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**Surgical treatment of ogilvie's syndrome. A monocentric outcome analysis**

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Ogilvie's syndrome, defined as acute colonic obstruction without mechanical cause, is a rare but serious clinical condition affecting mostly multi-morbid patients being treated in intensive care units. Current management guidelines describe a step-up approach of conservative, pharmacological and endoscopic therapy. Surgical treatment has traditionally been the last resort for critical patients with colonic ischemia or perforation. The evidence base for clinical outcome after surgical treatment of Ogilvie's syndrome is therefore scarce.

The purpose of this monocentric retrospective and prospective observational study was to evaluate the outcome of patients after surgical treatment for acute colonic pseudo-obstruction in a tertiary referral centre. Eighty-two patients were identified (58 males, 24 females, median age 62.3 years). The median amount of time between diagnosis and operation was 8 hours. Median cecum diameter was 10cm. Types of surgery included cecostomy (6.1%), hemicolectomy (48.8%) and subtotal colectomy (45.1%). Seventeen percent of the patients had a perforated colon while 29.2% showed peritonitis at the time of operation. Overall morbidity was 62.2% (2.4% insufficiency of the Hartmann's stump, 15.9% ostomy complications, 23.2% sepsis/abscess formation, and 9.8% postoperative haemorrhage). Mortality was 53.7%, with a median of 6 days from first operation to time of death.

The data revealed a statistically highly significant association between increased mortality amongst patients with organ failure, as well as those with a worse American Society of Anaesthesiologists score at the time of operation. In this population, the association between other factors, such as sex, colonic diameter, extracorporeal membrane oxygenation therapy or type of surgical operation and mortality was not statistically significant.

Early detection by means of clinical symptoms and radiological findings are precondition for successful non-surgical management. The initial conservative management includes the placement of a nasogastric tube, treating of the underlying condition, discontinuing of drugs impairing gut motility, replenishing of fluids and monitoring of electrolytes. Drugs improving gut motility, such as neostigmine and Summary 37 erythromycin should also be administered early on and can demonstrate a high success rate. When symptoms persist, endoscopic decompression with placement of a decompression tube is indicated and should be performed cautiously by an expert endoscopist. In cases of recurrence or long-persisting symptoms, a percutaneous endoscopic colostomy can be considered, while bearing in mind the high rate of complications involved with said intervention.

The surgical approach should be reserved for cases where every other therapeutic option has failed, and is associated with a high mortality rate. This finding has been corroborated by our data. The high morbidity and mortality of surgical therapy point to the necessity of avoiding surgery whenever possible. On the other hand, our data indicate that early, proactive consideration of surgical therapy may be key to improve outcomes once conservative management and endoscopic decompression are unsuccessful. Finally, emphasis should be laid on systematic prophylaxis and early detection of Ogilvie's syndrome in high-risk patients before colonic wall perfusion and clinical deterioration become evident and irreversible.