

- Joint Surg Am* 1990;72:161-8.
9. Engh CA, Glassman AH, Suthers KE. The case for porous coated hip implants. The femoral side. *Clin Orthop* 1990;261:63-81.
 10. Charnley J. The long term results of low friction arthroplasty of the hip performed as primary intervention. *J Bone Joint Surg Br* 1972;54:61-76.
 11. Roach JW, Paradies LH. Total hip arthroplasty performed during adolescence. *J Pediatr Orthop* 1984;4:418-21.
 12. Ruddlesdin C, Ansell BM, Arden GP, Swann M. Total hip replacement in children with juvenile chronic arthritis. *J Bone Joint Surg Br* 1986;68:218-22.
 13. Halley DK, Wroblewski BM. Long term results of low friction arthroplasty in patients 30 years or younger. *Clin Orthop* 1986;211:43-50.
 14. Learmonth ID, Heywood AW, Kaye J, Dall D. Radiological loosening after cemented hip replacement for juvenile chronic arthritis. *J Bone Joint Surg Br* 1989;69:45-55.
 15. Witt JD, Swann M, Ansell BM. Total hip replacement for juvenile chronic arthritis. *J Bone Joint Surg Br* 1991;73:770-3.
 16. Cage DJ, Granberry WM, Tullos HS. Long term results of total arthroplasty in adolescents with debilitating polyarthropathy. *Clin Orthop* 1992;283:156-62.
 17. Chmell MJ, Scott RD, Thomas WH, Sledge CB. Total hip arthroplasty with cement for juvenile rheumatoid arthritis. Results at a minimum ten years in patients less than thirty years old. *J Bone Joint Surg Am* 1997;79:44-52.
 18. Torchia ME, Klassen RA, Bianco AJ. Total hip arthroplasty with cement in patients less than twenty years old. Long-term results. *J Bone Joint Surg Am* 1996;78:995-1003.
 19. Porsch M, Siegel A. [Artificial hip replacement in young patients with dysplasia — long-term outcome after 10 years] [review]. *Z Orthop Ihre Grenzgeb* 1998;136:548-53.
 20. Maric Z, Haynes RJ. Total hip arthroplasty in juvenile rheumatoid arthritis. *Clin Orthop* 1993;290:197-9.
 21. Sochart DH. Relationship of acetabular wear to osteolysis and loosening in total hip arthroplasty. *Clin Orthop* 1999;363:135-50.
 22. Kobayashi S, Eftekhari NS, Terayama K, Joshi RP. Comparative study of total hip arthroplasty between younger and older patients. *Clin Orthop* 1997;339:140-51.

SESAP Critique Critique SESAP

Category 3, Item 19

The findings pictured are consistent with pseudo-obstruction (Ogilvie's syndrome), a syndrome in which the patient appears to have signs and symptoms of colonic obstruction with a mechanical etiology. Although the underlying pathophysiology is multifactorial, derangement of sacral parasympathetic tone is a common pathway. Decreases in neuroelectrical activity reduce colonic motility. Many intrinsic and extrinsic agents may be involved, but no histopathologic defects in the neural or muscular layers of the colon have been identified in the resected colons of patients with this problem. The condition is associated with many common chronic medical conditions, postoperative states, and a host of medications.

Colonic pseudo-obstruction may be difficult to diagnose because of its nonspecific presenting features. It may be mistaken for mechanical obstruction. Abdominal pain, distention, obstipation, and occasionally diarrhea are common features of the disorder. X-rays demonstrating massively dilated large bowel without evidence of mechanical obstruction are an integral part of the diagnosis. Endoscopy may be required for decompression as well as to exclude a constricting lesion. Contrast x-rays may also be required.

Nasogastric decompression, intravenous hydration, and correction of electrolyte abnormalities are standard interventions. Once resuscitation has been well established, efforts to decompress the colon may be used. Many authors favor endoscopic decompression. Epidural anesthesia and agents such as intravenous neostigmine that modify parasympathetic tone and enhance colonic motility have proven effective. Operative intervention is reserved for patients who do not respond to conservative measures, or those in whom colon perforation appears imminent.

E

References

1. Corman ML: Disorders of defecation, in Corman ML (ed): *Colon and Rectal Surgery*, ed 4. Philadelphia, Lippincott-Raven, 1998, pp 391-393
2. Ponc R, Saunders MD, Kimmey MB: Neostigmine for the treatment of acute colonic pseudo-obstruction. *N Engl J Med* 34:137-141, 1999