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Case Report

Coexistence of Ogilvie syndrome and rectus sheath hematoma after cesarean section: a rare combination of two potentially life-threatening conditions

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ABSTRACT

Ogilvie syndrome, or acute colonic pseudo-obstruction, occurs in less than 1% of patients undergoing surgery (organ transplant, orthopedic, gynecologic, and urologic surgeries), which increases both morbidity and mortality. Rectus sheath hematoma is another uncommon abdominal pathology, typically arising from trauma, anticoagulation or sudden increase in intra-abdominal pressure. The coexistence of these two entities in the same patient is extremely unusual and can pose significant diagnostic and management challenges.

Keywords: Ogilvie syndrome, Pseudocolonic obstruction, Caesarean section complications, Hematoma

INTRODUCTION

Ogilvie's Syndrome (OS) is a rare but serious functional disorder characterized by dilatation of the colon, which usually involves the caecum and right colon without any mechanical obstruction. It was first reported in 1948 by Sir William Ogilvie.[1] It occurs in less than 1% of patients undergoing surgery (organ transplant, orthopedic, gynecologic, and urologic surgeries), with increases both morbidity and mortality rates.[2,3] Abdominal X-ray (AXR) or a CT scan of the abdomen mainly is used in diagnosis. The primary finding is dilatation of the proximal colon, which may occasionally extend to the rectum, without any evidence of mechanical obstruction. Here, we report a case of a 28-year-old gravida 3 para 2 female, who presented with acute abdominal distension following caesarean section. In this study, we aim to highlight the importance of considering Ogilvie's syndrome post caesarean sections and other abdominopelvic and orthopedic surgeries for early diagnosis and management of these patients.

CASE REPORT

A 28-year-old, gravida 3 para 2, female presented with acute abdominal distension and discomfort following an emergency LSCS operation in view of fetal distress at 37 completed weeks.

On examination, patient had gross pallor, BP- 117/78 mmHg, PR-108/min, SpO2: 99% under room air. Abdominal girth was 116 cm. Hemoglobin dropped from 13 to 8 g/dl from preoperative value. Total Count increased from 13,120 to 17,470. CRP-35. CT abdomen and pelvis showed acute colonic dilatation along with rectus sheath hematoma. Emergency relaparotomy was done. Intraoperatively, 750cc of blood and blood clots were evacuated. Largely distended Caecum with a diameter of

10cm, ascending colon, transverse colon with collapsed descending colon. We found both these entities to exist independent of each other as lumen of the colon was not obstructed.

Figure 1: Abdominal distension on presentation.

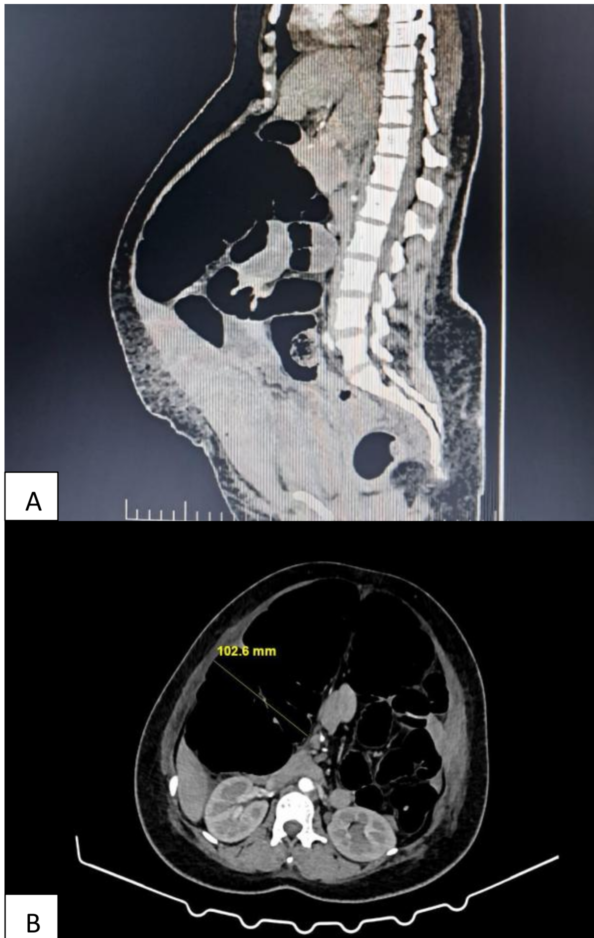

Figure 2 (A and B): Radiological image showing rectus sheath hematoma and colonic dilatation.

Large bowel deflation done with needle and looked for return of colour (reperfusion), while we waited for 15 minutes while giving 100% Oxygen and warm packs. Transverse colon regained normal colour but Caecum partially regained colour. Puncture sites were sutured with 3-0 vicryl. Intraoperatively, Patient was transfused with packed red blood cell and was started on inotropes and continued postoperatively.

