Ogilvie’s Syndrome

This is a syndrome of acute intestinal pseudo-obstruction associated with massive dilation, usually of the colon but also of the small intestine. Mechanical obstruction is absent and there is parasympathetic nerve dysfunction. It was first described by Sir William Heneage Ogilvie in 1948, an English surgeon who was also an examiner for Oxbridge and wrote papers on fractures and hernias.[1] This syndrome is also known as acute colonic pseudo-obstruction (ACPO).

Epidemiology

- It is a rare condition and the incidence rate is not actually known.
- Males are more commonly affected than females.
- Ogilvie’s syndrome is more common in the elderly.

Risk factors

Ogilvie’s syndrome is often associated with other conditions, including:[2]

- Recent obstetric, gynaecological or pelvic surgery.
- Recent trauma or orthopaedic procedure.
- Underlying infection.
- Recent cardiac events.
- Electrolyte imbalance.
- Medications (eg, opioids, antidepressants).
- Solid organ transplant.

Presentation

Although symptoms and signs of a large bowel obstruction commonly occur, Ogilvie’s syndrome can have a variable clinical presentation. It is important therefore to have a high degree of suspicion in these patients.

Symptoms

- Abdominal pain, usually cramping or colicky.
- Bloating feeling.
- Nausea and vomiting.
- Intermittent constipation.

Signs

- Massive abdominal distension.
- Normal, reduced or obstructed bowel sounds.
- Minimal tenderness.
- Empty, air-filled rectum on digital rectal examination.

If left unrecognised, progressive dilatation of the colon can result in mural ischemia, perforation, and increased mortality.[2]

Differential diagnosis

- Mechanical obstruction.
- Colonic adenocarcinoma.
- Scarring, adhesions.
- Inflammatory conditions - peptic ulcer, appendicitis, pancreatitis.
- Irritable bowel syndrome.
- Hirschsprung’s disease.
- Parasitic infection - eg, American trypanosomiasis.

Investigations

- Full history - symptoms, drug history, previous surgery, past medical history and family history, psychiatric history, habits and normal diet.
- Full examination - to identify other conditions and including digital rectal examination.
- Abdominal X-ray often shows massive dilation of the colon (megacolon) with caecal diameters measuring 10-14 cm.
- A CT scan is often undertaken to exclude a mechanical obstruction.
Management
Timely recognition and close monitoring are extremely important in the management of this condition. The majority of patients improve with conservative measures.

General measures
- If possible, treat the cause.
- Enable the patient to be mobile and, if possible, to exercise.
- Advise adequate fluid intake.
- Nasogastric tube to decompress the stomach and relieve vomiting.

Pharmacological
- Antiemetic prokinetics - eg. metoclopramide.
- Intravenous (IV) neostigmine is often given and it is a safe and effective option for patients with Oglivie’s syndrome who fail to respond to conservative management.[3] When given as a bolus it can lead to a rapid improvement.[4]
- IV fluids.
- Antibiotics are started if an underlying infection is suspected.

Surgical
- Perforation, ischaemia and peritonitis necessitate urgent surgical intervention.[2]
- Decompression with flexible colonoscope, especially when caecal dilatation reaches dimensions that are considered at high risk for perforation.[5]
- Surgery undertaken is usually a caecostomy or colectomy.
- Laparotomy is indicated for ischaemia and perforation, or if the diagnosis is not clear.

Prognosis
Patients avoiding surgery and perforation make good recovery generally, although recurrence is common.

The age of the patient, maximal caecal diameter and delay in colonic decompression have been shown to have a significant direct correlation to mortality.[2]

Surgery is associated with high rates of morbidity and mortality.[5]

Prevention
- Avoidance of bed rest.
- Adequate hydration.
- Avoidance of drugs which inhibit parasympathetic gastrointestinal muscle action.
Further reading & references


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Author: Dr Louise Newson
Peer Reviewer: Dr Adrian Bonsall

Document ID: 2539 (v23)
Last Checked: 23/06/2015
Next Review: 21/06/2020

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