



Acute Colonic Pseudo-Obstruction (Ogilvie's Syndrome) - A Rare Complication in Total Abdominal Hysterectomy and Bilateral Salpingo-Oophorectomy (TAHBSO) With Sigmoidectomy

Sarmukh S¹, MO Myint², Salleh M², Shaker Ah² and Thamilselvam P³

¹Department of Surgery, Hospital Serdang, Selangor, Malaysia.

²Department Of Surgery, University Putra Malaysia, Selangor, Malaysia.

³Department Of Surgery, Perdana University-RCSI, Selangor, Malaysia.

Abstract:

Background: Acute colonic pseudo-obstruction (Ogilvie's Syndrome) as a syndrome was first described by Ogilvie in 1948. It is characterized by colonic dilatation in the absence of mechanical obstruction or any obvious causes of paralytic ileus. The condition can occur in patients with various metabolic, surgical, and medical problems. It can also be idiopathic in a small percentage of patients.

Case Report: A 48 year old Malay lady. Diagnosed with Ovarian Carcinoma proceeded with TAHBSO, supracolicomentectomy and sigmoidectomy. Post operatively noted the abdominal drain was 600 cc (serous) proceeded with CT abdomen TRO anastomosis leak and the CT findings shows dilated large bowel with distal tapering and some narrowing at the presumed anastomotic site at the rectum. Impression was Mechanical obstruction. We proceeded with the Colonoscopy for decompression and to look for the anastomosis site. Our diagnosis was pseudo-obstruction of colon (functional obstruction / Ileus) as there is no evidence of mechanical obstruction and the whole colon was found distended.

Conclusion: We believe that Ogilvie's Syndrome, though uncommon, is a diagnosis to consider when investigating patients who have recently undergone TAHBSO with sigmoidectomy. Colonoscopy at the earliest possible time can be of both diagnostic and therapeutic value as it provides.

KEY WORDS:

Ogilvie's Syndrome, colonoscopy, decompression, TAHBSO.

INTRODUCTION

Acute colonic pseudo-obstruction, first described in 1948 by Ogilvie [1] is a nonmechanical dilatation of the colon often associated with severe illness or injury. Synonyms for the condition include Ogilvie's syndrome, colonic ileus, large intestinal colic and idiopathic large bowel obstruction. The dilatation involves the cecum and varying lengths of more distal colon. Often a "cutoff" of distention can be identified at the hepatic, splenic or sigmoid flexures. Cecal distention may become extreme (up to 20 cm or more) and result in perforation [2]. A total of 400 cases of acute pseudo-obstruction of the colon (Ogilvie's syndrome). Seven cases were reported at St. Elizabeth Hospital Medical Center between October 1982 and February 1985; 393 cases were reported in the literature from 1970-1985 [3]. Eighty-eight per cent of the cases were associated with various extracolonic affections (metabolic and organ dysfunctions,

postoperative and posttraumatic states, etc.). Twelve per cent of cases were not associated with known disorders and were defined as idiopathic. The pathophysiology of the syndrome is still unknown. Ogilvie, who first described the syndrome suggested an imbalance between the sympathetic and parasympathetic innervation of the colon: this neurogenic hypothesis has been shared by other authors, although explanations may differ slightly [4]. Ogilvie's syndrome is predominantly involves elderly patients with serious underlying diseases [5]. A case report of Ogilvie's syndrome in pregnancy of a 23-year-old female in the 28th week of pregnancy in Japan was also reported [6].

CASE REPORT:

A 48 year old malay lady, nulliparous was first seen in O&G clinic for prolonged menses for the past 1 year. Patient complaint of passing out bloody vaginal discharge with foul smelling for past 4 months, with prolong and irregular menses and have LOA and LOW. On physical examination noted patient alert, pale. Per abdomen was soft, uterus 20 weeks size palpable, firm, smooth, mobile sideways, can't get below, no ascites. Ultrasound examination of uterus revealed that uterus was enlarged about 20 cm x 17 cm x 16cm, uterine cavity filled in with mixed echogenicity clots admixed pus. The initial diagnosis was adenomyosis with pyometra TRO endometrial malignancy. Proceeded with examination under analgesia with suction, dilatation and curettage. Post-operative diagnosis was endometrial carcinoma with cervical involvement. Proceeded with TABHSO, supracolicomentectomy and sigmoidectomy. Post operatively day 4 noted the abdominal drain was 600 cc (serous) proceeded with CT abdomen TRO anastomosis leak and the CT findings shows dilated large bowel with distal tapering and some narrowing at the presumed anastomotic site at the rectum. Impression was mechanical obstruction. We proceeded with the colonoscopy for decompression and to look for the anastomosis site on day 7 post operatively. The finding was the whole colon was dilated (without any insufflation) and liquid faecal matter present all the way until caecum. No area of narrowing seen throughout the whole colon, especially in rectosigmoid area. Our diagnosis was Pseudo-obstruction of colon (functional obstruction or ileus) as there is no evidence of mechanical obstruction and the whole colon is found distended. A flatus tube was inserted to assist mobility of the colon. Post decompression patient recovered well and was discharge home.

