



Journal Homepage: - [www.journalijar.com](http://www.journalijar.com)  
**INTERNATIONAL JOURNAL OF  
 ADVANCED RESEARCH (IJAR)**

Article DOI: 10.21474/IJAR01/7475  
 DOI URL: <http://dx.doi.org/10.21474/IJAR01/7475>



**RESEARCH ARTICLE**

**POSTPARTUM ACUTE COLONIC PSEUDO-OBSTRUCTION (OGILVIE'S SYNDROME):  
 CORRECTION WITH NEOSTIGMINE, A CASE REPORT.**

**Dr. Mohamed Achraf Grohs, Dr. Rana Watfeha And Pr. Mohamed Hassan Alami.**

Department of gynecology and obstetric, National Center of reproduction health, Rabat, Morocco.

**Manuscript Info**

**Abstract**

**Manuscript History**

Received: 24 May 2018  
 Final Accepted: 26 June 2018  
 Published: July 2018

Copy Right, IJAR, 2018,. All rights reserved.

**Introduction:-**

Ogilvie's Syndrome or Acute Colonic Pseudo-Obstruction (ACPO) is a rare condition characterized by massive dilatation of the colon in the absence of mechanical obstruction. The condition, first described by Sir William Heneage Ogilvie in 1948 [1]

We present a case of Ogilvie syndrome following emergency cesarean section

This case was managed conservatively with neostigmine, an inhibitor of acetylcholinesterase following confirmation of an acute colonic pseudo-obstruction on computed tomography scan and she made a full recovery.

**Observation:-**

A 28 year old primiparous woman with 40 weeks of amenorrhoea was admitted for taking charge of her delivery

The examination of the patient at admission was normal but revealing fetal distress for which she benefited from cesarean delivery, a live male infant was delivered weighing 3300g with no subsequent complication

Following delivery after 24h hours post partum, on examination, its temperature was raised to 37.8 ° C, a respiratory rate of 22/min, and she was tachycardiac at 96/min, her blood pressure was normal, it was managed as a possible maternal sepsis with antibiotics. Her abdomen was tense and distended with sluggish bowel sounds. It was planned to carefully observe her and permit clear fluids orally, after 12 hours, she began feeling much better but her abdomen remained distended with no flatus passed

The abdominal distension persisted into day-3 postpartum at which point she began vomiting. A nasogastric tube was sited, a surgical consultation requested. an abdominal X-ray was performed showed marked gaseous distension of both the small and large bowel.

Computed tomography scan was subsequently performed which showed dilated colon to the level of the sigmoid colon. The mother was placed on a cardiac monitor and a physician administered 2 mg of intravenous neostigmine. Within minutes, she began to pass large amounts of gas accompanied by small amounts of soft stool per rectum.

**Corresponding Author:- Mohamed Achraf Grohs.**

Address:- Department of gynecology and obstetric, National Center of reproduction health, Rabat,

Within 30 min, the abdomen was soft, markedly reduced in size, and no longer tympanic. She did not manifest bradycardia over 1 h of observation and was discharged with no further interventions. After 24 hours, the patient begun passing flatus and her bowels opened. The patient self-discharged three days later

### **Discussion:-**

In 1948, Sir Heneage Ogilvie recounted two cases in which, “the symptoms so strongly suggested obstruction of the distal colon by a carcinoma that laparotomy was eventually undertaken in spite of normal findings in a barium enema” [2]

Ten years later, HA Dudley presented thirteen cases of patients who underwent surgery for colonic dilatation presumed to be due to obstruction but in whom no evidence of obstruction was found [3]. He proposed the first etiologic classification and coined the terminology of acute colonic pseudo-obstruction. The acronym ACPO first appeared in the literature in 1997

It is usually associated with medical conditions such as trauma, burns, major surgery (pelvic and orthopaedic surgery, caesarean section), pregnancy and sepsis [4]

The pathophysiology of OS seems to be paralysis of the intestinal muscularis allowing passive distention without an increase in intracolonic pressure.

The rate of spontaneous perforation has been reported to be 3% to 15%, with an attendant 40% to 50% mortality rate [5]

The risk of major complications/mortality and the morbidity of the long recovery led to a search for effective and safe therapies, not only to prevent ischemia and perforation but also to speed resolution.

Abdominal pain and distension are the commonest symptoms which were noted in 60% and 89% of cases, respectively. The onset of symptoms could be as early as 24 h postnatally or could be delayed for few days. Patients may have normal bowel sounds and pass flatus and defaecate like normal. Peritoneal signs may also be absent if there is no perforation or if the perforation is sealed off without leaking of faecal contents as there may not be any peritoneal irritation. It should, however, be differentiated from a simple ileus.

Abdomino-pelvic CT with intravenous contrast is the standard diagnostic test, with a sensitivity of 96% and a specificity of 93%. It confirms the presence of proximal colonic dilatation and excludes the presence of intrinsic or extrinsic mechanical obstruction.

