

Ogilvie's Syndrome: The Rectal Balloon Sign

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Abstract

Intestinal pseudo-obstruction as described by Ogilvie¹ in 1948 is a well recognized clinical entity of uncertain etiology and pathophysiology. Despite its well known clinical features, the diagnosis of intestinal pseudo-obstruction remains quite difficult and is often confused with mechanical obstruction. We describe three cases with an easily recognizable clinical finding, which can serve to distinguish Ogilvie's syndrome from mechanical large bowel obstruction.

CASE 1

An 89-year old female sustained a fractured femur after falling down a flight of stairs. Two days after insertion of an Austin-Moore prosthesis she began to develop gross painless distension of her abdomen. Bowel sounds remained normal and digital rectal examination (DRE) revealed a dilated, air-filled rectum without stool. Plain abdominal films showed gross distension of her entire colon and rectum. A tentative diagnosis of Ogilvie's syndrome was made. One day later she passed copious amounts of stool and her distension subsequently resolved completely.

CASE 2

A 62-year old male diabetic with chronic renal failure presented with constipation for one week. Examination revealed a grossly distended abdomen with normal bowel sounds. Plain supine abdominal X-rays revealed grossly distended colon up to the recto-sigmoid area. DRE revealed an air-filled rectum devoid of stool. Two days after presentation, the abdominal distension resolved with the passage of large amounts of watery stool and flatus.

CASE 3

A 57-year old alcoholic cirrhotic male was admitted with a two-day history of abdominal distension and constipation. There was a grossly distended, tympanic, mildly tender abdomen. DRE revealed a dilated, air-filled rectum without stool. He was managed conservatively and settled within 72 hours.

DISCUSSION

The accurate and early diagnosis of Ogilvie's syndrome remains elusive. Patients have concomitant disease in 80%

of cases², including femoral fractures and hip surgery³, myocardial infarction⁴ and renal failure⁵.

Symptoms include marked distension, colicky abdominal pain and constipation⁶. Nausea and vomiting are common complaints³. Examination reveals massive abdominal distension⁷ with normal, reduced or obstructive bowel sounds. Tenderness is usually minimal².

The features of Ogilvie's thus closely mimic mechanical large bowel obstruction^{8,9}. Since the treatment of these two clinical entities is vastly different, a firm diagnosis of Ogilvie's is paramount to avoid unnecessary surgical intervention.

The authors have noted that in all three cases of Ogilvie's syndrome, DRE revealed not only an empty rectum, but a rectum that was filled with air, such that the examining finger on passing via a snug fitting anal canal enters a massively ballooned, air-filled space, resulting in much difficulty in reaching its walls.

CONCLUSIONS

We believe that the related paralytic disorder that affects the colon should also affect the rectum, leading to distension of this portion of the gut as well. This finding is quite distinct from the empty but collapsed rectum palpated in a patient with mechanical colonic obstruction where the distal colon and rectum retains its muscular tone.

This feature may be the only frequent, easily detectable physical finding that differentiates mechanical obstruction from pseudo-obstruction, thus avoiding unnecessary surgical intervention or uncertainty in diagnosis.

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