ABSTRACT

***Background**: Incidence of gastrointestinal (GI) dysmotility is quite large reaching 60% in critically ill patients. It's manifestation can be very board and can be divided into upper GI dysmotility in form of gastroparesis and vomiting or lower GI dysmotility in the form of ileus and diarrhea.*

***Case**: The following 2 case report represent upper and lower GI dysmotility.*

Case 1, 17 years old male with diagnose of Guillain Barre Syndrome (GBS) experiencing recurrent infection, gastroparesis and massive nasogastric production triggered by sepsis and causes alkalosis metabolic, difficulties in initiating enteral feeding and difficulties in weaning from mechanical ventilation.

Case 2, 56 years old obese women diagnose with Obesity Hypoventilation Syndrome (OHS) and acute lung edema. GI problems manifest as paralytic ileus and diarrhea

***Discussion:** Upper GI dysmotility in first case manifest as delay gastric emptying, regurgitation, and acid base disturbances while in 2nd case lower GI dysmotily manifest as ileus with all the consequences including increase intra abdominal pressure (IAP) . GI problems in these two cases, causes difficulties in weaning and prolonged ICU stay.*

***Conclution:** GI dysmotility can be primary disorder such as sepsis, diabetes mellitus or secondary effect of the therapy that has been given, such as due to massive fluid resuscitation, vasopressor or opioid drug use in ICU. Whatever the causes, GI dysmotility must be handled appropriately and systematically.*

***Keywords**: bowel obstruction; gastroparesis; gut dysmotility; Ileus; intensive care unit*