanced directives are documented and considered early. |

## More information:


AMA Journal of Ethics. (2020). Believing in overcoming cognitive biases. AMA Journal of Ethics, 22(9): E773-778.

American Academy of Family Physicians. (2018). Intestinal Obstruction: Evaluation and Management. American Family Physician, 98(6), 362–370.

BMJ Best Practice. (2024). Intestinal obstruction. BMJ Publishing Group.

Clinical Excellence Commission. (2019). *Multidisciplinary team (MDT) with patient rounds: Guidance document.*

Clinical Excellence Commission. (2015). *Diagnostic Error: Learning Resource for Clinicians*.

Clinical Excellence Commission. REACH

NSW Health. (2025). *Recognition and management of patients who are deteriorating* (PD2025_014)

NSW Health. (2020). *Incident management policy directive* (PD2020_047)

NSW Health. (2025). *Health care records – documentation and management* (PD2025_035)