CLINICAL SNAPSHOT

Ogilvie Syndrome in Disseminated Tuberculosis

A 25-year-old male student from Indonesia presented with weight loss, deterioration in performance, dyspnea, and vomiting. On the basis of radiographically demonstrable lung infiltrates, abdominal air–fluid levels, CT-morphological signs of small-bowel stenosis, and the demonstration of acid-fast rods (sputum, gastric juice), we diagnosed disseminated tuberculosis (TB) with mechanical ileus. An HIV test was negative. Six weeks of tuberculostatic treatment brought no clinical improvement, and there were increasing massively distended intestinal loops with refractory painful obstipation. Resistance testing was normal, so we suspected a TB immune reconstitution inflammatory syndrome and started prednisolone. This achieved a partial response and the small-bowel stenosis was no longer evident; however, the massively dilated loops of colon remained just as prominent (*Figure*). We diagnosed infection-associated Ogilvie syndrome, and following failure of neostigmine we used the serotonin (5-HT₄) receptor agonist prucalopride, upon which intestinal function completely returned to normal. The term Ogilvie syndrome (acute colonic pseudo-obstruction) is used to describe a massively dilated, atonic large intestine. The cause probably lies in a functional disorder of the autonomic nervous system. If drug treatment fails, endoscopic decompression or (in rare instances) surgical treatment (resection, cecostomy) may be considered.

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Figure: Sagittal contrast-enhanced computed tomography of the abdomen after 6 weeks of tuberculostatic treatment followed by administration of prednisolone. The scan shows massively distended loops of large bowel (including the rectum) with no demonstrable mechanical cause. The diagnosis was Ogilvie syndrome in disseminated tuberculosis with involvement of the abdomen. The initially described small-bowel stenosis is no longer apparent.