Ogilvie syndrome is a relatively rare entity, also known as colonic pseudo-obstruction, non-obstructive colonic dilatation, idiopathic non-toxic colon or intestinal pseudo-obstruction. The condition was originally defined by William Heneage Ogilvie in 1948 (Ogilvie 1948). Patients exhibit marked dilatation of the proximal colon without apparent obstructive or traumatic cause. The actual incidence may be difficult to determine, as several cases may go unnoticed with a subclinical course. Timely diagnosis is imperative to initiate prompt treatment and decrease morbidity and mortality (Durai 2009). Although the exact pathophysiology of this condition is unknown, an imbalance in the autonomic nerve supply to the colon following a trigger, such as major surgery, has been suggested. In an analysis including 400 cases, 95% of the patients were reported to have a comorbid condition and/or advanced age (Vanek and Al-Salti 1986). The presenting sign of Ogilvie syndrome is progressive abdominal dilatation without a mechanical cause. Symptoms include abdominal pain, nausea, vomiting and abdominal distension. Plain frontal supine radiograph of the abdomen revealing a distended colon without air fluid levels suggests the diagnosis (Durai 2009). Initial treatment strategies include nasogastric and colonoscopic decompression and, occasionally, i.v. neostigmine. Surgery should be considered if conservative measures fail and/or signs of severe peritoneal irritation develop (Ponec et al. 1999). Here, we report a case of caecal rupture following caesarean hysterectomy and emphasise early and appropriate diagnosis from an obstetric point of view.