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Case Report

Acute colonic pseudo-obstruction after emergency lower segment caesarian section: a case report

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ABSTRACT

Acute colonic pseudo-obstruction (ACPO) is rare condition due to acute dilation of large bowel without any mechanical obstruction. It is usually found in patients with severe illness, trauma and surgical procedures; of which caesarian section is most common operation associated with it. It creates a diagnostic dilemma and caries high mortality if not managed early and appropriately with multidisciplinary approach. Here, I present a case report of ACPO developed after emergency lower segment caesarian section (LSCS).

Keywords: Acute colonic pseudo-obstruction, Lower segment caesarian section, Ogilvie's syndrome

INTRODUCTION

Acute colonic pseudo-obstruction (ACPO) also known as Ogilvie's syndrome is a rare condition characterized by acute dilatation of large bowel without any mechanical obstruction. It was first described by Sir Heneage Ogilvie in 1948 in two patients with malignant infiltration of splanchnic nerves, semilunar ganglia and celiac plexus.[1]

It usually occurs in hospitalized patients following severe illness, trauma or surgical procedures; with estimated incidence of 1 in 1000.[2]

Pathophysiology is not very clear but it has been found to occur due to imbalance between colonic sympathetic and parasympathetic innervations.[3] This condition creates a diagnostic dilemma as it has symptoms of abdominal distension similar to post operative ileus; but it carries a mortality rate of 15% if managed early and appropriately compared to 36-44% with delayed diagnosis due to bowel ischemia and perforation.[3] Also low level of general clinician awareness prolongs the time between development of symptoms and appropriate multidisciplinary management and hence may increase mortality rates.[4]

Here I present a case of ACPO developed after emergency LSCS; identified and managed conservatively with multidisciplinary team approach.

CASE REPORT

A 22 years old primigravida presented to obstetrics and gynecology emergency with labour pains at 40 weeks and 2 days period of gestation. She was a booked antenatal case with no high-risk factor. General examination was normal and vitals were stable. On obstetrical examination cephalopelvic disproportion (CPD) was diagnosed and cardiotocography (CTG) showed Cat 2 CTG. After sending routine investigations patient was taken for emergency LSCS for CPD with Cat 2 CTG and a single alive female child was delivered weighing 3.5 kg. Per operatively liquor was clear; patient had atonic Postpartum hemorrhage which was managed medically. On post operative day 2 she developed complain of abdominal pain and distension and has not passed the flatus till then.

On examination her vitals were stable; she had gaseous abdominal distention with sluggish bowel sounds for which surgery reference was done and tab. Dulcolax 2 stat and enema were given after digital rectal examination as

advised by them after which patient has passed stool and she got relieved of her symptoms for a while.

On POD 3 again she was found to have gaseous abdominal distension along with inability to pass flatus and X-ray abdomen erect AP view was ordered which showed dilated large bowel loops.

Patient was managed conservatively with NPO on IV fluids and vitals monitoring and AG charting and nasogastric tube was inserted; following which her symptoms were minimally improved.

A CECT whole abdomen was done on advice of surgical unit on POD 4 which showed markedly dilated large bowel loops without evidence of abrupt transition point or mechanical obstruction favoring diagnosis of pseudo colonic obstruction.

Patient was managed conservatively with IV fluids and nil per oral and vitals and electrolytes monitoring. On POD 6 she passed flatus and was allowed liquids following which stool was also passed and she allowed with semisolids and then solids and discharged in good condition on POD 8.

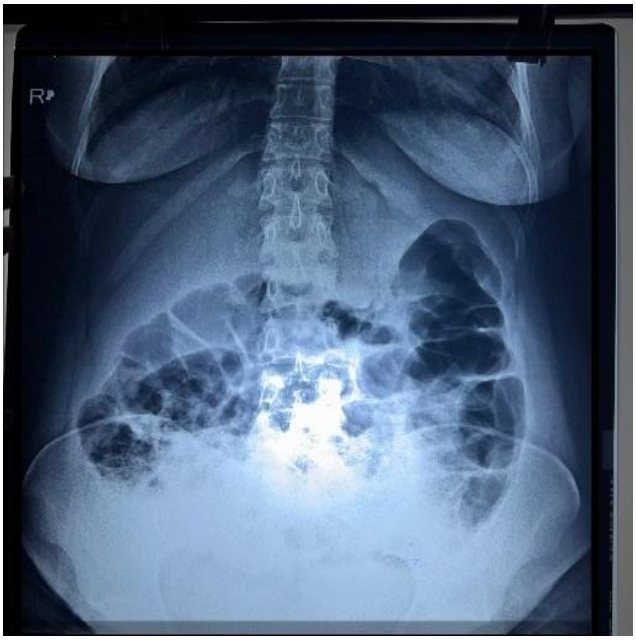

Figure 1: X-ray abdomen erect anteroposterior view of dilated large bowel.

DISCUSSION

ACPO is an uncommon condition which is difficult to diagnose due to its acute and sporadic nature. Caesarian section is found to be the most common operative procedure associated with this condition.[5,6] Commonly presenting as abdominal distention and inability to pass flatus between post operative day 2 to 12 leading to diagnostic delima.[7] Although Latunde-Dada et al reported it to present as early as 6 hrs post caeserian section; in this case patient developed symptoms on POD 2 of LSCS.[8] Abdominal X-ray erect in AP view is the first and most important investigation required which shows feature of dilated large bowel; as found in this case. CT scan with enhancement is considered to be the most important study for location and cause of large bowel obstruction.[9] Choi et al found proximal colonic dilatation without structural cause on CT scan of all patients with ACPO which is also found in this case.[10]

Management of ACPO is divided into non-surgical and surgical. With timely diagnosis initial non-surgical management with attempts to decompress bowel with nasogastric tube and keeping patient NPO and continuing IV fluids may suffice; as done in this case. However wrong and delayed diagnosis may lead to complications such as bowel ischemia and perforation and need surgical intervention. Hence; timely diagnosis is important to decrease morbidity and mortality.

CONCLUSION

Acute pseudo colonic obstruction should be considered in differential diagnosis of post LSCS abdominal distension. And after imaging studies it should be managed earliest to avoid its associated life-threatening complications.

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