

CONTINUING MEDICAL EDUCATION ΣΥΝΕΧΙΖΟΜΕΝΗ ΙΑΤΡΙΚΗ ΕΚΠΑΙΔΕΥΣΗ

Surgery Quiz – Case 61

A 46-year-old man presented at the emergency room with abdominal distension, abdominal pain during physical exam, nausea and multiple episodes of diarrhea. He has a history of chronic use of antipsychotic medication and he is bedridden due to disability. The X-ray of the abdomen is shown below (figures 1–3).

Comment

Ogilvie syndrome, also called acute colonic pseudo-obstruction, is a rare but serious condition in which the large intestine becomes massively dilated in a way that resembles a mechanical obstruction, but without the presence of any physical blockage such as a tumor, volvulus, or foreign body. It often appears in critically ill patients, for example after surgery, trauma, severe infections, or in the context of cardiac and neurological diseases. It may also be triggered by medications that slow down intestinal motility, such as opioids or anticholinergics. The underlying cause is thought to be a disturbance of the autonomic nervous system that normally regulates colonic activity.

The syndrome takes its name from the British surgeon Sir William Heneage Ogilvie (1887–1971). Ogilvie was a prominent abdominal surgeon who trained and worked in London, serving as a consult-



Figure 1.

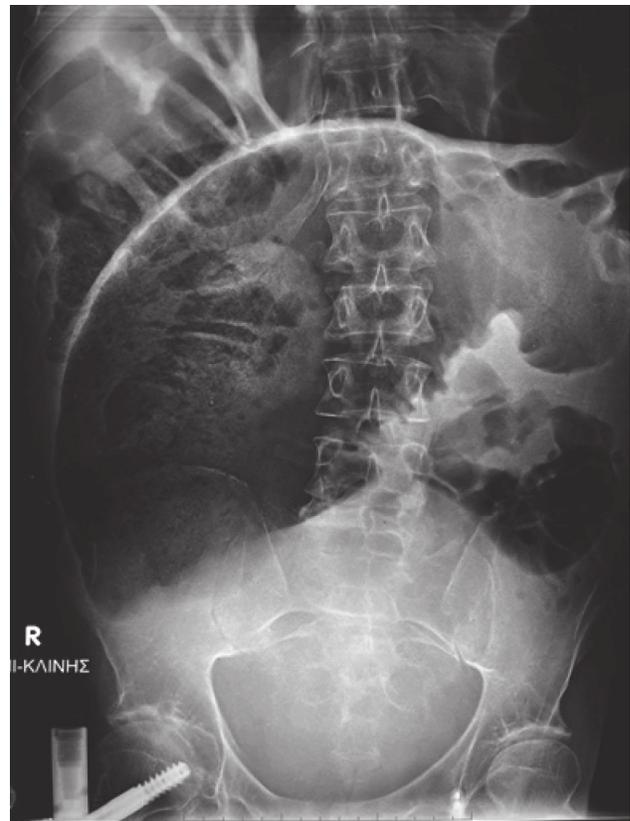


Figure 2.

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ΑΡΧΕΙΑ ΕΛΛΗΝΙΚΗΣ ΙΑΤΡΙΚΗΣ 2026, 43(3):431–432

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ant surgeon at Guy's Hospital. He had a distinguished career not only in surgery but also in military medicine, acting as a consulting surgeon to the British Army during World War II.



Figure 3.

In 1948, Ogilvie published a seminal paper in the *British Medical Journal* describing two cases of patients who developed massive dilatation of the colon that looked like a bowel obstruction, but no mechanical blockage was found at surgery or autopsy. He proposed that this phenomenon was due to an imbalance of the autonomic nervous system affecting the large bowel. His detailed observations brought attention to a previously unrecognized clinical entity, which was later named Ogilvie's syndrome in his honor.

Since then, many reports and studies have refined the understanding of the syndrome, identifying its association with postoperative states, trauma, severe systemic illnesses, and certain medications. Advances in diagnosis (radiologic imaging) and treatment (such as neostigmine and colonoscopic decompression) have significantly improved outcomes compared to the early cases described by Ogilvie.

Clinically, patients usually present with abdominal distension, abdominal discomfort or pain, nausea, vomiting, constipation, or an inability to pass gas. The main risk of the condition is progression

of the colonic dilation, which may lead to perforation of the bowel wall, especially of the cecum, and this can result in peritonitis, a life-threatening complication.

Management begins conservatively by stopping drugs that impair motility, decompressing the stomach with a nasogastric tube, decompressing the colon with enemas, and correcting fluids and electrolytes. If these measures fail, pharmacological treatment with intravenous neostigmine can be used to stimulate colonic motility. In more severe or refractory cases, decompression through colonoscopy may be necessary, and in the most critical situations surgical intervention is required. The form of surgical management depends on whether the acute pseudo-obstruction is complicated or not.

In cases of uncomplicated pseudo-obstruction, performing a cecostomy to decompress the intestine is sufficient, since the cecum is the first part to rupture when its diameter exceeds 12 cm. However, in cases of complicated pseudo-obstruction with ischemia and perforation, resection of the affected segment along with the creation of a colostomy is required. Some authors recommend a total colectomy with preservation of the rectal stump, to allow for an ileo-rectal anastomosis at a later stage. In patients with recurrent forms of the syndrome, once the acute phase of the disease has subsided, the best surgical solution is the creation of a colostomy at the level of the sigmoid colon.

Prognosis is based on the severity of the syndrome and the comorbidities of the patient.

In conclusion, Ogilvie syndrome should always be considered mostly in elderly patients with previous surgeries and severe comorbidities because it can be difficult to diagnose due to the heterogeneity of the symptoms.

References

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