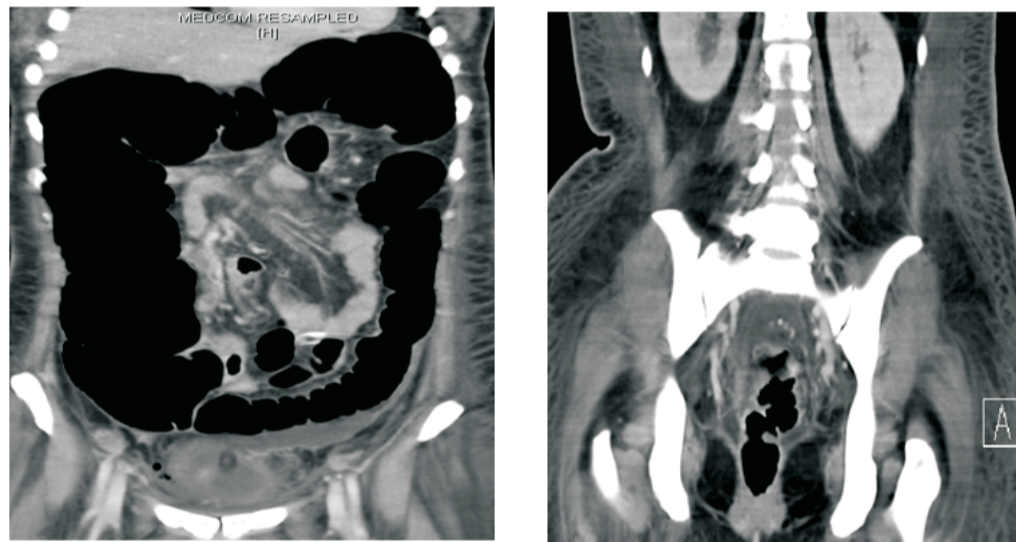


Figure 1 & 2: CT Abdomen shows dilated large bowel with distal tapering and some narrowing at the presumed anastomotic site at the rectum. Impression was Mechanical obstruction.

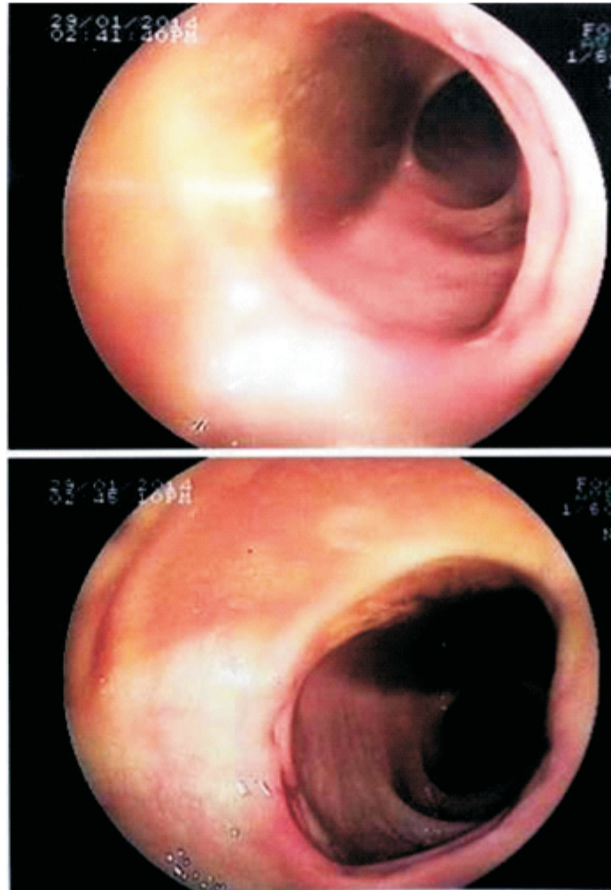


Figure 3 & 4: Whole colon is dilated (without any insufflation) and liquid faecal matter present all the way until caecum. No area of narrowing seen throughout the whole colon, especially in rectosigmoid area.

DISCUSSION:

Acute colonic pseudo-obstruction (Ogilvie's Syndrome) is rare and has been reported as isolated case reports or small case series. It is described by a clinical and radiological picture of acute large bowel obstruction without a mechanical cause. It has most commonly been reported after pregnancy or Caesarean section, although has also been reported to occur after trauma and severe burns [7]. The documented mortality of Ogilvie's syndrome ranges from 35% to 72% [8]. It has a higher incidence in men compared to women with a ratio of 3:2. Despite this, caesarean section was reported as the leading cause in a large meta-analysis [3]. The association between caesarean section or TAHBSO and Ogilvie's syndrome may be explained by the close proximity of the parasympathetic nerves (S2-S4) to the female reproductive organs, rendering them susceptible to damage intra-operatively [10]. As in our patient's case, the presenting symptoms include abdominal distension with vomiting and hyperactive bowel sounds. CT abdomen may be useful to rule out a mechanical cause for obstruction. Management of Ogilvie's Syndrome can be classified into non-surgical and surgical treatment, although arguably diagnosis and recognition are the most important aspects of care. Indeed, significant morbidity and mortality from the condition has been reported when there is a wrong diagnosis, most commonly paralytic ileus, and a delay in the diagnosis of bowel perforation, usually by junior obstetric or general surgical doctors [9]. The mode of treatment, age, cecal diameter, delay in decompression, and status of the bowel significantly influence the mortality rate, which is approximately 15 percent with early appropriate management, compared with 36 to 44 percent in perforated or ischemic bowel [3]. This risk naturally has led to considering colonoscopic decompression as an alternative form of treatment [2]. Colonoscopy provides a new effective treatment modality for colonic decompression. We discuss the case of this patient with Ogilvie's syndrome, who were successfully treated by colonoscopic decompression. Special guidelines for successful and safe performance of the procedure

