MANAGEMENT OF ACUTE COLONIC PSEUDO-OBSTRUCTION(OGILVIE'S SYNDROME) THROUGH AYURVEDA: A CASE REPORT

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ABSTRACT

Ogilvie's Syndrome (OS) or Acute Colonic Pseudo-Obstruction (ACPO) is a rare condition characterized by massive dilatation of the colon in the absence of mechanical obstruction.The exact pathophysiology of OS is still unknown but imbalance between the sympathetic and parasympathetic innervation of the colon is supposed to be responsible for it. No pharmacological intervention (except neostigmine) is found to be beneficial and surgery is needed to very few cases. A female of age 45 years with a complaint of constipation for 20 days and with diffuse distention of abdomen associated with nausea and vomiting was admitted in an Ayurveda Hospital. On clinical examination and radiological investigation it was diagnosed as OS. Conservative line of treatment was adopted along with Ayurvedic laxative (*Haritaki Khanda*) and herbal enema. The patient responded very well to the treatment and was discharged on the 7th day after the distention and pain was completely subsided.

Keywords: Ogilvie's Syndrome, Acute Colonic Pseudo-Obstruction, Ayurveda, *Haritaki Khanda*

Introduction

Ogilvie's Syndrome (OS) or Acute Colonic Pseudo-Obstruction (ACPO) is a rare condition characterized by massive dilatation of the colon in the absence of mechanical obstruction. It was first described by William Heneage Ogilvie in 1948.[1] It is often seen in association with other diseases and occasionally complicates the post-operative course of patients undergoing abdominal surgery.[2] Commonly, right colon and caecum is affected. Furthermore, if it is misdiagnosed, it can result in significant morbidity and mortality (31% and 45%) after spontaneous perforation.[3]

The pathophysiology of the OS is still not very clearly understood. However, as initially reported by Ogilvie in 1948.[1] an imbalance between the sympathetic and parasympathetic innervation of the colon is responsible for erratic peristaltic activity resulting in progressive colonic dilatation. The incidence of colonic ischaemia and perforation in patients of OS has been quoted as 10% and 20% respectively. Colonic decompression is the most widely accepted therapy to treat patients of OS. Intravenous neostigmine has also been proven effective for the medical management of this syndrome. [4] In Ayurveda, till date no proper protocol is available for the management of any types of colonic pseudo-obstruction like Ogilvie's syndrome.

Case presentation

A female of age 45 years came to the OPD of an Ayurveda Hospital with the complaint of inability to pass stool from 20 days and with diffuse pain on all quadrants of abdomen. The pain was continuous on nature, mild on severity, non-radiating and not relieved by any measures associated with nausea and vomiting from 7 days. Vomiting was non projectile, bilious and 2-3 episodes per day.

According to the patient, she was non diabetic, non-hypertensive and didn't have any history of Tuberculosis. She had a history of an Abdominal surgery (The patient is unaware of the indication and name of the procedure and no previous reports are available, scar of midline incision present) 20 years back, tubectomy(10 years back), and Total Abdominal Hysterectomy (8 years back).

Clinical Findings

General Examination:

Pallor, Icterus, Lymphadenopathy, Cyanosis, Clubbing, Oedema was absent. Mild to moderate Dehydration was present.

Systemic Examination:

Respiratory Examination: Bilateral equal air entry, Normal Vesicular Breath Sound

Cardiovascular Examination: 1st and 2nd heart sound heard, No murmur.

Central Nervous System Examination: Well oriented to time, place and person

Per Abdomen Examination:

Inspection: Diffuse distention of Abdomen, with scar of midline incision present

Palpation: Soft, generalised tenderness on all quadrants of abdomen

Percussion: Hyper-resonant sound on all quadrants of abdomen

Auscultation: Bowel sounds absent

Investigations

Laboratory investigations like, Complete Haemogram, Serum Electrolytes, Urine

Routine and Microscopic Examination were within normal limit.

Computed Tomography (CT) Scan of Abdomen and Pelvis:

Impression:

- Gross dilatation of large bowel loops involving the sigmoid colon, descending colon, transverse colon, ascending colon, caecum, terminal ileum, with average caliber measuring around 6-7cms. It is causing significant compression over adjacent stomach with compression over GE junction and resultant oesophageal dilatation (38mm). There is extrinsic compression over duodenum at the region of ampulla with resultant dilatation of CBD (12mm) throughout it's course. Findings are in favour of large bowel obstruction.
- Post hysterectomy status.

