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OGILVIE'S SYNDROME AFTER CAESAREAN SECTION

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INTRODUCTION

Acute colonic pseudo-obstruction, also known as Ogilvie's syndrome, is an uncommon puerperium condition characterised by significant colon dilatation without mechanical obstruction. It's uncommon, but it's been known to happen following a Caesarean section. It can cause ischaemia or bowel perforation. It can, however, happen after a vaginal birth, an instrumental birth, or during pregnancy in women.

DEFINITION

Ogilvie's syndrome (acute colonic pseudo-obstruction/ACPO) is characterised by acute dilatation of the colon, usually affecting the caecum and right hemi colon, with no mechanical obstruction.

ETIOLOGY

The cause and pathogenesis of Ogilvie's Syndrome are unknown, however if left untreated, the distension can lead to intestinal rupture or ischemic perforation

RISK FACTORS

• Although there were no specific risk factors for acute colonic blockage, instances were reported in connection with considerable narcotic analgesia, especially after caesarean section.

• Untreated cases of Ogilvie's syndrome resulted in intestinal perforation and faecal peritonitis, which resulted in increased morbidity and mortality.

SIGNS AND SYMPTOMS

In the postpartum period, the signs and symptoms of Ogilvie's syndrome are similar to those of mechanical intestinal obstruction.

- Abdominal Pain
- The most common finding is gradual abdominal distension, which occurs 2 to 12 days after a caesarean section.
- Bowel movements become infrequent or just a tiny volume of faeces is passed
- Nausea is common, although vomiting is frequently a secondary symptom.
- Bowel sounds are described by 90% of patients and might be hyperactive, high pitched, or missing.
- Between 40 and 50 percent of women continue to pass gas.

- Tachycardia
- In the absence of sepsis or indications of peritonism, a high white cell count
- Although the temperature is normally normal, pyrexia can suggest sepsis, intestinal necrosis, or perforation.
- The woman becomes quite unwell, with dehydration, oliguria, and electrolyte imbalance symptoms.
- If the colon perforates, it will require a laparotomy, bowel resection, and the creation of a stoma if it is not identified.
- Tenderness over the caecum in the right iliac fossa can signal impending rupture.

SYMPTOMS OF A DEVELOPING DISEASE OR PERITONEAL IRRITATION INCLUDE:

- Fever, chills, rigor
- Nausea and vomiting
- Diarrhoea, constipation, failure to pass flatus
- Minimal urine output
- Loss of appetite
- Persistent discomfort and increased distension, including Blumberg's sign (rebound tenderness in the abdomen)

For diagnosis and therapy, women with severe intestinal distension or symptoms of peritoneal irritation require URGENT senior obstetric and general surgical assessment.

DIAGNOSIS

To rule out colonic dilatation and perforation, a postpartum lady with abdominal distension and pain should have adequate imaging.

The most useful diagnostic test is a plain abdomen X-ray. It will display a characteristic picture of a gaseous distension in the colon, especially the caecum, in Ogilvie's syndrome. Perforation can happen even if the caecal diameter is less than 9cm, although it is more likely when the diameter is greater than 9cm. As the dilatation approaches 12cm, perforation becomes more likely.

A water soluble (ideally) contrast enema should be conducted to rule out mechanical obstruction if plain radiography fails to confirm the diagnosis. However, it is unknown what role it plays in individual cases of Ogilvie's syndrome.

Large bowel loop dilatation with no focal source of obstruction can be diagnosed using computerised tomography (CT) of the abdomen and pelvic.

Following a caesarean section, women should be checked by a medical officer at least every 24 hours.

TREATMENT

- It's critical to get a diagnosis and treatment as soon as possible to avoid caecal rupture and the high maternal death rate that comes with it.
- An initial trial of conservative/supportive care measures with the woman kept nil by mouth, nasogastric decompression, bowel rest, and correction of fluid and electrolyte imbalance (24-48 hours unless clinical deterioration warrants earlier intervention) should be used (unless clinical deterioration warrants earlier intervention).
- Medications that have the potential to worsen the disease, such as opioids, should be stopped.
- Aperients, anti-flatulent, and antispasmodics should be avoided.
- It's critical to keep track of the woman's hemodynamic state.
- Start a fluid balance chart and record all of your urine production.
- Promote mobility and ambulation. Prophylaxis against venous thromboembolism should be continued or started according to local guidelines.
- There is accumulating evidence that chewing gum is linked to early bowel motility recovery and the resumption of bowel function after a caesarean section, women regain bowel function and have a shorter hospital stay
- Laboratory tests such as a full blood count (FBC), C-reactive protein (CRP), electrolytes, and others are recommended.
- If sepsis is suspected, a blood culture should be performed.
- Surgery is the primary line of defence when peritoneal indications of perforation are present.

PHARMACOLOGIC TREATMENT

- If conservative therapy fails to produce results, other treatment alternatives should be investigated.
- Administering neostigmine, an acetylcholinesterase inhibitor that can be used to treat motility issues, is the best evidence available for medical intervention.
- Prior to starting neostigmine medication, a mechanical obstruction must be ruled out.
- Salivation, nausea, vomiting, abdominal pain, bradycardia, hypotension, and bronchospasm are among side effects of cholinesterase inhibitors. Signs of perforation, a baseline heart rate of less than 60 beats per minute, a systolic blood pressure of less than 90mm Hg, or active bronchospasm requiring medication are all contraindications to neostigmine therapy.
- A neostigmine injection of 2 to 2.5 mg is given intravenously during a 3–5-minute period.
- During neostigmine medication, women should have their cardiorespiratory systems monitored.
- If severe cholinergic events develop while taking neostigmine, atropine should be readily available to treat them. For symptomatic bradycardia, a fast intravenous infusion of 0.5 to 1 mg of atropine is used. If necessary, repeat the dose every 3 to 5 minutes until the desired heart rate is reached or 3 mg has been administered.

BOWEL DECOMPRESSION VIA COLONOSCOPY

• When intestinal perforation is not suspected, the caecal diameter is greater than 9cm, or supportive and medicinal therapy has failed, colonic decompression can be performed.

• This is a good procedure for removing air from the colon and, hopefully, minimising the risk of colonic perforation in the future.

• May be difficult to conduct due to difficulty to finish a comprehensive bowel preparation.

SURGICAL INTERVENTION

When conservative medicinal therapy and colonoscopic decompression fail, or when clinical symptoms of ischemia, abdominal infection, or perforation are present, surgery (laparotomy) is recommended.

CONCLUSION

Ogilvie's syndrome is uncommon, but it is critical for obstetricians, midwives, and general surgeons to recognise and treat it as soon as possible in patients who have had a C-section to avoid deadly complications. In any suspected case, the exact assessment and close monitoring, as well as conservative management. It's crucial to reassess whether the condition is progressing or regressing. Medical, interventional, and surgical management can be explored as the situation progresses, as indicated in the context.

After childbirth, women who develop Ogilvie's syndrome may experience psychological distress as a result of this unanticipated condition. So, Debriefing, emotional support, an explanation of the problem, and appropriate follow-up is all required.

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