Clinical features

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Symptoms include abdominal distension and vomiting akin to mechanical small bowel obstruction (see Chapter 78); however, colicky pain is less of a feature. On examination, other than evidence of the cause, e.g. recent surgery , the abdomen will be distended, tympanic and have reduced or absent bowel sounds. . Clinical features

Symptoms include abdominal distension, absolute constipa - tion and, as a later feature, vomiting akin to mechanical large), the bowel obstruction (see Chapter 78); however, colicky pain is less of a feature. The histor y is very important to establish risk factors, some of which may be modifiable. On abdominal examination, the abdomen is usually grossly distended and tympanic. In uncomplicated cases, the abdomen should not be tender. Tenderness and especially any evidence of peritonism indicate that massive colonic dilatation may have led to isch - aemia with/without perforation – a surgical emergency . Such complications occur in 3–15% of patients with advanced age and increased caecal diameter, with a delay in decompression increasing risk. Diagnosis relies upon accurate clinical observation and plain abdominal radiography showing deg rees of colonic dila - tation, mainly involving the proximal colon. CT is however the definitive in vestigation (Figure 73.5) to di ff erentiate mechan - ical fr om pseudo-obstruction, to provide a caecal diameter and to show any evidence of complications (e.g. perforation). A CT scan will also di ff erentiate pseudomembranous colitis with toxic dilatation, which is a further di ff erential diagnosis in hospitalised or institutionalised patients due to Clostridium di ffi cile infection.

Revision #1
Created 2025-12-31 15:27:10 UTC by Omar Ayman
Updated 2025-12-31 15:27:10 UTC by Omar Ayman