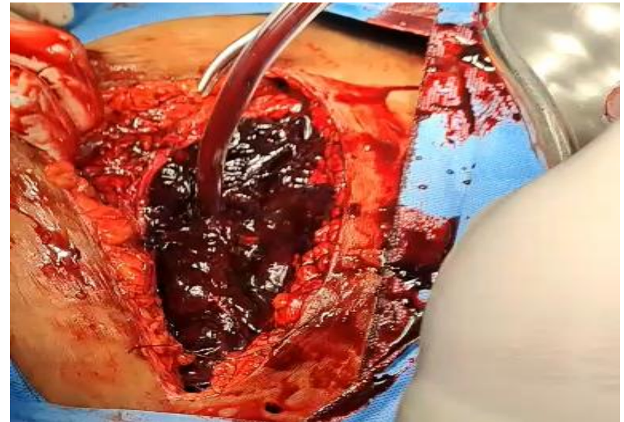

Figure 3: Rectus sheath hematoma.

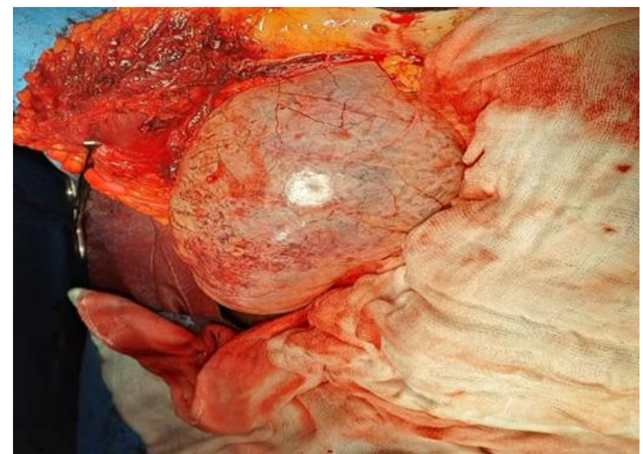

Figure 4: Intraoperative image of colonic dilatation with pre-gangrenous changes in the form of patchy mottling.

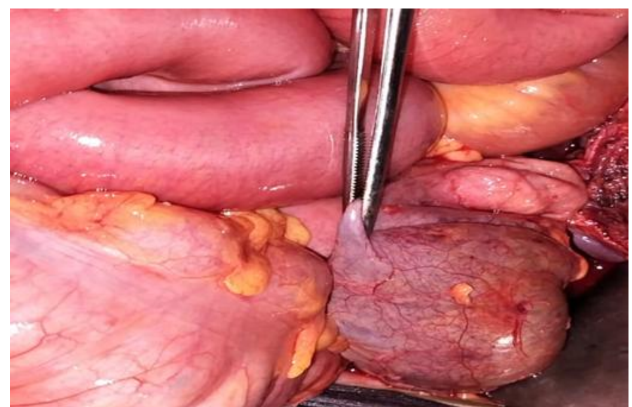

Figure 5: Return of pink colour in ascending colon with partial return of colour in ceacum after deflation (recirculation).

Close postoperative clinical monitoring maintaining nil per oral and other supportive care facilitated recovery, with resolution of both conditions and no recurrence on follow up.

The normal caliber of the bowel can be remembered using the 3–6–9 rule: the small bowel should measure less than 3 cm in diameter, the large bowel less than 6 cm, and the caecum less than 9 cm; additionally, the appendix is considered normal when its diameter is less than 6 mm.

DISCUSSION

The precise cause of Ogilvie’s syndrome remains unclear. It is thought that disruption of autonomic nervous system function resulting from factors such as trauma, spinal anesthesia, opioids, or interruption of parasympathetic fibers from S2 to S4 may lead to colonic dilation.[4] As the colon enlarges, the increasing diameter can place additional tension on the colonic wall. Clinically, the condition most commonly presents with abdominal distension, which usually develops gradually over three to seven days but may also appear rapidly within 24 to 48 hours.[4]

Diagnosis is established by ruling out other causes of intestinal obstruction, typically through abdominal imaging such as an abdominal X-ray or CT scan. A water-soluble contrast enema is generally avoided because it carries a significant risk of perforation and subsequent peritonitis.

The characteristic radiologic feature is dilation of the proximal colon with occasional extension to the rectum in the absence of any mechanical blockage.[5] The differential diagnosis includes mechanical bowel obstruction and toxic megacolon.[6] The most common surgeries associated with Ogilvie’s syndrome are cesarean sections and hip surgeries.[7]

Though, the first line of Ogilvie’s syndrome is medical management, assessing the patient’s clinical status of hemodynamic instability with CT image showing maximum caliber of colon up to 12 cm with associated rectus sheath hematoma, Relaparotomy was done.

Intraoperatively, lumen was intact suggesting no mechanical obstruction. Maximum colonic diameter was found to be up to 15cm with associated pre-gangrenous changes in the form of mottling was present. Resection anastomosis in the form of right hemicolectomy with Stoma creation could have been considered in view of pre-gangrenous and patchy mottling of ceacum /ascending colon. After, explaining the risk and benefits of right hemicolectomy versus conservative management with colonic decompression, we decided to go for conservative management. Colonoscopic decompression presents a promising intervention for Ogilvie syndrome, showing superior efficacy to neostigmine; however, relapses are common.[8] In this case, as relaparotomy was done for the management of rectus sheathe hematoma, and hugely distended colon with suspected compromise in vascularity, we resorted to colonic deflation along with postoperative stringent monitoring of the patient and patient showed significant recovery with no relapses.

CONCLUSION

Needle deflation with close clinical monitoring can be considered in selected patients to avoid extensive operations like hemicolectomy for the management of pseudo-colonic obstruction with pre-gangrenous changes.

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Ethical approval: Not required

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