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

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

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

Alavi K et al. Dis Colon Rectum 2021;64(9)
Clinical Practice Guidelines: (2/3) 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

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