Rare Atypical Presentation of Ogilvie Syndrome in a Hispanic Man

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Background

Ogilvie syndrome (OS) also known as acute pseudo-obstruction of the colon is a bowel motility disorder characterized by features of intestinal obstruction in the absence of an anatomical or mechanical cause. Typical presentation is with abdominal distension but atypical and more rare presenting features have also been reported including respiratory distress. Thus, we present the first case of Ogilvie syndrome presenting with respiratory distress in a Hispanic man.

Case Presentation

A 71-year-old gentleman with a history of diabetes mellitus, functional quadriplegia and other comorbidities was brought to the ED via EMS on account of altered metal status and constipation for about three days. Pertinent findings from the examination showed a chronically ill looking gentleman with a GCS of 8/15, respiratory rate of 34, pulse oximeter saturating at 86% on ambient air, and the usage of accessory muscles. Abdominal examination showed a mildly distended abdomen with tympanitic percussion notes and hypoactive bowel sounds in all the quadrants. Digital rectal examination revealed soft non bloody loose brown stools. Three was global muscle wasting and reduced muscle strength.

Blood gas showed a pH of 7.12, pCO2- 117.4 and pO2- 74 suggestive of severe hypoxic and hypercapnic respiratory acidosis.

Plain KUB Xray and CT scan showed significant colonic distension with no fecal or anatomic obstruction. Patient was intubated for airway protection and abdominal distension was managed conservatively with discontinuation of enteral feeding, nasogastric tube decompression, potassium and magnesium replacement. Management can be escalated in patients who failed to respond to conservative measures or in those with complications like intestinal ischemia and perforation. in patients with colonic diameter > 12 cm who failed 48 to 72 hours (about 3 days) of conservative therapy, pharmacologic therapy with neostigmine can be used.

Conclusion

Our patient responded to conservative measures including withholding of enteral feeding, nasogastric tube decompression, potassium and magnesium replacement. Management can be escalated in patients who failed to respond to conservative measures or in those with complications like intestinal ischemia and perforation. In patients with colonic diameter > 12 cm who failed 48 to 72 hours (about 3 days) of conservative therapy, pharmacologic therapy with neostigmine can be used.

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