Bowel pseudo-obstruction following an acute ST elevation myocardial infarction

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DESCRIPTION
An 84-year-old man was brought to the accident and emergency department, with chest pain. His ECG showed features consistent with an inferior ST elevation myocardial infarction (figure 1). As per guidance, he was loaded with aspirin and prasugrel and thereafter underwent a percutaneous coronary intervention (PCI) to the right coronary artery.

Over the next 3 days, he had increasing abdominal distension, had not opened his bowels, reported nausea and had multiple episodes of non-faeculant vomiting. His observations were stable. On examination, his abdomen was soft, non-tender, distended and tympanic. Bowel sounds were present. His rectum was empty.

An abdominal X-ray showed a dilated stomach and small bowel (figure 2). He had no history of abdominopelvic surgery, his electrolytes were within normal range and he was not taking any culprit medications. An erect chest X-ray ruled out pneumoperitoneum (figure 3). A CT of the abdomen and pelvis was unremarkable for a mechanical obstruction.

The patient was managed conservatively with intravenous fluids and antiemetics, and with a nasogastric tube for decompression.

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Figure 1 ECG on admission showing features consistent with an acute inferior ST elevation myocardial infarction.

Figure 2 Abdominal X-ray showing a dilated stomach and multiple dilated small bowel loops.

Figure 3 Erect chest X-ray, which ruled out pneumoperitoneum.

Figure 4 Repeated abdominal X-ray showing a reduction in the degree of dilation.
Over the next 3 days, his abdominal distension had decreased and he began to open his bowels. A repeated abdominal X-ray showed improvement (figure 4). Enteral nutrition was thereafter reintroduced.

Retrospective data of patients with acute colonic pseudo-obstruction (Ogilvie’s syndrome) show an association with cardiac disease and coronary intervention. For unclear reasons, these cause temporary parasympathetic dysfunction to the bowel. Although such an association is not as well established in acute small bowel pseudo-obstruction, a similar aetiology is likely to exist and is important to recognise as a consequence of myocardial infarction and PCI.

Competing interests None declared.

Patient consent Obtained.

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REFERENCES