

OGILVIE'S SYNDROME AND MYXOEDEMA CRISIS: A CASE REPORT

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Background

Ogilvie's syndrome (acute colonic pseudo-obstruction) presents as massive colonic dilatation without a mechanical cause. It is postulated to occur due to imbalance between sympathetic and parasympathetic innervations of the large bowel, although the exact pathophysiology of intestinal pseudo-obstruction remains to be elucidated.

- Causes include:
 - ✓ Trauma, especially fractures; Obstetrical surgery, especially involving spinal anesthesia
 - ✓ Severe medical illness, such as pneumonia, myocardial infarction, or heart failure
 - ✓ Neurologic conditions
 - ✓ Metabolic imbalance (eg, Hypothyroidism, Hypokalaemia)
 - ✓ Medication administration (eg, narcotics, phenothiazines, calcium channel blockers, alpha-2-agonists)
- The initial therapy remains conservative with supportive measures (*Nil Per Os*, nasogastric decompression, correction of fluid, electrolyte and metabolic disorders, reduction or discontinuance of drugs that inhibit gastrointestinal motility, and treatment of infections), followed by neostigmine, decompressive colonoscopy and finally surgery if signs of ischemia, abdominal sepsis or perforation are present.
- About 75% of cases resolve with conservative therapy in a median of 4 days

Case Report

Female, 51 years old, caucasian

PAST MEDICAL HISTORY

1. Hypothyroidism with poor adherence to therapy
2. Left subacromial bursitis
3. Status post plastic surgeries (lips and breasts)
4. Depressive syndrome

PRESENT ILLNESS

Abdominal colic pain, distension and obstipation, associated with nausea, puffiness of the eyes and adynamia for 1 month, aggravated in the last few days

EXAMINATION

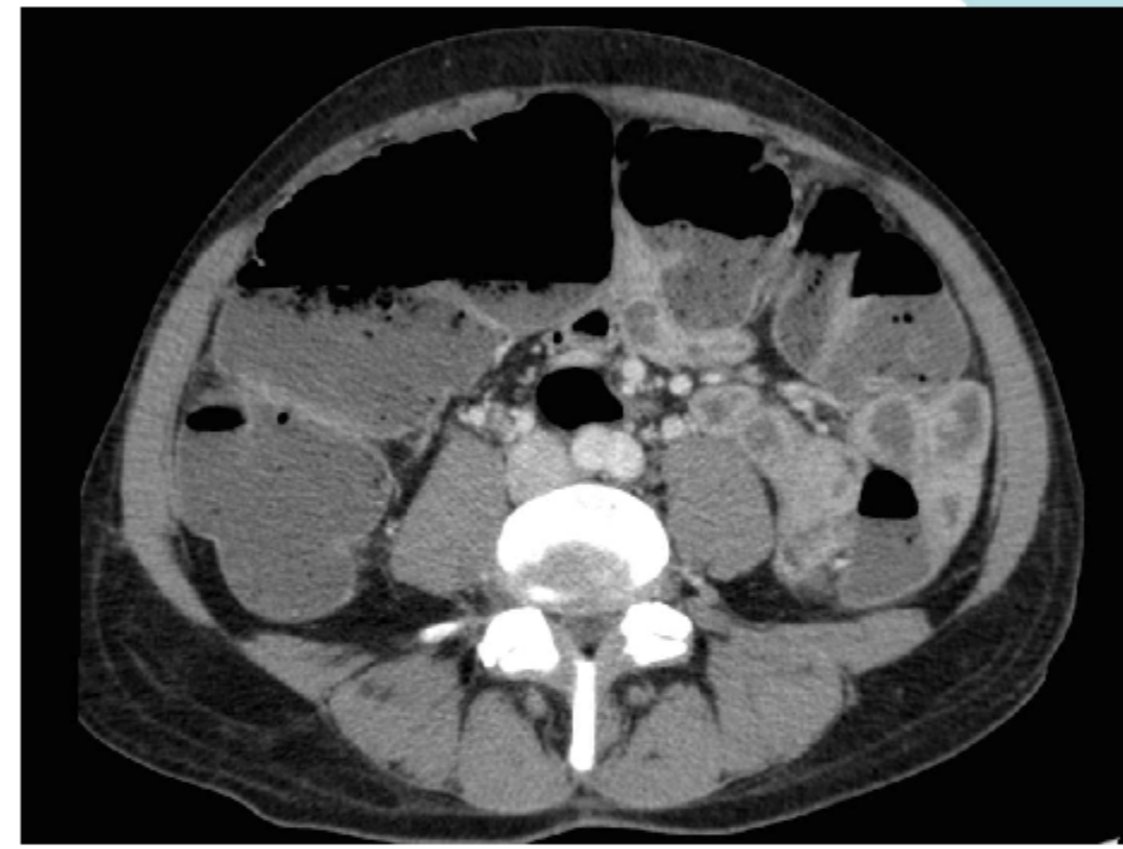
- At observation the patient was lethargic (GCS 14)
- Abdomen was distended, with normal bowel sounds, diffusely painful to palpation but without signs of peritoneal involvement
- BP: 128 / 74 mmHg; Pulse: 57 / min; Tympanic Temperature: 36.4 °C