are suggested [5]. If conservative management fails to control the dilatation and caecal rupture is impending or suspected emergency surgery is indicated[4].Surgical management is associated with a high mortality and morbidity. It is only implicated if there are signs of colonic ischaemia or perforation, a large caecal diameter (> 9 cm) or if conservative therapy has failed. Intraoperatively, if there is no perforated or ischaemic bowel, a caecostomy or appropriate colostomy is the procedure of choice. Otherwise a subtotal or segmental colonic resection is indicated. The bowel may then be exteriorised or an ileorectal anastomosis can be formed.Surgical intervention may become necessary inthe patient with megacolon who appears at high riskof perforation and has failed pharmacological and colonoscopicattempts at decompression[11]. In a case study of Dott.Fausto Catena et al described that a majorityof patients, 72% were submitted to surgeryand this result can be explained by the fact that in the DPT only severe OS are admitted.In 2 cases there was a perforation risk whereas inthe remaining patients there was long lasting medicaltreatment failure.Dott.Fausto Catena et al carried out 6 decompressivecaecostomyand 2 subtotal colectomies: these last operationshave to be reserved to selected cases.As a matter of fact surgical procedures for OS havehigh morbidity and mortality in Dott. Fausto Catena et al series it was 37% in whichthese patients have poor general conditions.However medical treatment has recurrences whilesurgery is a problem solving therapy.In conclusion surgery has to be considered a goodoption for severe OS with failure of medical and endoscopicictreatment[11].

CONCLUSION:

We believe that Ogilvie's Syndromethough uncommon, is a diagnosis to consider when investigating patients who have recently undergone TAHBSO withsigmoidectomy.Colonoscopy at the earliest possible time can be of both diagnostic and therapeutic value as it provides: a) exclusion of obstruction and establishment of the diagnosis among other possible causes of colonic dilatation and b) successful decompression of the colonof the patients.Colonoscopy provides a new effective treatment modality for colonic decompression inOgilvie's Syndrome.

REFERENCES:

- 1).Ogilvie H: Large intestine colic due to sympathetic deprivation. Br Med J 1948; 2:67 1-673
- 2.Fausel CS, Goff JS: Nonoperative management of acute idiopathic colonic pseudo-obstruction [Ogilvie's syndrome]. West J Med 1985 Jul; 143:50-54)
- 3.Vanek VW, Al-Salti M. Acute pseudo-obstruction of the colon (Ogilvie's syndrome).An analysis of 400 cases.Dis Colon Rectum. 1986 Mar;29(3):203-10.
4. Nanni G, Garbini A, Luchetti P, Nanni G, Ronconi P, Castagneto M. Ogilvie's syndrome (acute colonic pseudo-obstruction): review of the literature (October 1948 to March 1980) and report of four additional cases.Dis Colon Rectum. 1982 Mar;25(2):157-66.
- 5.Wegener M, Börsch G, Schmidt G. Acute pseudo-obstruction of the colon--significance of colonoscopy for diagnosis and therapy.
- 6.Nishida S1, Tanaka K, Kawaji H, Hamada N, Ono T, Taira A. Ogilvie's syndrome in pregnancy--a case report.Nihon GekaGakkaiZasshi. 1993 Feb;94(2):182-4
- 7.Dickson MA, McClure JH: Acute colonic pseudo-obstruction after caesarean section. Int J ObstetAnesth 1994, 3:234-236.
- 8.Dua A, Onyeka BA. Ogilvie syndrome complicated by caecal perforation in a post-caesarean section patient: a case report. Internet J Gynecol Obstet. 2006; 5.
9. Srivastava G, Pilkington A, Nallala D, Polson DW, Holt E: Ogilvie's syndrome: a case report. Arch GynecolObstet 2007, 276:555-557.
10. Claire Chambersa, b, Rumina Beguma, Pratik Sufi , Surgical Management of Ogilvie's Syndrome Post Caesarean Section, Journal De Cas Clinique.
- 11.Fausto Catena, AntonelloCaira, Luca Ansaloni, Gabriele Calò, Filomena De Bonis,Sonia Agrusti, Luigi D'Alessandro, Mario Taffurelli ,Ogilvie's Syndrome treatment, Emergency Surgery DPT, St Orsola-Malpighi University Hospital, Bologna, Italy