Ogilvie's syndrome in sickle cell disease

Orak hücre hastalığında Ogilvie sendromu

To the Editor,

Sickle cell disease (SCD) is an inherited disorder of red blood cells characterized by vasoocclusive painful episodes and hemolysis (1). Vasoocclusive phenomena may involve every organ system in the body as well as the gastrointestinal system. Abdominal complications in SCD usually accompany vasoocclusive painful crisis, and are likely the result of ischemia of the mesentery and abdominal viscera (2). To our knowledge, there are two previous reports of Ogilvie's syndrome complicating SCD (3,4). Here, we present the case of a young female SCD patient with acute pseudo-obstruction of the colon.

A 23-year-old woman with a history of SCD (S-β^+ thalassemia) and a prior splenectomy presented to the emergency department with a two-day history of vague abdominal pain and nausea. Physical examination revealed a distended and tympanic abdomen. There was mild hepatomegaly and generalized tenderness over the abdomen. Bowel sounds were absent. The patient was afebrile. Laboratory investigation revealed white blood cells (WBCs) 11.3 x 10^9/L; hemoglobin 6.9 g/dl; aspartate aminotransferase (AST) 29 IU/L, alanine aminotransferase (ALT) 19 IU/L, total bilirubin 3.2 mg/dl, direct bilirubin 0.5 mg/dl, creatinine 0.5 mg/dl, potassium 3.9 mmol/L, and calcium 9.3 mg/dl. The abdominal X-ray films showed a marked gaseous dilatation of the colon up to the hepatic flexure without any air-fluid levels, with preserved haustral markings. She was hospitalized, and intravenous fluid maintenance with nasogastric decompression and rectal tube insertion was initiated. Opiates and other narcotic medications were avoided. The severity of symptoms lessened after a few days of admission. However, upon initiation of oral intake her symptoms recurred. Abdominal computed tomography with intravenous injection of contrast agent confirmed the dilatation of the colon segments without any evidence of mechanical obstruction (Figure 1). HbS content was 67.4%. The patient declined erythrocytapheresis. Following two units of packed erythrocyte transfusions, her symptoms resolved completely without complication.

In our case, the suspicion of acute colonic pseudo-obstruction was raised by lack of signs and symptoms of an inflammatory bowel disease. There was acute dilation of the colon without intestinal air-fluid levels or detectable mechanic obstruction. To our knowledge, this is the second report of an adult patient presenting with Ogilvie's syndrome complicating SCD (3,4). Although a causal relation between vasoocclusion and acute colonic pseudo-obstruction in SCD is obscure, a reversible microvascular occlusion might explain the pathology in these patients. We believe that in colonic pseudo-obstruction in patients with SCD, initial management should be similar to the management of acute painful episode since evidence suggests the efficacy of such a therapeutic approach. A conservative approach is usually sufficient considering our case and previous reports; thus, unnecessary surgical explorations can be avoided.

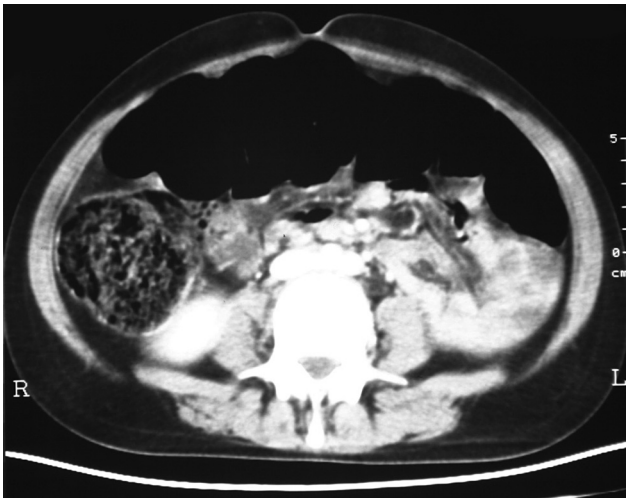

Figure 1. Abdominal computed tomography demonstrating abnormal distension of the colon.

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Choreiform movements associated with pegylated interferon-alpha in a patient with chronic hepatitis C

Kronik hepatit C'li bir hastada pegile interferon-alfa ile ilişkili koreiform hareketler

To the Editor,

Combination of pegylated interferon-alpha (PEG-IFN-α) plus ribavirin is the first-line treatment of chronic hepatitis C virus (HCV) infection. Common side effects are flu-like symptoms and reversible hematologic cytopenia. However, neuropsychiatric side effects, such as depression, cognitive disturbances, anxiety, mania, and psychotic states (1), and more rarely, movement and extrapyramidal disorders, such as chorea, parkinsonism, akathisia, dystonia, and myoclonus, can be observed (2). We report herein choreiform movements associated with the use of PEG-IFN-α 2b in a patient with chronic HCV.

A 67-year-old woman with chronic HCV infection was admitted to our clinic, and PEG-IFN-α 2b 100 mcg weekly plus ribavirin 1000 mg daily was started. At the fifth month of treatment, the patient was admitted to the hospital with the complaints of involuntary, irregular, jerky movements of the legs and "piano-playing" finger motions. She was evaluated by a neurologist and diagnosed as chorea. Mini-Mental State Examination and cognitive functions were normal. Electroneuromyography revealed motor neuropathy. Electroencephalogram, cranial magnetic resonance imaging and 24-hour urinary copper level were normal. Kayser-Fleischer ring was not detected with split lamp examination. Acanthocytes were not observed on peripheral blood smear. Autoimmune markers, antiphospholipid antibodies, anti-human immunodeficiency virus (HIV), and serologic tests for syphilis were negative. There was no mutation on DNA analysis for Huntington's disease (HD). We considered that this condition may be associated with PEG-IFN-α. Treatment was stopped, and choreiform movements gradually decreased and had completely resolved in a three-month period.

Chorea is defined as abrupt, unpredictable and nonrhythmic involuntary movements resulting from continuous random flow of muscle contractions. Genetic choreas such as HD, neuroacanthocytosis and benign hereditary chorea, Wilson disease, basal-ganglia lesions, infectious and autoimmune disorders, metabolic or toxic encephalopathies, and drug-induced chorea should be considered in the differential diagnosis (3).

Interferon (IFN)-α-induced choreiform movements were reported in five cases (2,4-7). Two of these cases were treated with PEG-IFN-α for HCV (2,4). In these reports, only one patient had a prior history of HD (4). The time between the initial expo-

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