



Clinical Practice Guidelines: (1 / 3)

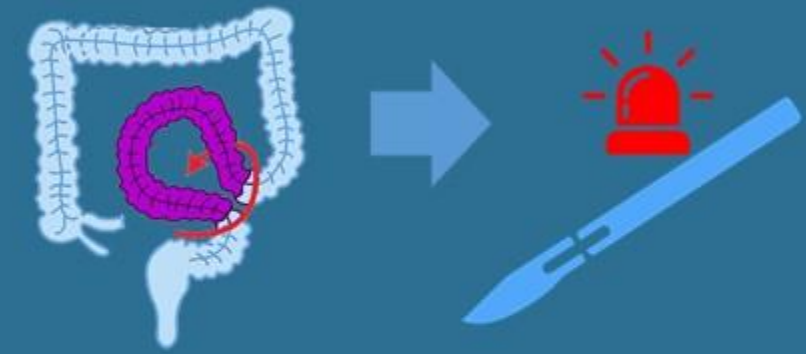


Surgical Tx of **Volvulus** & Pseudo-Obstruction

Patients **SIGMOID volvulus**: without hemodynamic instability, peritonitis, or perforation should undergo **lower endoscopy** to assess sigmoid colon viability, **detorse** and decompress the colon **1C**



Urgent sigmoid resection is indicated if: endoscopic detorsion fails or with non-viable or perforated colons **1C**



After detorsion, consider **elective sigmoid colectomy** to prevent recurrence (during the same hospital admission) **1C**



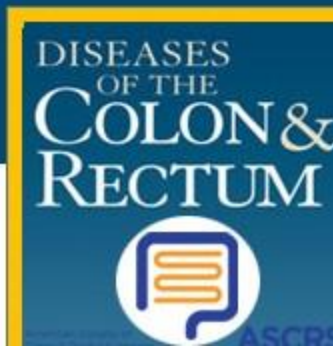
Operations **without resection** are inferior to sigmoid colectomy to prevent recurrence **1C**
16-21% recurrence rates in largest series



Endoscopic fixation of the sigmoid colon may be considered in selected patients where surgery is prohibitive risk **2C**



Alavi K et al. *Dis Colon Rectum* 2021;64(9)





Surgical Tx of **Volvulus** & Pseudo-Obstruction

- Patients **CECAL** volvulus: Attempts at endoscopic reduction are generally not recommended. 1C



Segmental resection is the preferred treatment for patients with cecal volvulus 1C



For cecal volvulus with viable bowel, the use of **non-resectional** operative procedures should be **limited** to patients who are considered unfit for resection 2C



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Surgical Tx of Volvulus & **Pseudo-Obstruction**

Initial treatment of ACPO is **supportive** and includes eliminating or correcting predisposing conditions **1C**

Non-operative approach led to resolution ACPO in 70% to 90% of patients



Pharmacologic treatment with **neostigmine** is indicated supportive therapy fails **1B**

Neostigmine 2-2.5mg typically given IV as bolus or infusion. Resolution of dilation in up to 90% of patients



Endoscopic decompression when neostigmine therapy is contraindicated or ineffective **1B**



Operative treatment if: colon ischemia, perforation or refractory to all other therapies

1C



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