

# Clinical Practice Guidelines: (1 / 3)

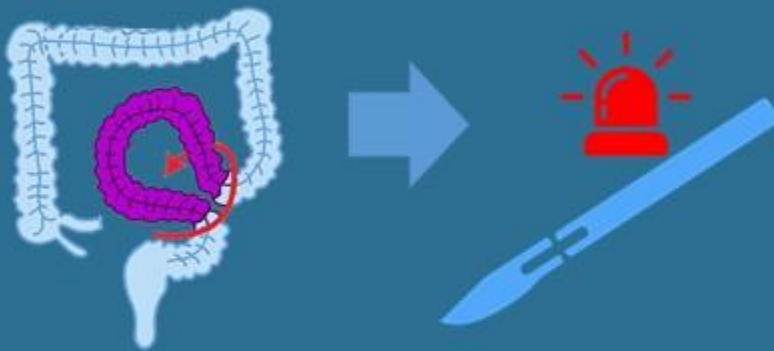


## Surgical Tx of **Volvulus** & Pseudo-Obstruction

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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# Clinical Practice Guidelines: (3/3)



## 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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