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Acute Uterine Inversion: A Case Report & Review of the Literature

KEYWORDS: Uterus inversion, Postpartum haemorrhage

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ABSTRACT *Acute uterine inversion, although rare is one of the potentially life threatening obstetric emergency. Its incidence is 1 in 2500 to 1 in 3700 deliveries. In 80% of cases cause of uterine inversion is faulty management of third stage of labour but in rest it may occur spontaneously. The immediate risk to the patient is due to postpartum haemorrhage and shock. The shock is both haemorrhagic & neurogenic in origin. The treatment is immediate replacement of inverted uterine fundus along with resuscitation of the patient .We report a case of Acute Uterine Inversion in a patient following uneventful vaginal delivery. This case report illustrate the importance of the condition as it is crucial for clinicians to have a heightened awareness of the condition and know how to best manage it.*

CASE REPORT:
A 23 yr old primigravida at 40 wk 4 day gestational age was admitted in labor ward for confinement .she was a registered case with regular antenatal visits. At the time of admission all her reports were normal & Hb was 11.2 gm%. Her uterus was relaxed ; cervix was long, posterior ,Os closed & pelvis was adequate. Obstetric USG reported estimated fetal weight – 3.4kg & AFI -8 cm.

In view of postdate pregnancy induction of labor was done with intracervical instillation of cerviprime at night. Second dose of cerviprime was repeated in the morning on next day following which patient went into active labor.ARM done at 11am followed by oxytocin infusion. At 3.30pm she was full dilated .At 4.10pm she delivered a term female 3.3 kg vaginaly with episiotomy , applying ventouse for poor maternal bearing down. Placenta & membrane delivered completely by controlled cord traction at 4.25 pm. However, following delivery of the placenta she developed a major atonic postpartum haemorrhage.A fleshy mass was felt at the introitus which on examination was found to be inverted uterine fundus. Manual reposition of fundus was tried but failed . Immediately resuscitation was started and patient was shifted to operating room for reposition of uterus under general anaesthesia.

On O.T table her B.P was 75/50 mmHg & pulse was 58/min. Three Ringer lactate , 2 pint Hexteryl was infused rapidly and general anaesthesia was given. Manual reposition of uterus was done by giving digital pressure on the part of the uterus nearest the cervix & slowly fundus was pushed upward. While carrying out this manipulation other hand was placed over the abdomen for counter support. After complete reposition right hand fist was kept inside cavity & oxytocin drip was started, inj methergin was given. Once uterus was completely contracted ,fist was removed. Oxytocin drip was continued &episiotomy was stitched. Two PCV were transfused & I.V antibiotics were given. Next day her Hb was 7.6 gm/dl. Three doses of intravenous iron sucrose, 200mg in 100ml normal saline each were given on alternate days. She was discharged on 7th day without any complaints.

This case highlights the importance of early recognition and a prompt response by a multidisciplinary team in the management of uterine inversion. A review of the literature provides helpful insight into making a diagnosis & the optimal M/M of this potentially life threatening condition.

DISCUSSION
Uterine inversion is said to occur when the uterine fundus prolapses within the endometrial cavity or when the uterine fundus turns inside out,into the cavity

There are three degrees of uterine inversion. In first degree, the fundus inverts but does not herniate through the level of the internal os. In the second degree, the fundus passes through the cervix and lies within the vagina &in the third degree the entire uterus is turned inside out and hangs outside the vulva. The two most important predisposing factors for inversion are incompletely separated placenta and an atonic uterus. Other aetiological factors are a morbidly adherent placenta, short cord , a fundal fibroid and precipitate delivery. Complications are shock, puerperal sepsis, anuria &Sheehan's syndrome. If untreated , mortality can be very high.

Immediate resuscitation must be started simultaneously with the efforts to reduce inversion. While repositing manually the part which has inverted last should be reduced first, in other words , the part nearest the cervix should be reposited first.

If manual reduction alone is not successful, hydrostatic pressure (O'Sullivan method)may be used to push fundus back to its normal anatomical position.

In long standing cases, surgery may be required. Of the vaginal procedures, in Spinelli's method cervical ring is cut anteriorly & in Kustner's it is divided posteriorly. By abdominal route, Huntington's procedure involves pulling on the round ligaments gradually to restore the uterine position. In case the cervical ring is very tight it can be incised anteriorly as described by Ocejo & posteriorly as in Haultain's procedure.

CONCLUSION
Although rare, acute uterine inversion should be one of the first possibilities to cross the obstetrician's mind in case of postpartum collapse due to PPH. The best person to treat the condition is the attendant present at the time of its occurrence. Immediate resuscitation & intervention in time can save the life of the patient .

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REFERENCE

1. You WB ,Zahn CM.Postpartum hemorrhage: uterine inversion and puerpal hematomas. Clin Obstet Gynecol 2006 Mar; 49(1):184-97. | 2. Robson S, AdairS, Bland P.A new surgical technique for dealing with uterine inversion.Aust Gynecol Obstet 2005 jun;45(3):250-1. | 3. Beringer RM,Patteril M. Puerperal uterine inversion and shock. Br J Anaes.2004 Mar;92(3):439-41. | 4. Tan KH, Luddin NS.Hydrostatic reduction of acute uterine inversion.Int J Gynaecol Obstet s2005 Oct;91(1):63-4. | 5. Abouleish E, Ali V, Joumaa B,Gupta D. Anaesthetic management of acute puerperal uterine inversion.Br J Anaesth 1995 Oct;75(4):486-7 |