NPO diet, and pain medications. Serial abdominal images were obtained, and he was eventually advanced to soft diet. Tirzepatide was discontinued on discharge. As a response to enteral nutrition, distal small bowel and colon release GLP-1 hormone. Exogenous and endogenous GLP-1 are associated with reduced gastric motility. GLP 1 RA and dual GIP/GLP-1 RA are advised to be used with caution in patients with established gastroparesis, as they can worsen the symptoms. GLP-1 effect on small intestinal motility is not extensively studied, however, small bowel motility inhibition was noted in animal models. Some of these actions were dose-dependent. There are some case reports of SBO due to GLP-1 RA. An observational cohort study noted an increased incidence of SBO with GLP1 RA when compared to SGLT2i. They noted most incidents of SBO happened early within the initiation of therapy (within 3 months). At the time of writing this abstract, there are no published SBO case reports associated with tirzepatide. Further large-scale clinical trials need to be conducted to explore the association of SBO in patients with GIP/GLP-1 and GLP-1 RA. These studies will help guide if these drugs should be contraindicated or used with caution in people with a previous history of SBO or colonic obstruction.

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Tirzepatide Associated Partial Small Bowel Obstruction: A Case Report

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Glucagon-like peptide-1 receptor agonists (GLP1 RA) are quickly becoming an adjunctive treatment modality for people with type-2 diabetes and is approved for chronic weight management. Tirzepatide has a dual GIP/GLP-1 RA action and has a synergistic effect when administered together. GLP-1 RA are associated with improved cardiovascular and all-cause mortality outcomes in patients with type-2 diabetes. Tirzepatide is associated with gastrointestinal (GI) side effects like nausea, diarrhea, abdominal pain, decreased appetite, and constipation. This case report discusses a case of small bowel obstruction (SBO) that was noted after patient was changed from dulaglutide to tirzepatide. Mr. X is a 61 y/o male with PMHx of type-2 DM, HTN, and HLD who presented to ER for severe epigastric pressure- like 7/10 abdominal pain. No association with food intake. He had 1 episode of semi-loose stools. Denied any abdomen cramping, sick contacts, nausea/vomiting, fever/chills, or constipation. His previous endoscopy was only relevant for benign colonic polyps, which were removed. He had been on GLP1 RA for more than a year, and previously on dulaglutide 3mg, which was switched to tirzepatide 2.5mg 5 weeks ago. He was able to tolerate the medication without significant side effects and was recently up-titrated to 5 mg. Labs showed WBC 7.2, Hb 13.6, Cr 1.45, BUN 12, lipase 25, and normal LFTs. Abdominal X-ray and CT abdomen were noted to be significant for a partial vs evolving SBO without any identifiable small bowel intrinsic pathology. Mr. X was managed conservatively with fluids,