An erect abdominal X-ray will show dilated caecum and colon and free air if there is perforation. The average caecal diameter is approximately 6.4 cm and in 90% of the patients there will be no post laparotomy free air in the abdomen by the 5th postoperative day [6]

The major concern during conservative management is the risk of colonic perforation, which has an incidence of 15—20% with a mortality risk of 40—50% [7]. The colon can tolerate fairly massive dilatation and the risk of perforation is often overestimated, especially since the distention is not associated with high intraluminal pressure.

Caesarean section is the single most common associated risk factor for postpartum ACPO. However, ACPO can occur even after a normal or an instrumental vaginal delivery. Caesarean section for preeclampsia/HELLP syndrome, multiple pregnancy, and antepartum haemorrhage/placenta praevia appears to be more common in patients who develop ACPO [8]

The symptoms and signs of ACPO may be missed in the postpartum period due to laxity of abdominal wall and signs like mild pyrexia, leucocytosis may occur in the normal postpartum period, which may cause a delay in the diagnosis. Clinicians should therefore, not rely only on these features if there is suspicion of perforation [9]

Most series consider limits greater than 9 cm [9], whereas Vanek feels that the maximal tolerable cecal diameter is 12 cm because more than a quarter of patients beyond this limit will perforate [10]

Several possible therapeutic approaches can be considered: conservative treatment, pharmacologic treatment, colonoscopic exsufflation, and surgery. The mortality of patients who undergo surgery varies from 30—50% versus 14—30% for non-operated patients [11]

Management is well codified by the 2010 guidelines of the American Society for Gastro-intestinal Endoscopy (SAGES) [12]

Current treatment recommendations for colonic pseudoobstruction include a conservative pathway that includes observation, nasogastric tube suctioning, intravenous hydration, electrolyte correction discontinuing precipitating medications when possible, and the placement of a rectal tube or rectal examination every 6 h along with patient ambulation or bed turning.

Its effectiveness can be judged by a decrease in abdominal distention, passage of flatus and stool, and decreased cecal diameter on abdominal plain films [12]

Should the above measures fail, practitioners then utilize alternative treatment strategies, including neostigmine or colonic decompression, with surgical intervention reserved for those cases that have not responded to the above interventions [13]

If conservative measures fail, colonoscopic decompression is generally recommended. Surgery is then reserved for those who fail or suffer a complication of colonic decompression

### References:-

1. Arch Gynakol OS. Casuistry in ovarian pregnancy. . p. 73–5
2. Ogilvie H. Large intestinal colic due to sympathetic denervation: a clinical syndrome. Br Med J 1948;1:671–3.
3. Dudley HA, Sinclair IS, McLaren IF, McNair TJ, Newsam JE. Intestinal pseudo-obstruction. J R Coll Surg Edinb 1958;3(3):206—17.
4. Vanek VW, Al-Salti M. Acute pseudo-obstruction of the colon (Ogilvie's syndrome). An analysis of 400 cases. Dis Colon Rectum 1986;29(3):203–10.
5. Jetmore AB, Timmcke AE, Gathright B, et al: Ogilvie's syndrome: colonoscopic decompression and analysis of predisposing factors, Dis Colon Rectum 35:1135–1142, 1992.
6. Vanek VW, Al-Salti M. Acute pseudo-obstruction of the colon (Ogilvie's syndrome). An analysis of 400 cases. Dis Colon Rectum 1986;29(3):203—10.
7. Lawaetz O, Jensen HK. Survey radiography of abdomen following caesarean section, with particular reference to caecal diameter and the presence of free subdiaphragmatic gas. Acta Obstet Gynecol Scand 1976;55(4):311–4.
8. Nanni G, Garbini A, Luchetti P, Nanni G, Ronconi P, Castagneto M. Ogilvie's syndrome (acute colonic pseudo-obstruction): review of the literature and report of four additional cases. Dis Colon Rectum 1982;25(2):157—66.
9. Pradeep Jayaram, Manoj Mohan, Stephen Lindow, Justin Konje . European Journal of Obstetrics & Gynecology and Reproductive Biology 214 (2017) 145–149
10. Barth X, Chenet P, Hoen JP, et al. La colectasie aiguë idiopathique ou syndrome d'ogilvie : à propos de 43 observations. Lyon Chir 1991;87(3):230—6
11. Davis L, Lowman RM. An evaluation of cecal size in impending perforation of the cecum. Surg Gynecol Obstet 1956;103(6):711—8.
12. Harrison ME, Anderson MA, Appalaneni V, et al. The role of endoscopy in the management of patients with known and suspected colonic obstruction and pseudo-obstruction. Gastrointest Endosc 2010;71(4):669—79.
13. Rex DK. Colonoscopy and acute colonic pseudo-obstruction. Gastrointest Endosc Clin N Am 1997;7:499–508