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Chronic intestinal pseudo-obstruction: An unusual presentation

To the Editor,

Chronic intestinal pseudo-obstruction (CIPO) is characterized by impaired gastrointestinal propulsion with signs of bowel obstruction in the absence of organic, systemic, or metabolic disorder (1). This dysfunction in turn leads to food restriction, enteral and parenteral nutrition dependency, and more rarely cardiopulmonary complications due to compression (2). CIPO presents with vague symptoms including abdominal pain, nausea, and vomiting for more than 6 months. These nonspecific symptoms, particularly in the elderly, can become a nightmare for clinicians to accurately diagnose.

Here we present the case of an 82-year-old male with a history of hypertension and atrial fibrillation who presented with one episode of unwitnessed fall. He admitted to chronic anorexia and urinary and bowel incontinence. He denied any chest pain, palpitations, aura, or post syncopal confusion. On admission, he was hemodynamically stable with abdominal examination remarkable for significant abdominal distention that had been present for more than 6 months. Abdominal X-Ray showed extensive gas in colon (Figure 1). An abdominal computed tomography (CT) scan with contrast was ordered, but not completed as patient went into pulseless electrical activity while lying supine in the CT scanner. ACLS protocol was initiated with return of spontaneous circulation in 6 min.

Laboratory data revealed a glucose level of 140 mg/dL, creatinine level of 1.66 mg/dL, lactic acid level of 6.7 mmol/L, troponin-I level of <0.030 ng/mL, tryptase level of 9.5 ng/mL (normal: <11.5), and normal serum IgA level. Post-resuscitation electrocardiogram showed atrial fibrillation and was overall similar to the one on admission. Bedside echocardiogram (ECHO) showed preserved structure and function with no wall motion abnormality and no tamponade. CT scan of the abdomen was repeated after the patient was stable; it revealed a smooth progression of the oral contrast through the colon with no obstruction and a 17-cm dilation of the sigmoid colon (Figure 2).

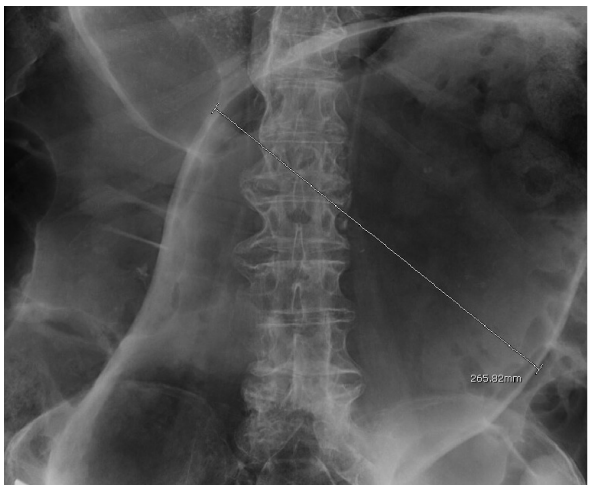

Figure 1. Abdominal X-Ray showing a large air-filled structure oriented from the left upper quadrant to the right lower quadrant measuring up to 26 cm

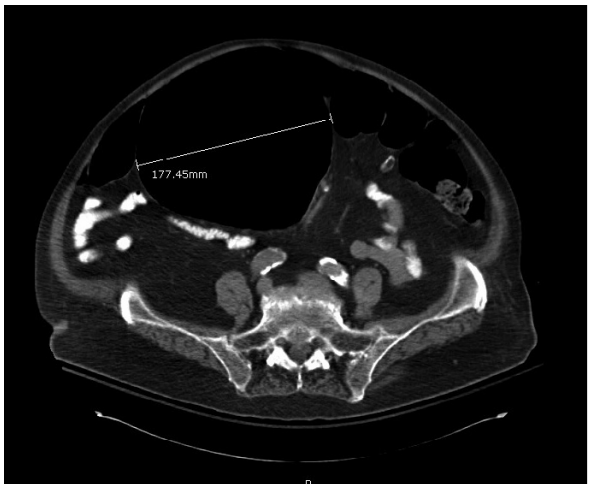

Figure 2. Abdominal computed tomography with contrast showing marked dilation of the sigmoid colon measuring up to 17 cm in diameter containing air-fluid level, fecal debris, and lack of retro-peritoneal bleeding

As previously hypothesized by Vettoretto et al. (3) we believe our patient had increased vagal tone in the setting of colonic distention causing the sudden deterioration. Anaphylactic shock was excluded, as tryptase and serum IgA levels were normal. Cardiogenic shock was unlikely

with a mild elevation in troponin, well-perfused extremities, and normal ECHO. Electrolytes were within normal limits prior to the arrest.

A successful bedside colonoscopic decompression was performed without evidence of bleeding or obstruction. A trial of neostigmine was not attempted because of the patient's cardiac history. Metoclopramide and erythromycin were tried, but with little effect. Total colectomy was offered for residual distention but the patient refused; thus, a rectal tube was placed with marked improvement.

In conclusion, this atypical presentation and sequel despite a 26-cm colon dilation was remarkable. CIPO is a rare and less reported condition that needs to be reported more often for better understanding. It can present in various situations and hence needs to be probed in patients with abdominal distention.

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