CASE REPORT **Damascene Kurukulasuriya MD**

A 62 year old female was admitted to the hospital for elective, two-stage spinal surgery. She had a history of type 2 diabetes mellitus, hypertension, anemia, subclinical hypothyroidism, mild mental retardation, Ogilvie's syndrome and a compression fracture of her thoracic spine; she had a history of multiple past episodes of ileus, requiring hospitalizations. Following the initial, posterior procedure, the patient was kept intubated for stage 2, an anterior approach on postoperative day (POD) 3. After this second surgery, the patient developed episodic hypotension and hypoxemia, associated with anemia and a host of metabolic derangements (hyponatremia, hypokalemia, marked hypoalbuminemia and a labile serum glucose).

On POD 4, the patient developed a recalcitrant ileus, treated with NG suction, NPO status, electrolyte correction and TPN; by POD 5, a KUB film showed colonic dilatation up to 9 cm. The GI Service was consulted but, over the next 5 days, multiple interventions, including enemas and sigmoid decompression, failed to relieve the ileus. When the colonic dilatation reached 11.5 cm, neostigmine therapy was tried with no success. Finally, on POD 10, decompressive colonoscopy and surgical cecostomy were performed and the patient's condition gradually improved. Following transition to an oral diet and ongoing PT/OT (with use of a Miami J brace), the patient was discharged to a skilled nursing facility on POD 20, to be followed in clinic by Orthopedic Surgery and General Surgery.

DISCUSSION: While Ogilvie's Syndrome represents an advanced form of ileus, lesser degrees of postoperative ileus are relatively common. Unfortunately, when not managed appropriately, clinical outcomes are often poor, with a significant increase in length of stay, ongoing patient discomfort (especially following spinal, thoraco-abdominal or pelvic surgery) and frequent development of postoperative delirium.

The prevention of postoperative ileus begins during the preoperative medical evaluation. Attention to inadequately managed constipation, underlying mobility disorders, diabetic gastroparesis, chronic bowel dysmotility, hypothyroidism, hypokalemia, hypercalcemia and constipating medications are all important; the latter include narcotics, calcium supplements, calcium channel blockers, diuretics and any medication with anticholingergic activity (which includes many psychoactive medications).

While these preoperative measures are very important, it is also essential to pay close attention to bowel function in the postoperative period; electrolyte abnormalities, medications, inactivity and inadequate bowel regimens can all complicate the patient's management. Excessive use of narcotics, often triggered by the misinterpretation of symptoms in demented and delirious patients, is perhaps the most common cause of iatrogenic ileus.