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A Rare Case of Oglive Syndrome Secondary To Antipsychiatric Medication - Case Report

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Introduction

Acute colonic pseudo-obstruction (ACPO or Ogilvie syndrome) is an under-recognized disorder characterized by acute and extensive dilatation of the colon in the *absence* of an anatomic lesion obstructing the gastrointestinal tract. The condition is uncommon, however it is vital to recognize as, untreated, it is potentially lethal. It can be caused by a range of conditions, however post partum, post Caesarean section women are at particular risk.

Keywords: Acute colonic pseudo-obstruction, smoking, hypertension.

Case Report

A 64 year old male patient came with complaints of fever with chills with abdominal discomfort and distension since 4 -5 days. He also complained of strain while passing stools since 5 days with drowsiness since 1 day. There was no history of burning micturition, joint pain, rashes, cough, loose stools Patient had no history of alcohol consumption, cigarette smoking, tobacco consumption.

The patient was a known case of type 2 diabetes mellitus hypertension since 5 years and known case of schizophrenia and bipolar disorder since 12 years. He was on Tab Lithium 450mg BD since last 12 years and was recently started on Tab Clozapine 100mg BD since 10 days. He was on Tab Metformin 500mg BD and Tab Amlodipine 5 mg OD from last 5 years for diabetes & hypertension respectively

On examination the temperature of 100 degree farenhiet, pulse rate of 100/min, Blood pressure of 100 /60 mm of Hg & Respiratory rate of 24 /min

Oxygen saturation was 97 % at room air. The patient was drowsy and disoriented with distented abdomen showing sluggish bowel sounds with everted umbilicus. Respiratory system air entry bilaterally equal no adventitious breath sounds with vesicular breathing. Cardiovascular system revealed normal heart sounds with no murmurs.

His laboratory investigation revealed Hb -16.97 gm %, TLC- 18490 cumm, Platelet-1.84 lacs, Urea -110 mg/dL, Serum creatinine -2.7 mg/dL, Na^+ - 129 mmol/lit, K^+- 3.1 mmol/lit & total bilirubin was 0.9 mg/dl.

Management

The patient was diagnosed of Oglive syndrome secondary to long term use of antipsychiatry medications. Patient was conservatively managed initially with correction of hypokalaemia with IV Potassium chloride, keeping patient NBM and using nasogastric decompression with parenteral nutrition. He was started

on Inj Monocef 1 gm iv BD initially but had persistent fever spikes with TLC counts were persistingly on higher side.

Patient started developing respiratory distress and patient desaturated. patient was initially managed with oxygen support via 02 mask His blood cultures were sent which were positive for Kleibsella and patient antibiotic was upgraded to Inj Magnex forte 1.5 gm IV BD Patient respiratory distress worsened and patient was intubated i/v/o respiratory distress and airway protection. Patient showed gradual improvement with decreased ventilatory requirement and with regainment of consciousness, however patient had persistent complaints of constipation so he was started on syrup duphalac and duphalac enema which didn't resolve the constipation. Manual evacuation was attempted but to no avail and then a flatus tube was passed which led to passage of stools. Patients abdominal girth was monitored and was found to be in increasing trend.

USG- abdomen and pelvis revealed dilated bowel loops but showed no signs of mechanical intestinal obstruction. His contrast abdomen revealed dilated large bowel colon with caecum dilated more than 10 cm and findings consistent with pseudocolonic obstruction i.e Oglive syndrome.

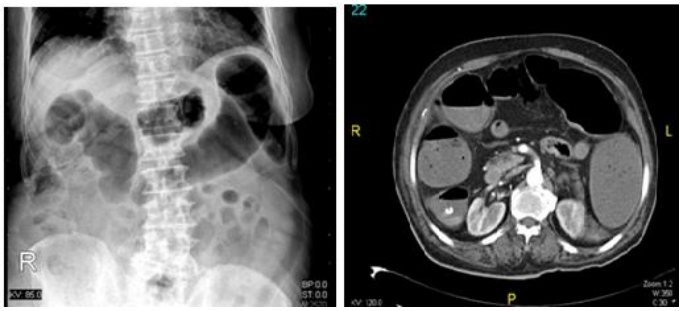

Figure 1 &2: USG ABDO-PELVIS. & CT-ABDO-PELVIS- Dilated bowel loops (10 cms) suggestive of Oglive syndrome.

Patient went into hypotension and was started on ionotropic support, during which his antipsychiatric medications were stopped and patient was given IV Neostigmine 2 mg over 5 min. Patient started passing motions frequently. Patient condition gradually improved. Ionotropic support was tapered off & blood sugar levels were controlled with Inj Human Actrapid insulin.

Discussion

Acute colonic pseudo-obstruction (Ogilvie's syndrome) is a disorder characterized by acute dilatation of the colon in the absence of an anatomic lesion that obstructs the flow of intestinal contents. Pseudo-obstruction is characterized by signs and symptoms of a mechanical obstruction of the small or large bowel in the absence of a mechanical cause. Pseudo-obstruction may be acute or chronic and is characterized by the presence of dilation of the bowel on imaging. Other causes of colonic distension, including toxic megacolon, mechanical obstruction, and chronic intestinal pseudo-obstruction. The symptoms include abdominal pain, bloating, constipation, nausea and vomiting, swollen abdomen (abdominal distention) & weight loss.

Acute colonic pseudo-obstruction usually occurs in hospitalized patients or in those residing in a long-term care facility, in association with a severe illness or after surgery, and in conjunction with a metabolic imbalance or culprit medication. Risk factor include Trauma, Burns, Recent surgery, Opioids, Phenothiazines, Clozapine, Respiratory failure, Electrolyte disturbances, Diabetes mellitus, Uremia, Neurological disease (e.g. Parkinson disease, paraneoplastic neuropathy), Postpartum (particularly post-Cesarean section delivery)

Some predisposing conditions includes nonoperative trauma, infection, and cardiac disease. Acute colonic pseudo-obstruction is also well-documented after kidney

transplantation, and possible contributing factors include obesity, cumulative dose of prednisone received, and mycophenolate mofetil.

Colonoscopy may be used to remove air from the large intestine. Fluids can be given through a vein to replace fluids lost from vomiting or diarrhea. Nasogastric suction involving a nasogastric (NG) tube placed through the nose into the stomach can be used to remove air from the bowel. Neostigmine may be used to treat intestinal pseudo-obstruction that is only in the large bowel (Ogilvie syndrome). Stopping the medicines that may have caused the problem. Common complications of Oglive syndrome includes Diarrhea, Rupture (perforation) of the intestine, Vitamin deficiencies & Weight loss.

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