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Letter to the Editor

Endoscopic decompression of acute large bowel pseudo-obstruction

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Sir, acute colonic pseudo-obstruction is a complication that usually occurs in hospitalized patients with serious underlying medical or surgical conditions and it is characterized by acute colonic dilatation in the absence of mechanical obstruction. The pathogenesis is incompletely elucidated but changes in autonomic nervous system function are likely to contribute, as are metabolic and several pharmacologic factors. Early diagnosis and appropriate intervention is critical in this disorder, which results in high morbidity and mortality intrahospital rates up to 30%. Treatment options include conservative measures, pharmacologic treatment with neostigmine and endoscopic decompression. Surgical decompression or resections are necessary in case of refractoriness or perforation, respectively.[1]

A 44-year old woman with unremarkable previous history presented to the Emergency Department of our Hospital with abdominal pain and discomfort lasting several hours. Clinical examination and laboratory tests including abdominal X-ray (Figure 1a) and abdominal computed tomography were compatible with acute colonic pseudo-obstruction and no signs of sigmoid volvulus. We decided to treat the patient conservatively and to perform endoscopic decompression, as there were no signs of inflammation or other systematic diseases. The risk of bowel rupture due to the high degree of bowel distension was estimated to be high and patient was scoped in the operating room.

Decompression, without any kind of previous bowel cleansing, was successfully performed through careful flexible sigmoidoscopy with minimum air insufflation and wire-guided tube inserted sixty centimeters up to the area of splenic flexure. The patient immediately improved clinically and abdominal X-ray confirmed this improvement the next day (Figure 1b). The patient was discharged one day later in excellent condition and underwent diagnostic colonoscopy two weeks later, which was negative. We

Figure 1a. Acute idiopathic large bowel pseudo-obstruction.

Keywords: Endoscopic decompression, bowel, pseudo-obstruction.

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advised the patient to have extensive investigation in case of a new bowel pseudo-obstruction episode.

Bowel pseudo-obstruction can be successfully treated with conservative measures including neostigmine and erythromycin.[2] Endoscopic decompression when decided and carefully performed is a safe and successful technique for the management of acute bowel pseudo-obstruction.

Except of the routine use of a -wide in diameter- nasogastic or colorectal tube, other types of tubes have been suggested including Dennis Colorectal Tube (DCT),[3] and Bilbao-Dotter hypotonic duodenography tube.[4] The level of tube placement in the bowel depends on the ability to safely perform a total colonoscopy in every particular clinical case but a study demonstrated that decompression tube positioned in the right colon and in the transverse colon had similar clinical success. Complete colonoscopy and cecal tube placement at the time of the acute episode is unnecessary according to this study.[5] Endoscopic failures and complications during decompression are usually very rare and include ischemic lesions and perforation.[6] It has been suggested that administration of polyethylene glycol electrolyte balanced solution in patients with Ogilvie's syndrome after initial resolution of colonic dilatation may increase the sustained response rate after initial therapeutic intervention.[7] We would like also to stress that patients with relapsing episodes of intestinal pseudo-obstruction need further evaluation with endoscopic intestinal inspection, colon transit time and careful exclusion of any concomitant systematic disease affecting intestinal motility.

Figure 1b. Large bowel 24 hours after endoscopic decompression.

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