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Research Article

OLI GIVES SYNDROME IN ALCOHOLIC LIVER DISEASE WITH ABDOMINAL PARACENTESIS. CASE REPORT AND MANAGEMENT

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A B S T R A C T

Ogilivie syndrome, which is also known as pseudo obstruction is acute dilatation of the colon without any mechanical obstruction in severely ill patients[(1)]. This is a rare association of Ogilvie syndrome with alcoholic liver disease following paracentesis. A series of investigations were carried out to establish the diagnoses and torule out any mechanical obstruction which is of utmost importance before planning the treatment. Diagnoses was confirmed on CECT abdomen and water-soluble enema. Patient was treated conservatively and recovered without any further complications.

INTRODUCTION

Pseudo obstruction of the colon also known as Ogilvie syndrome derived in name from Sir William Heneage Ogilvie who first described it in 1948[(2)]. Pseudoobstruction is a condition characterised by massive colonic distension in the absence of mechanical obstruction[(3)]. This condition is known to be associated with 1) metabolic disturbances, 2) major surgery 3) shock 4) anticholinergic drug[(3,4,5,6)]. However, a rare case of Ogilvie syndrome associated with alcoholic liver disease is reported here.

Case Presentation

A 60 years old male presented to the emergency with complaints of abdominal distension and loose stool for 2 days. Patient had a medical history of alcoholic liver disease with paracentesis done for ascites every 15 days for the past 2 months. He had similar complaints following previous paracentesis. Patient was afebrile, tachycardic and hypotensive. On examination, patient was observed to be pale and icteric with bilateral pedal edema. On per abdomen examination, abdomen was nontender, distended. Shifting dullness and tympanic note was elicited. Bowel sounds were present. Patient passed flatus. DRE revealed dilated air-filled rectum. Xray abdomen erect showed distended large bowel loop with multiple air fluid levels.

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USG abdomen showed features suggestive of acute intestinal obstruction with mild peritoneal thickening and ascites with liver parenchymal changes Blood investigations showed Hb-7.6 gm%, TLC – 9.5 x 1000cumm, Total Bil- 1.43 mg/dl, Albumin- 2 gm/dl, Lipase- 540 IU/L, PT/INR- 17.3/1.45. Patient was resuscitated immediately with IV fluids, nasogastric decompression and bowel rest. He was started on antibiotics to cover for bacterial peritonitis. CECT abdomen was done which showed dilated small and large bowel without any transition point suggestive of Ogilvie syndrome with moderate ascites and hepatic parenchymal changes suggestive of alcoholic liver disease. Water soluble contrast enema showed no mechanical obstruction[(7)]. Paracentesis was done which showed inflammatory cells on cytology. Once the diagnosis was confirmed, patient was managed conservatively by decompressing the colon using a flatus tube[(8,9)]. Patient's response was closely monitored using a series of abdominal radiographic scans. Neostigmine, a parasympathetic agent, 2 mg IV was given[(10,11,12)] over a period of 5 minutes and monitored for bradycardia[(11)]. Patient passed stool/flatus within 20 mins of drug administration. Abdominal distension was relieved and patient was monitored for 24 hours. Following which, oral feeds were started and on observing no complaints of nausea/vomiting, abdominal distension over a period of 48 hours, patient was discharged under satisfactory condition.

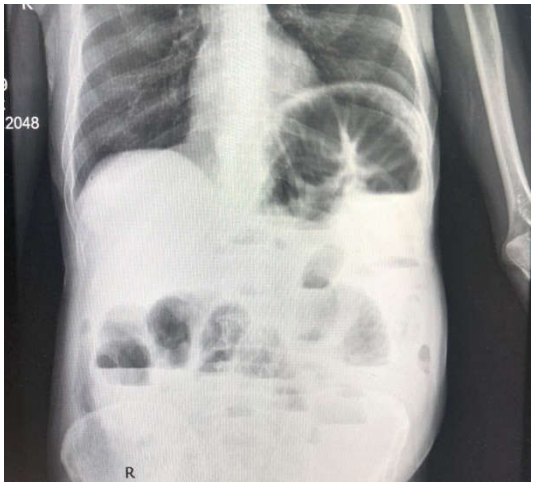

Fig 1 Xray Abdomen Erect

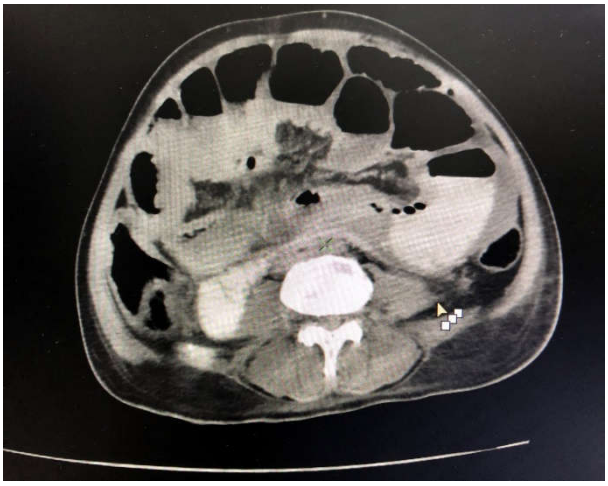

Fig 2 CECT Abdomen (axial section)

Fig 3 CECT Abdomen (coronal section)

DISCUSSION

Ogilvie syndrome is previously known to be associated with metabolic disturbances, major surgeries, shock, various drugs[4,5,6]However, this is a rare case where it is associated with alcoholic liver disease and repeated abdominal paracentesis. Symptoms include marked abdominal discomfort, colicky pain[13]. On examination, there is massive abdominal distension[14] and tenderness is usually minimal[15], with normal or reduced bowel sounds[14].

Features of Ogilvie syndrome closely mimic mechanical large bowel obstruction[16,17]. Since the treatment of the 2 clinical entities varies vastly, confirmed diagnosis is of paramount importance to avoidunnecessary surgical intervention. Ogilvie syndrome usually involves the caecum and right colon but can involve any part of the colon[18]. Typically, diameter >14 cm are believes to be associated with high risk of perforation[5,6]. Different approaches have been used in managing Ogilvie syndrome. It can be managed by first addressing the underlying condition, ie discontinuation of narcotic drugs, correction of electrolytes[4]. Colonic decompression should be achieved by conservative measures such as bowel rest, nasogastric tube placement, rectal tube placement[8,9]. Medical therapies such as neostigmine is used at the single dose of 2 mg IV over 3- 5 minutes period and monitored for side effects[10,11,12]. Atropine should be available at the bedside in case of bradycardia[11]. Perforation and intestinal ischemia are the most serious complications associated with delayed treatment[19]. If the patient is unresponsive to treatment, caecostomy is performed[20].

CONCLUSION

Ogilvie syndrome associated with alcoholic liver disease following paracentesis of ascitic fluid is a rare entity, treatment is planned after differentiating it from mechanical obstruction. Conservative management serves to be the best line of management, if diagnoses is not delayed.

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