LETTERS TO THE EDITOR

The knee-elbow position relieves distension

EDITOR,—In their article in *Gut* 1993; 34: 1726–7 Panos *et al* described colon decompression after assuming a knee-chest position and state they are 'not aware of any previous reports of its use ... in toxic megacolon' and suggest that a prospective assessment of outcome is appropriate.

Unfortunately, for the authors, little is new in clinical medicine and a similar technique has already been well described in our paper.¹ We had also cited a previous paper by Kramer and Wittenberg² describing redistribution of gas in toxic megacolon by changing the anatomical position. Kramer and Wittenberg did not clinically apply this technique to their patients.

Panos *et al* also requested longterm follow up, which was presented in our paper in 19 patients in which 13 (68%) treated with this technique did well and did not require surgery (mean follow up 6.5 years). Since this report we have treated at least 15 more patients with this technique and have never had to perform emergency surgery for persistent colonic dilatation, although some patients require surgery for persistent activity after decompression.

Fortunately for inflammatory bowel disease patients, this article hopefully will reawaken interest in the comprehensive medical treatment programme required to treat fulminant colitis and toxic megacolon. Many patients will respond to intensive medical treatment and thus avoid emergency surgery. This comprehensive programme including the rolling technique is detailed in a more recent publication.³

D H PRESENT

Mount Sinai Medical Center,
12 East 86th Street,
New York, NY 10028, USA

1 Present DH, Wolfson D, Gelernt IM, Rubin PH, Bauer J, Chapman ML. Medical decompression of toxic megacolon by rolling. A new technique of decompression with favourable long-term follow-up. *J Clin Gastroenterol* 1988; 10: 485–90.

2 Kramer P, Wittenberg J. Colonic gas distribution in toxic megacolon. *Gastroenterology* 1981; 80: 433–7.

3 Present DH. Toxic megacolon. *Med Clin North Am* 1993; 77: 1129–48.

EDITOR,—We have recently used the intriguing knee-elbow position described by Dr Panos (*Gut* 1993; 34: 1726–7) in a 45 year old man with acute colitis and progressive dilatation of the sigmoid colon.

He presented with a seven week history of worsening diarrhoea. Over the preceding week he had passed 10 stools a day containing blood and pus. On examination, he was afebrile, with no tachycardia and his abdomen was soft with normal bowel sounds. Sigmoidoscopy showed a granular friable mucosa with spontaneous haemorrhage ahead of the instrument. Histological tests were consistent with active ulcerative colitis. Haemoglobin was 13.1 g/dl, platelets

Abdominal x rays of the patient showing response to the adoption of the knee-elbow position

509×10⁹/l, C reactive protein 207 mg/l, α-1 acid glycoprotein 2275 (normal range <1150) and albumin 36 g/l. No pathogens were identified on stool culture. Plain abdominal x ray showed a 8.5 cm dilated sigmoid loop (Fig (A)). He was treated with bed rest and intravenous hydrocortisone 100 mg 6 hourly with metronidazole 500 mg 8 hourly.

Two days after admission he developed abdominal discomfort and distension. Abdominal x ray confirmed persisting sigmoid dilatation (Fig (B)). He was

instructed to adopt the knee-elbow position for five minutes every half hour. In this position he passed large quantities of flatus often triggered by coughing. Four hours later he felt more comfortable with a soft abdomen. A repeat x ray showed decompression of the sigmoid loop (Fig (C)).

Six days after admission his abdomen again became distended and again responded to adoption of the knee-elbow position (Fig (D) and (E)). After nine days his bowel had returned to normal and he was discharged with a reducing course of oral prednisolone.