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Recurrence of Acute Inversion of Uterus After Manual Replacement

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ABSTRACT

Uterine inversion is a rare but a serious obstetric complication. It is a potentially life threatening complication occurring during the third stage of labour which requires prompt diagnosis and treatment. The incidence of uterine inversion is approximately 1 in 2500 to 1 in 3700 deliveries. In an average 1 in 3000 deliveries. Here is a case of 23 years old Mrs.Durga ,P1L1 , who delivered in a PHC by spontaneous vaginal delivery at 39 weeks gestation , now admitted for correction of acute inversion.

KEYWORDS : Inversion of uterus, vaso-vagal shock, Haultain's method

INTRODUCTION

Uterine inversion is most often associated with immediate and life threatening haemorrhage. Shock occurs due to parasympathetic stimulation due to stretching of tissues. The common cause of puerperal inversion is mismanaged third stage of labour.

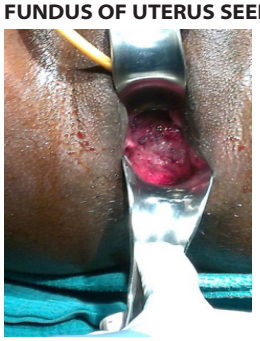
Causes of uterine inversion are excessive traction during placental delivery , fundal pressure , short umbilical cord , precipitate labour , tocolytics (magnesium sulphate) and oxytocin. Inversion of uterus during caesarean is much more common though not reported because these are promptly and easily corrected.

Patient presents commonly with classic triad with severe pelvic pain, haemorrhage , shock , altered shape of abdomen , bladder symptoms , non palpable uterus per abdominally.

CASE REPORT:

Mrs. Durga , P_1L_1, 23 years old , PND-0 , delivered vaginally at PHC at 42 weeks (post term pregnancy) , was referred to the hospital as a case of inversion of the uterus. On examination , patient was in shock responding to painful stimuli , she was severely pale . Her blood was 60 / ? mm Hg ,, pulse rate was 120 / min, systemic examinations were within normal limits . On per abdominal examination uterus not palpable , on per speculum examination fundus along with uterus seen at introitus.

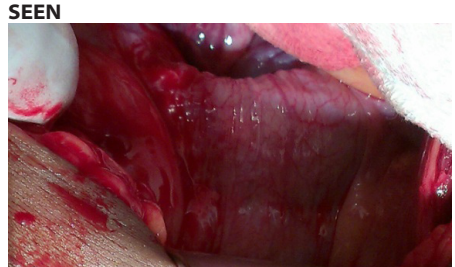
FUNDUS OF UTERUS SEEN THROUGH PER SECULUM

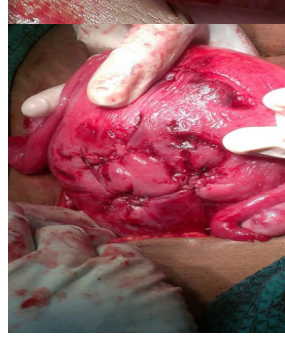


On per vaginal examination , uterus palpable at level of introitus. Patient was investigated and her haemoglobin was found to be 2.6 g% , haematocrit was 16% , all other investigations were within normal limits.

Patient was resuscitated and immediately shifted to emergency OT and manual replacement was done under general anaesthesia by Johnson's manoeuvre. As it failed , laparotomy was proceeded after 2 days and inversion was corrected by Haultain's method and uterus restored to its normal position . Bilateral fallopian tubes and ovaries were found to be normal.

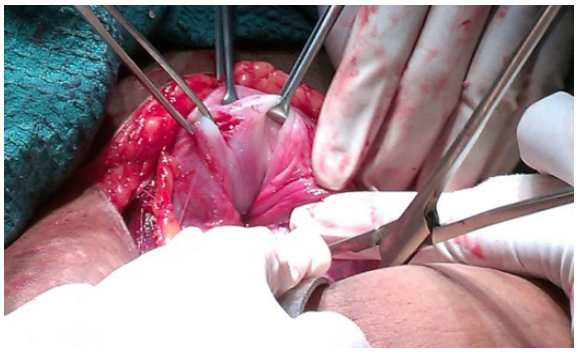
THROUGH LAPAROTOMY DIMPLING OF FUNDUS IS SEEN



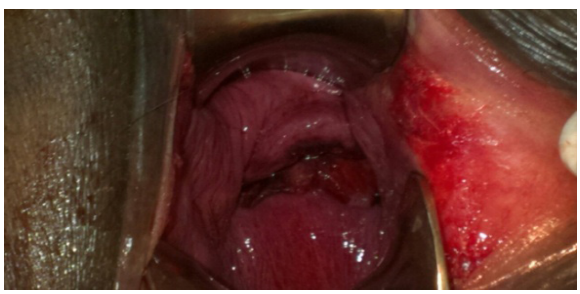


REPOSITIONED UTERUS

HAULTAINS METHOD OF REPOSITIONING



EXTERNAL OS OF CERVIX IN REPOSITIONED UTERUS



DISCUSSION:

Inversion of the uterus is a rare phenomenon and occurs due to mis management of third stage of labour . Patients usually present with shock and post partum haemorrhage which occurs due to atonicity of uterus . Patient should be first resuscitated and then uterine inversion should be corrected in OT under general anaesthesia . Once uterine inversion occurs , it should be corrected within 10 to 30 minutes . Otherwise maternal mortality is inevitable due to post partum haemorrhage and shock .

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