

# POST CAESAREAN SECTION OGILVIE’S SYNDROME – AWARENESS AND UNDERSTANDING THE NEED FOR INDIVIDUALISED MANAGEMENT

## DEFINITION

Severe distension of the colon without mechanical obstruction<sup>2</sup>

## DIAGNOSIS

Usually by Comuted Tomography

## RISKS

Ischaemia  
Bowel perforation

Ogilvie’s syndrome, or Acute Colonic Pseudo-Obstruction, is a recognised bowel related complication of pregnancy which most commonly occurs following Caesarean Section. The risk of requiring medical or surgical intervention rather than conservative measures alone is higher in this circumstance compared to other populations<sup>1</sup>. The pyschological effects of requiring treatment with other specialties and being away from the baby are significant. We have used 3 recent cases at our institution to draw together themes of the presentation and call for individualised management.

### Case 1

Background: 40 year old primip had an emergency Caesarean at 4cm dilated for failure to progress and sepsis. At delivery there was a small uterine angle extension repaired.  
Progress: 24 hours post-op developed tense abdominal distension and worsening pain, with bowel sounds present. By 36 hours she had vomiting so an NG tube was inserted and a CT was done.  
Treatment:  
Day 2 two doses of Neostigmine  
Day 3 flexible sigmoidoscopy in theatre with decompression and Magnesium replacement  
Day 4 colonoscopy found punctate ischaemia of the atonic colon, cautious decompression  
Complication: Day 5 no improvement in pain or inflammatory markers so CT repeated – caecal perforation diagnosed.  
Proceeded to laparotomy and right hemicolectomy and end ileostomy with HDU care post-operatively.  
Recovery: Prolonged with revision surgery 6 months later.



Dilated colon and small bowel, caecum measuring >10cm

### Case 2

Background: 35 year old primip had an emergency Caesarean for abnormal CTG at 4cm dilated.  
Progress: 36 hours post-op looked unwell with a tense distended abdomen and pain. Bowel sounds were present. CT scan performed and Ryles tube inserted.  
Treatment:  
On day 2 colonic decompression was undertaken in theatre. A flatus tube was placed. One dose of Neostigmine given.  
Recovery: There was an immediate post colonoscopy improvement and after initial HDU stay stepped down on day 3.



Marked faecal impaction of caecum, large bowel distension at risk of perforation

### Case 3

Background: 37 year old para 1 had an emergency Caesarean for failure to progress in the second stage complicated by an angle extension and 3.3 litre Postpartum haemorrhage.  
Progress: 36hrs post-op developed tender distended abdomen with bowel sounds present and no vomiting. CT performed and flatus tube inserted.  
Treatment:  
On day 2 rigid sigmoidoscopy performed and flatus tube left in-situ. Neostigmine infusion over 12 hrs given and dose doubled on day 3.  
Steady recovery and discharged on day 4.



Distended colon consistent with features suggestive of pseudo-obstruction

## CONCLUSION

It is essential to personalise management to the clinical situation including recognition that obstetric patients are more likely to need active management of Ogilvie’s Syndrome. Despite early interventions one in three of our patients required stoma formation with later surgery for reversal. The impact of this condition on the early postnatal period both physically and psychologically is huge. All 3 patients had to go to theatre a second time and 2 out of 3 needed care on HDU/ITU both of which meant being away from their babies.

Of note, all three patients had Caesareans complicated by all three patients had bowel sounds present. Often this is used as a rule out tool for post-operative ileus but should be interpreted with caution.

References: REYNOLDS, I.S., MCDERMOTT, E., LIDDY, R., AIRD, J.J., FLOOD, K., MCCORMACK, O., GEOGHEGAN, T. AND BRANNIGAN, A.E, 2024. Acute colonic pseudo-obstruction post-cesarean section is not a benign entity: A case series and review of the literature. *Int. J Gynecol Obstet.* 165, pp. 59-66.  
CHUDZINSKI, A.P., THOMPSON, E.V., AYSCUE, J.M., 2015. Acute colonic pseudoobstruction. *Clin Colon Rectal Surg.* 28, pp. 112-117.