LABORATORY EVALUATION

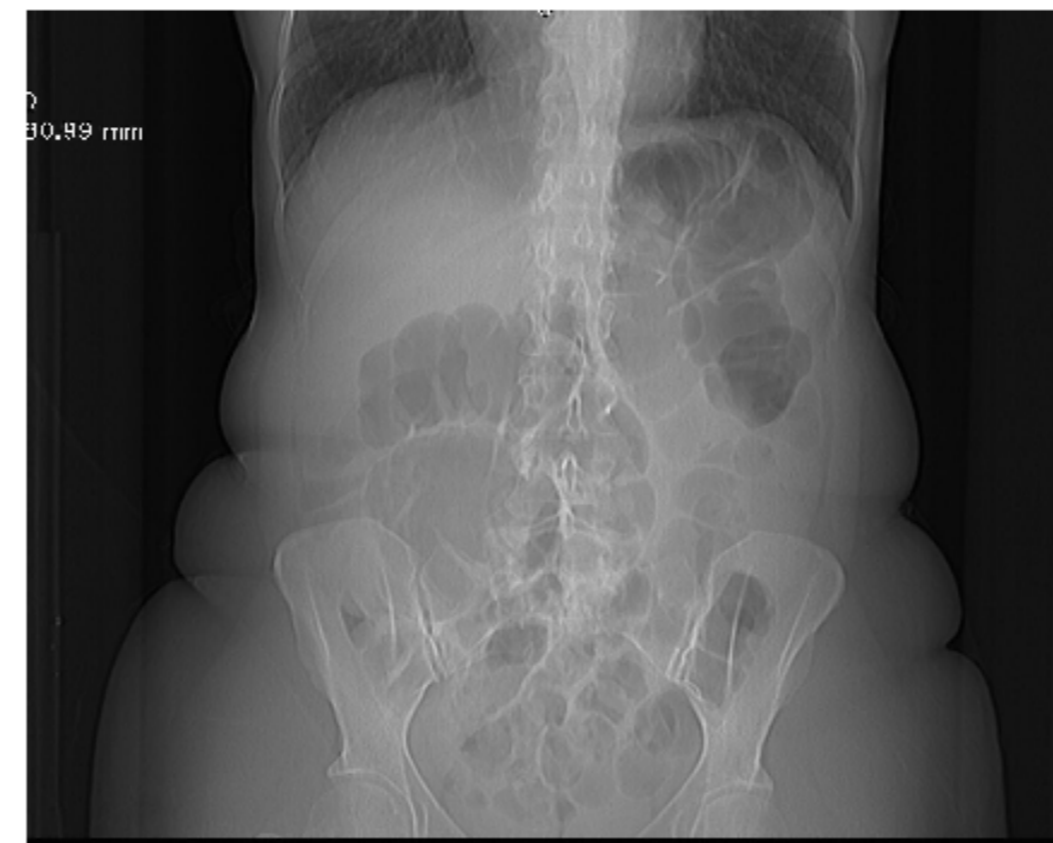
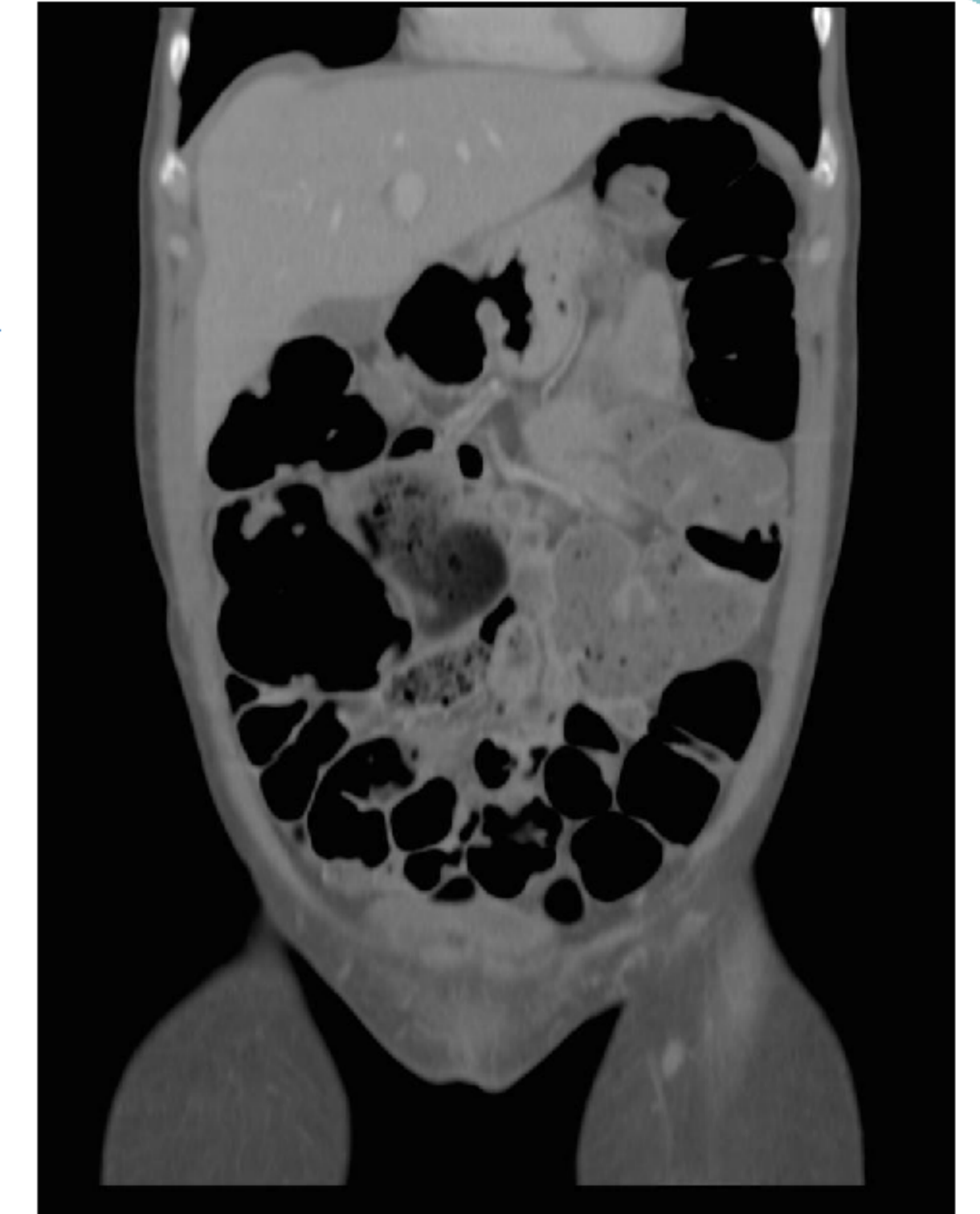
Variable	Value
BIOCHEMISTRY	
Urea (mg/dL)	19
Creatinine (mg/dL)	1.2
Creatine kinase (U/L)	1252
Na ⁺ (mmol/L)	141
K ⁺ (mmol/L)	3.3
Glucose (mg/dL)	88
PCR (mg/dL)	0.9
ENDOCRINOLOGY	
TSH (µg/mL)	80.8
FT ₄ (ng/dL)	<0.10
Anti-TPO (U/mL)	>1000
Anti-TG (U/mL)	36
Cortisol (µg/mL)	14.9

