When bowel motility goes awry: The mysterious condition of Ogilvie syndrome

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ABSTRACT

Introduction: Ogilvie's syndrome is a condition characterized by massive colonic distension in the absence of mechanical obstruction. It is a rare but serious post-operative condition that often went unrecognized by clinicians. We wish to highlight the many similarities of this syndrome to the commonly diagnosed post-operative paralytic ileus which may mislead clinicians and hinder correct diagnosis. **Case Description:** A clinically well lady underwent elective repeat caesarean section, complicated by intra-abdominal bleeding requiring re-laparotomy. She had extensive abdominal distension afterward. Ileus was initially suspected. However, she was able to pass flatus with an active bowel sound and a minimal amount of stool. There were no features to suggest peritonism. Blood investigations showed deranged electrolytes. CECT abdomen showed dilated small and large bowels. The surgical team was involved as soon as Ogilvie's syndrome was recognized. She was managed conservatively by keeping nil-by-mouth with nasogastric tube insertion left on free drainage for bowel decompression, rehydration, and correction of electrolytes. She was also given broad-spectrum intravenous antibiotics to cover for infection and erythromycin as prokinetics. Symptoms improved with conservative therapy. **Discussion:** Timely recognition is of utmost importance in the initial assessment of patients with Ogilvie's syndrome is to prevent further complications of caecal perforation, and conservative management is possible with early detection. Hence, it is important to maintain a high index of suspicion in the post-pelvic surgery patient presenting with progressive abdominal distension, despite the presence of falsely reassuring bowel sounds and passage of flatus.

A review on management of cervical stump prolapse.

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ABSTRACT

Introduction: Supracervical hysterectomy has the advantage of preserving vaginal apical support by maintaining the normal anatomy, though it does not prevent subsequent pelvic organ prolapse (POP). Cervical stump prolapse is a known complication of a subtotal hysterectomy with an incidence of 31.4%. We present a case of trachelectomy with pelvic floor repair (PFR) for a symptomatic Stage III cervical prolapse, after an abdominal supracervical hysterectomy. **Case Description:** A 68-year-old post-menopausal Para 4, presented with progressive symptoms of POP, after an abdominal supracervical hysterectomy 20 years ago. Clinically, there was a Stage III POP with the cervix at 2 cm below the hymenal ring with Ba and Bp at +1 and 0, respectively. Conservative management with a ring pessary failed and she opted for a trachelectomy with PFR. A circumferential incision was made at the inferior aspect of the cervical stump's apex to minimize the risk of bladder and bowel injury. Bowel adhesions to the cervical stump were identified by palpation between the stump and peritoneum. Ureteric injury during the cardinal ligament clamping was avoided by identification of the ureters at 3 and 9 o'clock positions and deflecting the bladder well. Blood loss was minimal, and the patient recovered well post-operatively. **Discussion:** Cervical stump prolapse may be managed conservatively with lifestyle modifications and a ring pessary, or surgically with sacrocervicopexy, trachelectomy and colpoclesis. A vaginal trachelectomy has risks of bladder, bowel, and ureteric injury. With meticulous preparation and surgery, trachelectomy following supracervical hysterectomy is a safe and effective procedure for cervical stump prolapse.