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HeartCongress2020:Ogilvie'sSyndromePresentedasAngina-ZakariyaAbdulazeez-MedwayMaritimeHospital

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Introduction:
Ogilvie's syndrome is a non-mechanical, acute pseudo-obstruction of the colon, causing massive colonic dilation. Medical or surgical conditions can predispose patients to Ogilvie's syndrome; however, the pathogenesis and clinical findings are still not well understood. Here, we present a case of a 48-year-old male patient who presented to the Emergency Department with intermittent self-resolved left-sided lower chest pain on a background of ischaemic heart disease and positive risk factors for acute coronary syndrome. Troponin testing was negative and an electrocardiogram showed no acute changes. Chest radiography showed a dilated bowel under the left hemidiaphragm and a computed tomography (CT)scan of the abdomen-pelvis confirmed the diagnosis of Ogilvie's syndrome. The patient was treated conservatively with a short period of nil by mouth and intravenous fluids. From this case there are many learning points as non-cardiac causes of chest pain should be always considered even in patients with previous cardiac history, especially those patients for whom there is no evidence to support recurrent cardiac ischaemia. Acute colonic pseudo-obstruction (Ogilvie's syndrome) can be presented as chest pain that mimics angina pectoris. Chest radiography is of great value in cases of acute chest pain; a dilated bowel segment can be the only finding of Ogilvie's syndrome in the initial assessment.

Learning points Non-heart reasons for chest agony ought to be constantly thought to be even in patients with past cardiovascular history, particularly those patients for whom there is no proof to help repetitive heart ischaemia.Intense colonic pseudo-check (Ogilvie's condition) can be introduced as chest torment that mirrors angina pectoris. Chest radiography is of incredible incentive in instances of intense chest torment; an enlarged entrail section can be the main finding of Ogilvie's condition in the underlying evaluation.

Catchphrases Chest torment, intense coronary condition, Ogilvie's disorder, pseudo-impediment of the colon

Case Description A 48-year-old male introduced to the Emergency Department with a 2-hour history of discontinuous left-sided lower chest torment, depicted as greatness on the lower chest emanating to the upper mid-region. The power of the torment differed from 8/10 to 4/10 on the agony scale, related with some brevity of breath. The patient revealed encountering comparative uneasiness irregularly over the past not many weeks before this specific introduction.He was known to have asthma, hypercholesterolaemia and a past filled with myocardial localized necrosis 3 years sooner,which was treated with coronary angioplasty and stenting. The patient had been admitted to the medical clinic multiple times in the past 2 years with comparable side effects and rewarded for angina given his cardiovascular history, in spite of unaltered electrocardiograms (ECGs), negative troponin testing and no proof of repetitive ischaemia on follow-up heart perfusion checks. He had a rehashed coronary angiogram a year prior to this introduction, which indicated stable coronary supply route infection. Stoppage was likewise detailed by the patient during this scene however he had the option to pass flatus. The chronicle of fundamental signs indicated circulatory strain of 104/65 mmHg and a heartbeat pace of 61 bpm. Chest assessment was unremarkable with an unmistakable chest and ordinary heart sounds on auscultation. Stomach assessment uncovered a delicate non-delicate midsection with mellow distension. Research center blood tests were terribly typical with negative troponin and D-dimer results. The ECG demonstrated sinus musicality , with no intense changes contrasted with past ECGs. Chest radiography demonstrated a raised left hemidiaphragm and widening of the colon at the splenic flexure . Therefore, a stomach radiograph was mentioned, which uncovered widely expanded huge inside circles.A figured tomography (CT) output of the midsection pelvis was done , affirming a determination of huge gut expansion and no mechanical check. The cardiology and careful groups at the medical clinic were counseled, and a myocardial perfusion filter affirmed past myocardial dead tissue however no noteworthy myocardial ischaemia. On this premise, and by barring the conceivable differential determinations, a finding of Ogilvie's condition was made. The patient was dealt with minimalistically with a brief time of nil by mouth and intravenous liquids. His antianginal meds were surveyed.

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