Day 1

- Supportive measures + Hormone replacement with Levothyroxin
- Abdominal CT scan: distended bowel loops with a cutoff at the sigmoid colon, without any structural lesion visualized

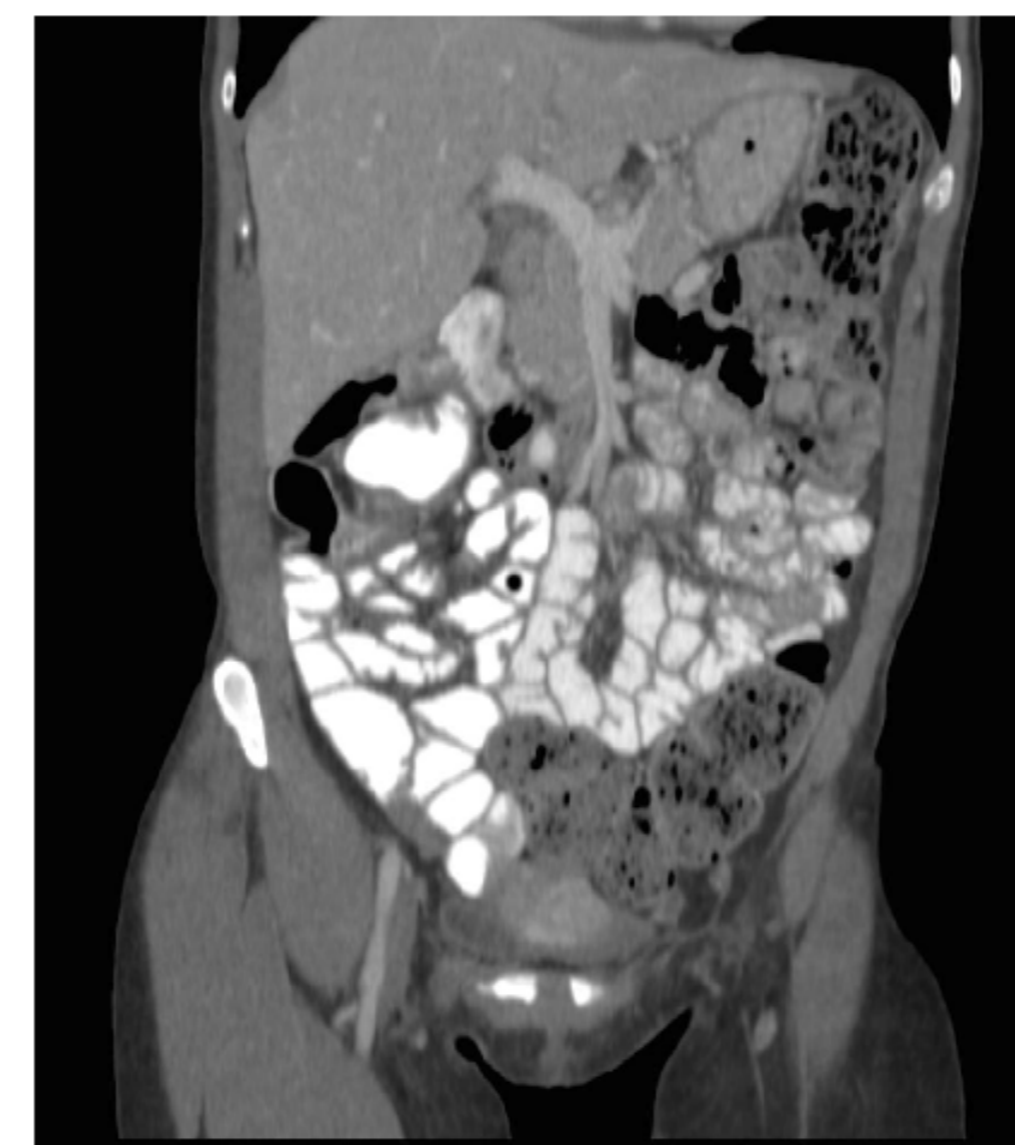
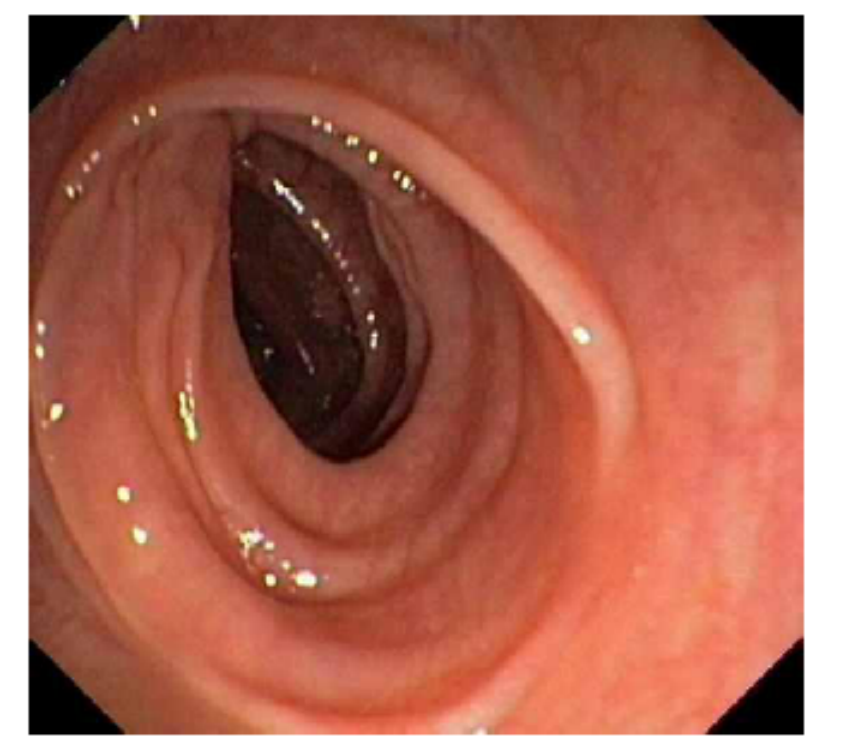


HOSPITAL ADMISSION



Day 3

- No clinical improvement
- Intestinal subocclusion
- Abdominal X-ray: distended bowel loops
- Urgent Colonoscopy: normal



Day 5

- Clinical improvement, with subocclusion resolution
- 2nd Abdominal CT scan: normal
- Discharged

Conclusion

- We have described a patient with myxoedema crisis presenting as Ogilvie's syndrome, which is diagnosed only after excluding mechanical large bowel obstruction.
- The vast majority of cases resolve spontaneously with conservative therapy in a few days; if not, other measures must take place, such as neostigmine, decompressive colonoscopy and finally surgery.
- This case illustrates a rare association between myxoedema crisis and Ogilvie's syndrome and the importance of prompt recognition and treatment of a reversible medical cause, in order to avoid other invasive measures.

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