

OGILVIE'S SYNDROME

Definition: Functional obstruction of the large intestine. Diagnosis of exclusion.

Presentation: (painless) abdominal distension, obstipation, constipation, nausea, vomiting, paradoxical diarrhea. Abdominal tenderness develops in late state.

Imaging:

- X ray:
 - Dilated cecum.
 - Few or no air fluid levels.
 - Paucity of gas in small bowel, gas/stool in rectum
 - gradual transition to collapsed bowel
 - preserved contour of large bowel.
- Water soluble contrast enema or colonoscopy to confirm diagnosis and to rule out mechanical obstruction.

Differential Diagnosis:

- Toxic megacolon secondary to IBD/ C. Diff colitis
- Mechanical obstruction

Etiology:

- Autonomic dysfunction:
 - sympathetic hyperactivity
 - decreased parasympathetic activity.
- Predisposing factors
 - postoperative state
 - trauma
 - pregnancy
 - electrolyte abnormalities
 - uremia
 - hypoxia
 - sepsis
 - CHF
 - MI
 - DM
 - Pheochromocytoma
 - Hypothyroidism
 - Scleroderma
 - Amyloidosis
 - neuromuscular disorders
 - malignancy
 - Herpes Zoster
- Medications that decrease colonic motility:
 - Narcotics
 - Anticholinergic

- TCA
- Phenothiazines
- Antiparkinsonians
- Calcium channel blockers
- Clonidine
- Aluminium antacids
- Anthraquinone laxatives.

Therapy:

- Conservative:
 - NPO
 - NG tube
 - Rectal tube
 - Enemas
 - d/c offensive meds
 - correct predisposing factors (e.g. electrolytes imbalances).
- Pharmacologic:
 - IV Naloxone 0.4mg,
 - Erythromycin, Cisapride,
 - IV Neostigmine 2-2.5mg administered over 3 min.
 - Effective in 70-95%.
 - Side effects: salivation, abdominal crampings, bronchconstriction, bradycardia.
 - Contraindications: Bradycardia, active bronchospasm, renal failure, mechanical obstruction.
 - Requires monitoring for bradycardia. Atropine should be at beside.
- Colonoscopic decompression:
 - Successful in 60-80%.
 - For best result (90%), advance to the cecum and leave right colonic tube.
 - Decompression tube will frequently occlude by stool.
 - Morbidity 3%. Mortality 1%
 - Use minimal use air.
 - Stop if obvious ischemia is present.
- Surgery:
 - Indications:
 - Peritonitis/ perforation,
 - persistent cecal dilatation > 10-12cm,
 - failure of all other treatment modalities
 - Procedures:
 - Cecostomy – if no cecal necrosis is present
 - Loop colostomy
 - Segmental resection – if there is necrosis or vascular compromise

Prognosis:

- Most patients will get better with conservative treatment within 3-6 days.
- Risk of perforation 3%

- Overall mortality 15%.
- Mortality in patients with ischemia/ perforation- 36%

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