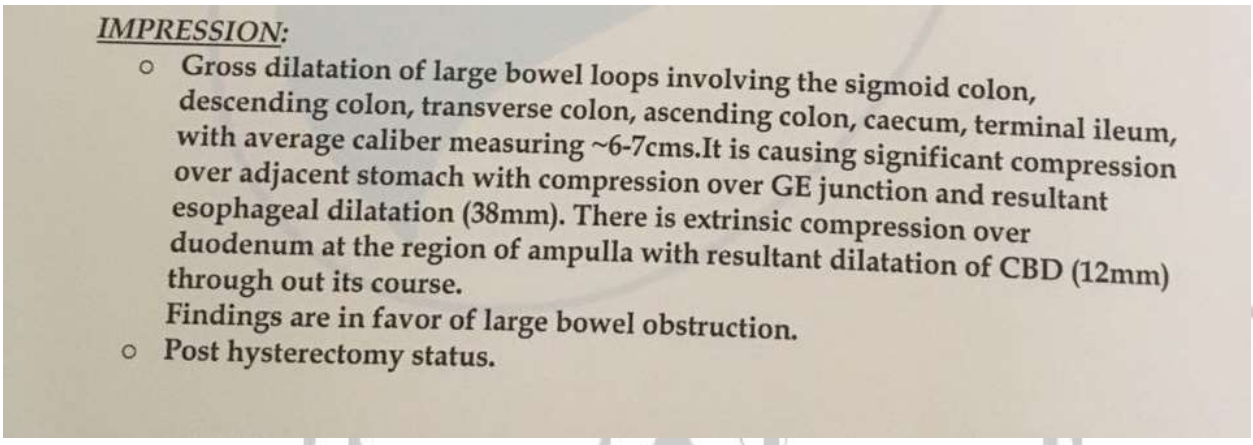

Fig: 1 Findings of Contrast enhanced Computed Tomgraphy of Abdomen and pelvis.

