Ogilvie's syndrome presented with delirium in an older patient with renal cell carcinoma and multiple myeloma

Renal cell karsinom ve multiple miyelomu olan yaşlı hastada dueliriumla kendini gösteren Ogilvie sendromu

To the Editor,

Acute colonic pseudo-obstruction (Ogilvie's syndrome [OS]) is a disorder characterized by gross dilatation of the cecum and right hemicolon, in the absence of an anatomic lesion that obstructs the flow of intestinal contents (1). Delirium is often not recognized by health professionals, either due to the clinical condition itself or due to the variability of symptoms, as well as to the concomitance of etiologic factors (2).

A 77-year-old male admitted to the emergency department with symptoms of sudden change in mental status, nervousness, abdominal distention, and no defecation for three days. He had hypertension, renal cell carcinoma and multiple myeloma. On physical examination, although bowel sounds were present, the abdomen was tympanic. In addition, he had cognitive and perceptual problems and was presenting psychomotor agitation and irritability. According to these clinical signs and symptoms, delirium was diagnosed by confusion assessment method (3). On admission to hospital, blood analyses revealed: white blood cell: 10600/µL, hemoglobin: 10.6 g/dl, glucose: 133 mg/dl, urea: 66 mg/dl, creatinine: 1.6 mg/dl, sodium (Na+): 142 mM/L, potassium (K+): 5.1 mM/L, and ionized calcium: 1.25 mM/L. Plain and upright abdominal radiograph showed a dilated colon (Figure 1). He was hospitalized and nasogastric aspiration was initiated. In order to stabilize the patient, haloperidol up to 2 mg was started intravenously. He was then supported with intravenous fluids, and a rectal tube was inserted. At the same time, he was placed in the prone position. Six hours later, although psychotic symptoms were under control, decompression was not achieved. Neostigmine (1.5 mg) infusion was started, and defecation was achieved. The following day, neostigmine infusion was repeated. On the 4th day of hospitalization, colonic decompression was completely achieved and the patient was discharged.

Ogilvie's syndrome is a rare condition usually arising in older people (1). Until this report, there had been no previous case in the literature of OS presenting with delirium in an older patient with both renal cell carcinoma and multiple myeloma. We suggest initial conservative therapy after mechanical causes of obstruction have been excluded in patients without significant abdominal pain or signs of peritonitis and in those with one or more potential factors that are reversible. Supportive care, including eliminating possible precipitating factors, is a part of the management of all patients

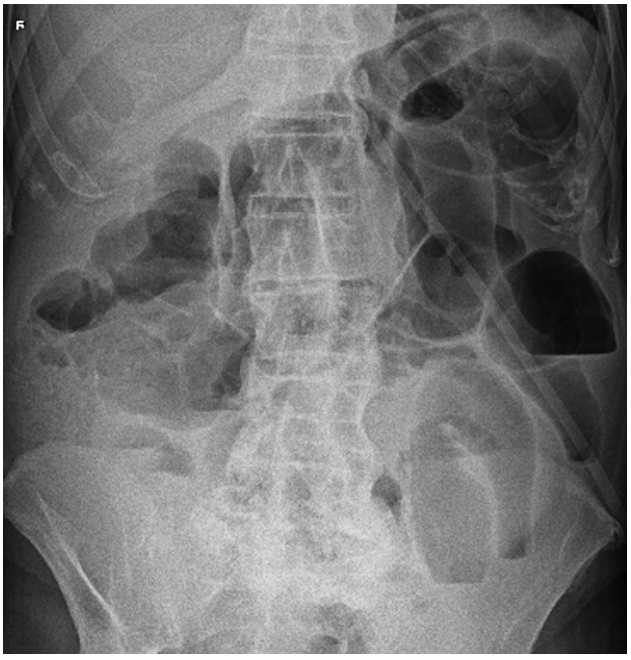

Figure 1. Plain and upright abdominal radiography showed a dilated colon, especially from the cecum to the splenic flexure, with air-fluid levels.

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with OS (4). To avoid unnecessary interventions, comprehensive geriatric assessment should be recommended for the optimum management of older patients (5), as in our case.

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Mesenteric fibromatosis: A case report

Mezenterik fibromatozis: Olgu sunumu

To the Editor,

Mesenteric fibromatosis (MF) accounts for approximately 8% of all cases with fibromatosis. The mesentery of the small bowel is frequently involved; however, it can originate from ileocolic mesentery, gastrocolic ligament, omentum, and retroperitoneum (1). Since the value of the pathological diagnosis of gastrointestinal stromal tumor (GIST) has been increasing with the introduction of recent and successful biological therapy protocols, it is important to establish the differential diagnosis of MF.

A 54-year-old male was admitted to the hospital with abdominal pain. Examination of the abdomen showed a palpable mass without tenderness in the lower quadrant. Ultrasonography revealed a mass 10 cm in diameter; however, its origin could not be determined. It was thought to be an intestinal tumor, and resection of the ileal segment with mass was performed. Pathological examination demonstrated the small bowel segment with an adjacent large mass with regular contours measuring 12x11x8.5 cm. The tumor, settled in the mesentery of the bowel, was firm and nodular and fairly well circumscribed. Opening the bowel revealed a mucosal surface with entirely normal appearance. The cut surface of the tumor exhibited a grey-brownish, coarsely trabeculated surface (Figure 1a). The samples taken from the tumor had a similar spindle-shaped appearance without atypia in a collagenous stroma (Figure 1b). Immunohis-

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