

CASE REPORT

CHRONIC INVERSION OF UTERUS

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The inversion of the uterus is a post-partum complication which is an obstetric emergency. The inversion of uterus may be acute, sub-acute and chronic inversion. The acute inversion is very rare and occurs in 1:20,000,00 to 1: 200,000 cases¹. The causes of acute inversion of uterus are mismanagement of third stage of labour; e.g. trial of delivery of the placenta when the uterus is not yet involuted and placenta not yet separated, by pulling at the cord or by delivering it by Crede's Method. It could also happens immediately after the delivery by sudden increase in intrabdominal pressure, like coughing and sneezing^{2,3}. If the acute inversion is missed at that time, and patient present later in puerperium, it is called chronic inversion. This is the most common cause of chronic inversion. Other causes of chronic inversion are fundal neoplasm and atrophic uterus.

A 28 years old gravida para 3+0+3 was admitted through Casualty Department, to the Obst/Gynae Deptt. on 24.4.1991. She presented with irregular bleeding per vaginum for the last three months. She had a baby born by N.V.D. at home one year ago and she did not have menstrual periods for nine months. Then she started having irregular periods which used to last for 5-6 days. She used 10-12 pads a days, then after a break of 5-6 days after finishing the period, she used to start bleeding irregularly. The bleeding was not accompanied with any pain.

Her previous medical history and family history were not of any significance.

Her previous menstrual history (before the last child) was normal. She had had three full term uneventful pregnancies which ended up in normal vaginal deliveries. All were performed by a traditional birth attendant; there was no history of any P.P.H. in either of the delivery; but a short span of unconsciousness after the last child birth, she mentioned this, after a direct question was put to her. The unconsciousness lasted for one hour.

On examination, a five feet tall woman, weighing 50 kg, normal vital signs, well hydrated but looked pale; her chest was free of any adventitious sounds, and no abnormality over cardiac examination. No mass palpable over abdominal examination.

Per speculum examination, a rounded reddish coloured mass in the vagina, the size about 7x7 mm; it was thought to be a fibroid polyp. It bled on examination.

On pelvic digital examination, a fine, smooth, mobile non tender mass, coming from the vault of vagina was felt. The rim of the cervix could not be felt. No uterine mass was felt in pelvis. No mass palpable in fornices. A provisional diagnosis of fibroid

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polyp/chronic uterine inversion was made and it was decided to examine her in O.T. under General anaesthesia. Her haemoglobin concentration was 11 gm/dl blood group A Rh +ve, no abnormality in urine, and chest X-ray was clear.

On 27-4-1991; under general anaesthesia she was examined in lithotomy position. A Sims speculum was put, a rounded, reddish, easily bleedable mass was seen occupying the vagina, the rim of the cervix was not seen higher up around the pedicles; uterine sound could not be passed around the pedicles near the vault of the vagina. Uterine body was not felt by abdominal palpation; so a diagnosis of chronic inversion of the uterus was confirmed; it was third degree uterine inversion. The patient was put in supine position and laparotomy was performed. The uterine body had gone inverted out with both the fallopian tubes, round ligament and ovarian ligaments pulled in to half a length as well. The posterior cervical ring was released by giving a longitudinal incision about one and a half cm in length. Gentle traction was performed on both round ligaments and thus the body of the uterus was brought in and thus the inversion corrected. The incision was closed. The patient had an uneventful post-operative recovery and went home on 8th post-up day.

A pelvic examination was performed to confirm the success of the operation. She was advised to come after the next menstrual period.

DISCUSSION:

This patient was a unique case in a way that she did not have severe shock and haemorrhage after delivery to raise an alarm to be examined. As she had had a home delivery by an untrained birth attendant; she did not examine her. The patient was unaware of the condition till she started menstruating which caused the symptoms and forced her to come to a hospital. Chronic inversion of the commonest aetiology and for a such long duration is a very rare case. Magnetic resonance of the pelvis can reveal findings which are virtually pathognomic of incomplete inversion of uterus with far greater capacity than on corresponding ultrasound⁴. In this case the chronic inversion was controlled by abdominal operation (Haultain's Operation).

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