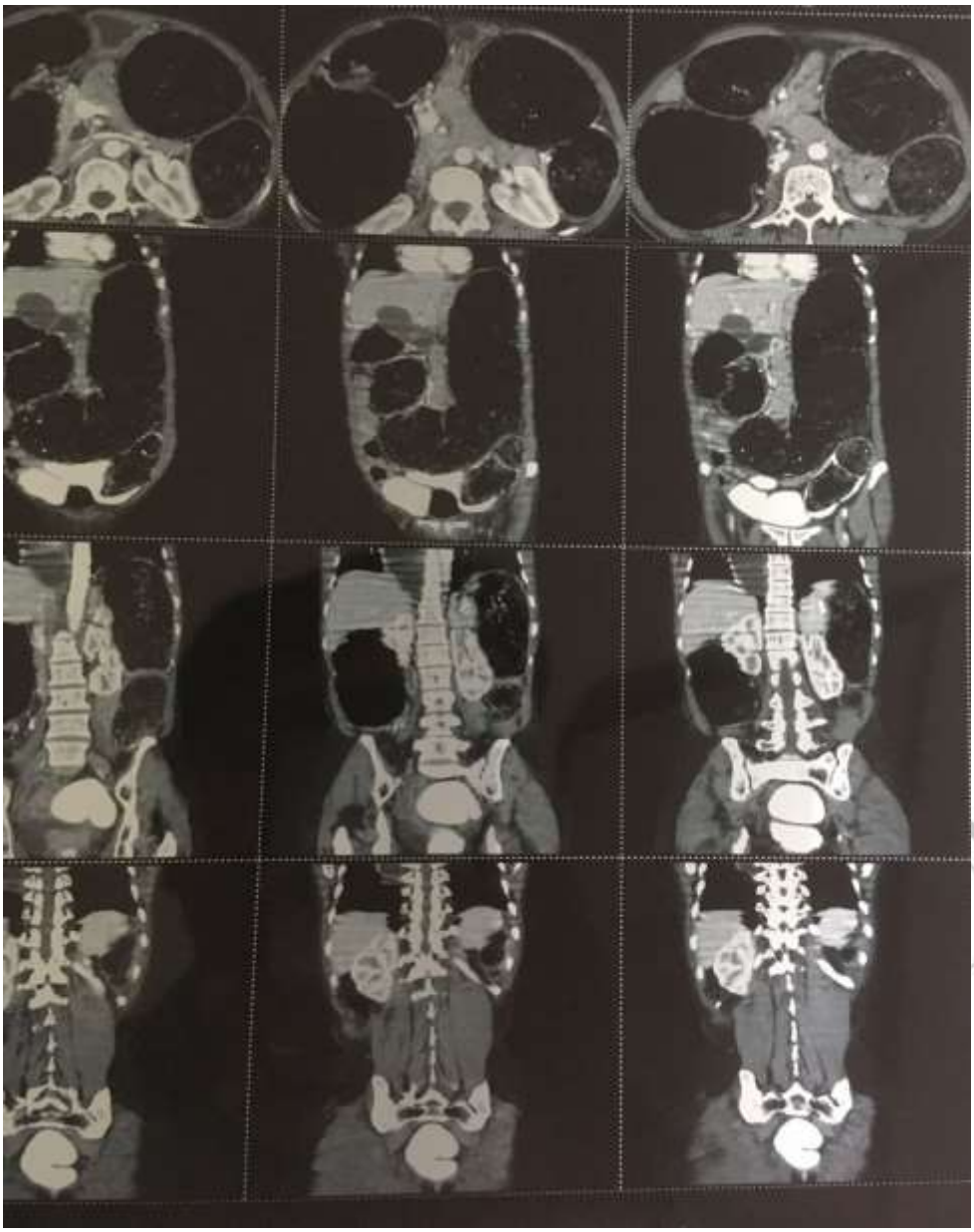

Fig 2: CECT film of Abdomen and Pelvis

Therapeutic Intervention and Outcomes

- Nil per Oral for 24 hours
- Ryle's Tube Aspiration, Insertion of rectal tube
- Intravenous fluids ,DNS and RL alternatively-100ml/hour

Within 24 hours, the nausea and vomiting of patient was stopped.

Then, Ayurvedic Laxative i.e. Haritaki Khanda (Ingredients:*Terminalia bellerica, Terminalia chebula, Emblica officinalis, Zingiber officinarum, Piper longum, Piper nigrum, Cinnamomum zeylanicum,Cinnamomum tamala, Trachyspermum ammi, Mesua ferrea, Cyperus rotundus, Syzigium aromaticum, Foeniculum vulgare, Elettaria cardamomum*) was started at the dose of 10mg of powder 8th hourly with 1 glass of luke warm water.

From next day, the patient started passing flatus and the abdominal distention was

reduced. An Ayurvedic enema of *Dasmoola* (formulation of 10 herbal roots) was started from that day along with the Ayurvedic laxative.

The next day, the abdominal distention was markedly reduced and the patient had 1 episode of defecation.

At the end of 4th day of admission, the abdominal distention was completely reduced and the patient started to have proper bowel movements. The Ryle's tube was the taken out and orally semisolid food was allowed.

On the 7th day of admission the patient was discharged.

Discussion

Ogilvie's syndrome although has high chances of perforation where surgery is needed but successful resolution is achieved in 83% to 96% of patients within 2 to 6 days of treatment.[5] If the case was not improving with the conservative methods trial of neostigmine is the common protocol to be started.[6] Rectal tube along with ayurvedic laxative must have helped to release the flatus continuously. The enema given in the 2nd day of admission must have helped to decompress the terminal part of colon along with removal of residue faecal materials. As no exact pharmacological intervention is very helpful (except neostigmine)[7], absolute bowel rest was given along with conservative ayurveda modalities were adopted, which were found to be helpful in this very case.

Conclusion

A case of Ogilvie's syndrome was managed by following conservative management protocol along with different Ayurvedic medicines and procedures. As it was a single case, we cannot derive any valid conclusion that can be generalized in every cases. Study must be conducted in large sample size to come with a valid conclusion.

Acknowlegement

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Conflict of Interest: None.

Consent: The consent was signed by the patient.

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