



Image of the Month

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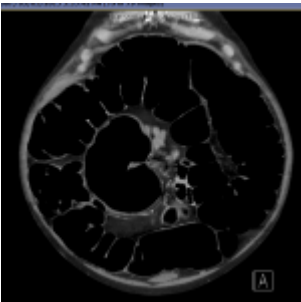
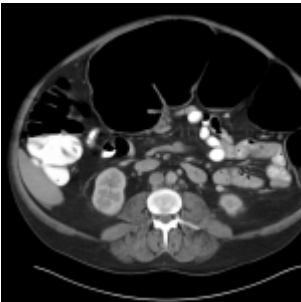
May 17, 2015 [Image of the Month](#)

Keywords [pseudo-obstruction](#)

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A 47 year-old male with history of bipolar disorder on multiple psychotropic medications was admitted to the hospital with progressive abdominal pain and distension stating that his abdominal girth increased from 130 cm to 145 cm over the past few days. He also reported loud gurgling and episodes of non-bloody diarrhea alternating with constipation. He has not had fever, chills, nausea, vomiting, or urinary symptoms. Upon physical exam, the patient was afebrile, in no acute distress, with significant abdominal distension and visible peristalsis. No peripheral edema was noted. His lab work was essentially unremarkable. There is no history of abdominal surgeries. His abdominal images showed the findings below:





The most likely diagnosis is:

1. Toxic megacolon
2. Colonic obstruction secondary to adhesions
3. Colonic pseudo-obstruction
4. Shigellosis

Correct answer is 3

This patient had colonic pseudo-obstruction. The CT abdomen showed a diffusely dilated colon with a diameter up to 13 cm in the transverse colon and no evidence of mechanical obstruction. Patients with toxic megacolon are usually quite ill, toxic, with fever, abdominal tenderness with or without signs of peritonitis and leukocytosis; other signs and symptoms of an underlying inflammatory bowel disease or infection may be apparent. The patient did not have a history of abdominal surgeries to suspect adhesions causing obstruction. But it is very important to rule out mechanical obstruction before making the diagnosis of colonic pseudo-obstruction. Shigellosis usually presents with fever, abdominal cramps and voluminous watery stools (small intestine phase), followed 48 hours later by tenesmus, less frequent stools with blood and mucus (colonic phase).

Patient outcome: The patient was admitted directly from the gastroenterology clinic with the presumptive diagnosis of acute colonic pseudo-obstruction or Ogilvie's syndrome. He had a colonoscopic decompression which additionally didn't show any evidence of colitis. He was treated with a nasogastric tube on suction, rectal tube and nothing per mouth status, under the guidance of the gastroenterology team. One dose of neostigmine was given. The management also included intravenous hydration, correction of electrolyte abnormalities, and avoidance of opiates and anticholinergic agents. Due to the lack of clinical or radiographic improvement after several days and the potential risk of perforation, gastroenterology recommended a surgical consult for possible colectomy. The surgical team recommended conservative management. Diet was gradually advanced with good tolerance, tubes were removed and the patient was discharged in stable medical condition with close follow up with gastroenterology, surgery and psychiatry. The most likely cause behind the pseudo-obstruction was thought to be the chronic use of multiple psychotropic medications.

Suggested reference:

Coulie B, Camilleri M. Intestinal pseudo-obstruction. . 1999; 50:37-55.