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OGILVIE SYNDROME: A CASE REPORT

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INTRODUCTION

Ogilvie syndrome is a rare complication which can occur following caesarean section, this case displays the presentation, diagnosis and management of Ogilvie syndrome. Although this condition is associated with significant morbidity, this case report illustrates how appropriate recognition and multidisciplinary management of Ogilvie syndrome can aid full recovery.

A 30 year old primiparous female with a normal BMI receiving midwifery led antenatal care presented in spontaneous labour at term +4 days. Due to inadequate contractions oxytocin was commenced, the CTG was subsequently classified as pathological, combined with pyrexia suggesting possible chorioamnionitis and subsequent failure to progress in labour led to a category 2 caesarean section.

Intraoperative findings included a high bladder, free fluid and occipitoposterior presentation with caput and moulding raising the suspicion of cephalopelvic disproportion. Uterine tone was poor and an oxytocin infusion was required, total estimated blood loss was 1200ml.

On the third postnatal day the patient was reviewed for abdominal distension and oral antibiotics were changed back to intravenous therapy. The patient did not pass any stools and had a tender abdomen although bowel sounds were present.

A CT of the abdomen and pelvis was performed which showed significantly dilated bowel loops (figure 1).

Initial conservative management took place until the patient deteriorated 2 days later with hypotension of 80/40 and a lactate of 6.4.

An urgent repeat CT scan demonstrated air and free fluid in the abdomen with perforation of hollow viscus (figure 2). A midline laparotomy was performed, and this confirmed a perforated caecum. A right hemicolectomy was performed, the patient remained in intensive care for 48 hours postoperatively. Further CTAP suggested ongoing peritonitic process and two days later a radiologist performed ultrasound guided drainage. Three days later a fourth CT scan showed a moderate reduction in the intraabdominal fluid. The patient 12 months after the primary procedure had full reversal of ileostomy.

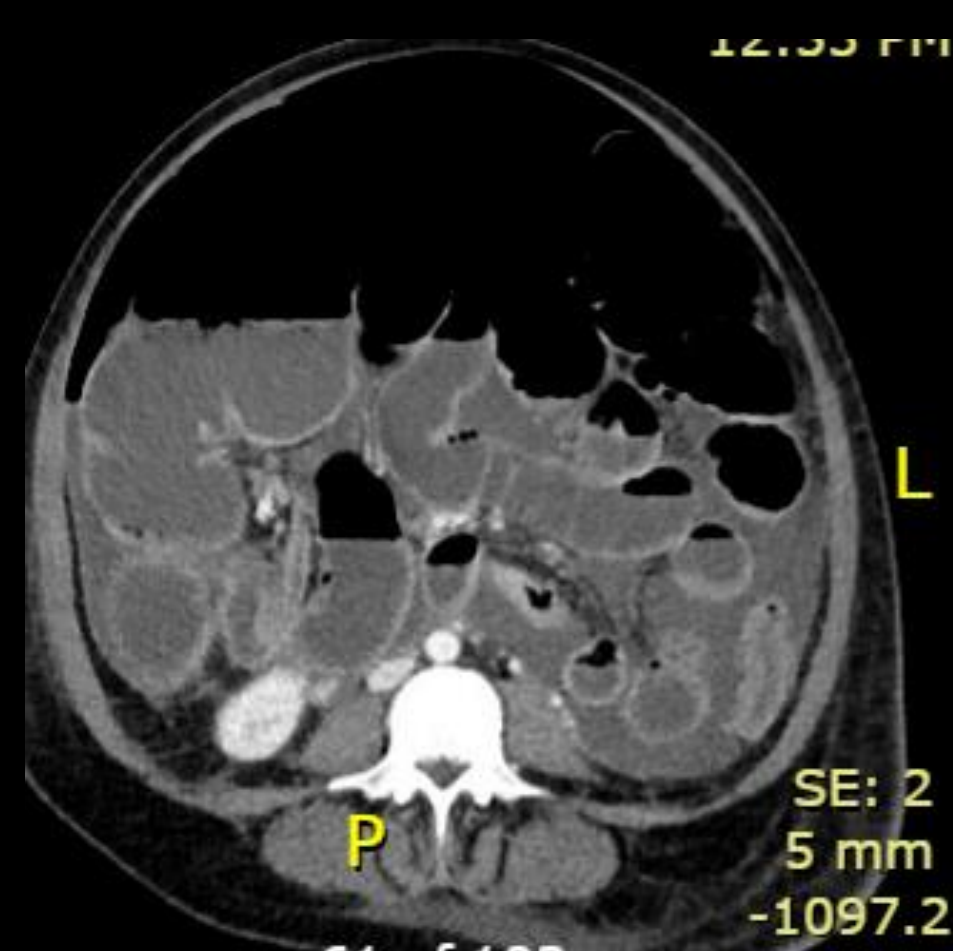
Ogilvie syndrome (also known as acute colonic pseudo-obstruction) is characterised by massive colonic distension in the absence of any mechanical obstruction

It is important to differentiate Ogilvie syndrome from paralytic ileus which is a more common postoperative complication. In Ogilvie syndrome the patient might have bowel sounds and passage of flatus leading to false reassurance that there is no sinister pathology.

Figure 1: CT scan showing distended bowel loops (day 3 postop)



Figure 2: CT scan showing perforation (day 5 postop)



CONCLUSION

Ogilvie syndrome is an important differential diagnosis in postoperative abdominal pain, where clinically concerned it is important to obtain imaging and specialist review early. Early intervention and multidisciplinary management are crucial in optimizing patient outcome.

Conner, S., Nassereddin, A. and Mitchell, C., 2018. Ogilvie syndrome.
Tenofsky, P.L., Beamer, R.L. and Smith, R.S., 2000. Ogilvie syndrome as a postoperative complication. Archives of Surgery, 135(6), pp.682-687.

CLINICAL FEATURE	OGILVIE SYNDROME	PARALYTIC ILEUS
Bowel Sounds	Hyperactive/high-pitched/absent	Absent
Nausea & Vomiting	Mild and intermittent	More common
Passing Flatus	Present	Absent
Passing Stool	Present/diarrhoea/constipation	Absent
Area of bowel	Limited to colon	Small & large intestine