Pseudo-obstruction

Pseudo-obstruction

This condition describes an obstruction, usually of the colon, that occurs in the absence of a mechanical cause or acute intra-abdominal disease. It is associated with a variety of syndromes in which there is an underlying neuropathy and/or myopathy and a range of other factors. Small intestinal pseudo-obstruction This condition may be primary (i.e. idiopathic or associated with familial visceral myopathy) or secondary . The clinical picture consists of recurrent subacute obstruction. The diag nosis is made by the exclusion of a mechanical cause. Treat ment consists of initial correction of any underlying disorder. Metoclopramide and erythromycin may be of use. Colonic pseudo-obstruction This may occur in an acute or a chronic form. The former, also known as Ogilvie's syndrome, presents as acute large bowel obstruction. Abdominal radiographs show evidence of colonic obstruction, with marked caecal distension being a common feature. Indeed, caecal perforation is a well-recognised complication. The absence of a mechanical cause requires urgent confirmation by colonoscopy or a single-contrast water- soluble barium enema or CT . The aetiology , investigation and management are covered in detail in Chapter 73 . Sir William Heneage Ogilvie , 1887–1978, surgeon, Guy's Hospital, London, UK. Alavi K, Poylin V , Davids JS et al . American Society of Colon and Rectal Surgeons clinical practice guidelines for the management of - colonic volvulus and acute colonic pseudo-obstruction. Dis Colon - Rectum 2021; 64 : 1046–57. Bickell NA, Federman AD, Aufses AH. Influence of time on risk of bowel resection in complete small bowel obstruction. J Am Coll Surg 2005; 201 : 847–54. Ceresoli M, Coccolini F , Catena F et al . Water-soluble contrast agent - in adhesive small bowel obstruction: a systematic review and meta-analysis of diagnostic and therapeutic value. Am J Surg 2016; 211 (6): 1114–25. Fevang BT , Fevang J, Lie S et al . Long-term prognosis after operation for adhesive small bowel obstruction. Ann Surg 2004; 240 : 193–201. Finan PJ, Campbell S, V erma R et al . The management of malignant large bowel obstruction: ACPGBI position statement. Colorectal Dis 2007; 9 (Suppl 4): 1–17. Ha GW , Lee MR, Kim JH. Adhesive small bowel obstruction after laparoscopic and open colorectal surgery: a systematic review and meta-analysis. Am J Surg 2016; 212 (3): 527–36. Miller AS, Boyce K, Box B et al . The Association of Coloproctology of Great Britain and Ireland consensus guidelines in emergency colorectal surgery . Colorectal Dis 2021; 23 : 476–547. ten Broek RP , Stommel MW , Strik C et al . Benefits and harms of adhesion barriers for abdominal surgery: a systematic review and meta-analysis. Lancet 2014; 383 (9911): 48–59. - van Hooft JE, V eld J, Arnold D et al . Self-expandable metal stents for - obstructing colonic and extracolonic cancer: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2020. Endoscopy 2020; 52 : 389–407. V ogel JD, Feingold DL, Stewart DB et al . Clinical practice guidelines for colonic volvulus and acute colonic pseudo-obstruction. Dis Colon Rectum 2016; 59 : 589–600. Williams SB, Greenspon J, Y oung HA, Orkin BA. Small bowel obstruction: conservative vs. surgical management. Dis Colon Rectum 2005; 48 : 1140–6. Wolthuis AM, Bislenghi G, Fieuws S et al . Incidence of prolonged postoperative ileus after colorectal surgery: a systematic review and meta-analysis. Colorectal Dis 2016; 18 : O1–9.

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