The findings pictured are consistent with pseudo-obstruction (Ogilvie’s syndrome), a syndrome in which the patient appears to have signs and symptoms of colonic obstruction with a mechanical etiology. Although the underlying pathophysiology is multifactorial, derangement of sacral parasympathetic tone is a common pathway. Decreases in neuroelectrical activity reduce colonic motility. Many intrinsic and extrinsic agents may be involved, but no histopathologic defects in the neural or muscular layers of the colon have been identified in the resected colons of patients with this problem. The condition is associated with many common chronic medical conditions, postoperative states, and a host of medications.

Colonic pseudo-obstruction may be difficult to diagnose because of its nonspecific presenting features. It may be mistaken for mechanical obstruction. Abdominal pain, distention, obstruction, and occasionally diarrhea are common features of the disorder. X-rays demonstrating massively dilated large bowel without evidence of mechanical obstruction are an integral part of the diagnosis. Endoscopy may be required for decompression as well as to exclude a constricting lesion. Contrast x-rays may also be required.

Nasogastric decompression, intravenous hydration, and correction of electrolyte abnormalities are standard interventions. Once resuscitation has been well established, efforts to decompress the colon may be used. Many authors favor endoscopic decompression. Epidural anesthesia and agents such as intravenous neostigmine that modify parasympathetic tone and enhance colonic motility have proven effective. Operative intervention is reserved for patients who do not respond to conservative measures, or those in whom colon perforation appears imminent.

References