Important things in the history that aid in reaching (assessing) the cause of intestinal obstruction

When a patients complaints of acute constipation, abdominal pain and distension, nausea & vomiting, the probability that either mechanical bowel obstruction or ileus is present, is very high.
Mechanical obstruction can often be distinguished from ileus or pseudo obstruction on the basis of the location, character, and severity of the abdominal pain.
Pain from mechanical obstruction is usually located in the middle of the abdomen, whereas pain from ileus & pseudo obstruction is diffuse.
Pain from ileus is usually mild and pain from mechanical obstruction is usually more severe.
In general, pain increase in severity and depth over time as obstruction progresses. However, in mechanical obstruction, pain severity may decrease over time as a result of bowel fatigueness and atony.
The periodicity of pain can help localize the level of obstruction:
Pain from proximal intestinal obstruction has short periodicity (3-4 min.), and distal small bowel, or colonic pain has longer intervals (15-20 min.) between episodes of nausea, cramping & vomiting.
Abdominal distension, nausea & vomiting usually develop after pain has already been felt for sometimes.
The patients should be asked what degree of abdominal distension is present & whether there have been sudden or rapid changes.
Distension developing over many weeks suggests chronic process or progressive partial obstruction.
Massive abdominal distension coupled with minimal crampy pain, nausea & vomiting suggest long standing intermittent mechanical obstruction or some form of chronic intestinal pseudo obstruction.
The condition of gradual change in bowel habits, progressive abdominal distension, early satiety, mild crampy pain after meal, and weight loss also suggest chronic partial mechanical bowel obstruction.
If the patient has undergone previous abdominal evaluations for similar symptoms before, any previous abdominal radiographs or contrast studies should be reviewed.
The patient should be asked when flatus was last passed; failure to pass flatus may signal transition from partial to complete obstruction.
Patients with intestinal stomas (ileostomy or colostomy) who present with signs & symptoms of obstruction often reports abdominal distension and pain after a sudden change in stomal output of stool, liquid or air.
The patient should be asked about:

1) Previous episodes of bowel obstruction.
2) Previous abdominal or pelvic operations.
3) History of abdominal cancer.
4) History of intraabdominal inflammation (e.g. inflammatory bowel disease, cholecystitis, pancreatitis, pelvic inflammatory disease or abdominal trauma). Any of these factors increase the chance of the obstruction secondary to an adhesion or recurrent cancer.

Obstructive symptoms that comes and go suddenly over several days in a patient over 65 yrs. old should increase the index of suspicion for gall stone ileus.
If the patient has experienced episodes of obstruction before, one should ask about the etiology and the response to treatment.
If the patient had undergone an abdominal operation, one should try to obtain & read the operative report, which can provide a great deal of helpful information.
The clinical setting often provides clues to the cause and type of bowel obstruction.
In hospitalized patient, there is likely to be an associated medical condition or metabolic derangement that led to obstruction.
One should ask the patient about any previous abdominal irradiation and should note and take into account all medications the patients is taking, especially anticoagulants (excessive of such drugs can lead to retroperitoneal, intra abdominal or intramural haematoma that can cause mechanical obstruction or ileus) & agents with anticholinergic effect.
Patients who are receiving chemotherapy or abdominal radiotherapy are prone to develop ileus.
Acute massive abdominal distention in a hospitalized patient usually result form acute gastric dilatation, small bowel ileus or acute colonic pseudo obstruction.