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Chronic Uterine Inversion: A Rare Complication of Mismanaged Labour

KEYWORDS: Chronic uterine inversion.Improper obstetric management.

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ABSTRACT *Uterine inversion is turning inside out of uterus. Most often it is the catastrophe of 3rd stage of labour[1] caused by improper obstetric management of the same. Reported incidence is 1:1584 to 1:20000 [1].The diagnosis is based on 3 clinical symptoms: postpartum haemorrhage[2], shock and pelvic pain. The condition sometimes goes unnoticed & patient presents rarely a as case of chronic uterine inversion. We report a case of 23 year primipara who delivered 6 weeks back with grade 2 chronic uterine inversion after delivery at home.*

CASE REPORT:
A 23 year old primipara attended our hospital on August 24th, 2011 because of excessive vaginal bleeding after 40 days of home delivery. She had a term vaginal delivery by an "untrained dai."The delivery was reported to be difficult but details were not divulged. She delivered a healthy male baby of average weight. Twenty four hours later parturient reported expulsion of a mass (placenta) during passage of stools. She reported continuous bleeding off & on since then.

On admission she was pale, conscious, bleeding profusely per vaginally with pulse 96/min, blood pressure 136/70 mm of Hg.The uterus was not palpable abdominally. Per speculum revealed a red polypoid structure coming out of external os of about 2½" x 2½" .On bimanual examination uterus was not palpated, rim of cervix was felt around the mass while fornices were free.

Diagnosis of chronic inversion uterus (2nd degree) was made. Ultrasound confirmed the diagnosis of chronic inversion & Haultain's operation was planned one week later on august 29, 2011 after improvement of anaemia and control of infection.

FIGURE - I

On laparotomy, .the round ligaments & uterine tubes were seen emerging from a cup shaped depression while ovaries were seen on the top of it (Fig 1).Posterior rim of inverted uterus is incised about 1 inch. Inversion was then easily corrected, aided by a finger passed through vagina to gently push up the fundus (Fig.2). Uterus was closed in 2 layers using polyglactin 910: interrupted sutures (Fig.3)

Postoperatively patient recovered well and was discharged on day 8.

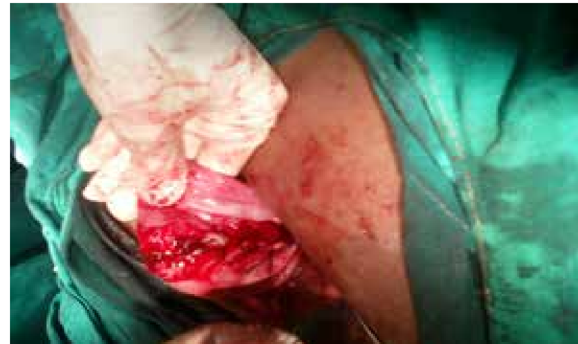

FIGURE - II

FIGURE - III

DISCUSSION:
Exact etiology remains unclear. Inversion can be puerperal or non puerperal.

Umbilical cord traction in a relaxed uterus, fundal pressure, injudicious use of oxytocics, primiparity, uterine hypotonia, fundal implantation of placenta, fundal myoma is predisposing factors. Rarely the condition goes unnoticed and presents as chronic inversion.

The prevalence of acute (occurring within 24 hours of delivery) ,sub-acute(within 24 hours and 4 weeks) and chronic[3] puerperal inversion(diagnosed after4 weeks) is 83.4 %, 2.62% and 13.9 % respectively[4].

Non-puerperal inversion has few published figures regarding its incidence.

Non puerperal inverted uterus is likely to be confused with

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sloughing polyp, uterine prolapse or malignant neoplasm.

Ultrasonographical[5,6] features include hyperechoic mass in the vagina with a central hypoechoic H shaped cavity in the transverse image, while the longitudinal image shows a U shaped depressed groove from the fundus in the centre.

Commonly performed surgery is Hautain`s operation. Huntington abdominal operation, Spinelli's and Kustner'stechniques involving replacing the uterine fundus through the anterior and posterior transections respectively[7] are rarely done.

PROGNOSIS:

Several successful pregnancies after corrected inversion of the uterus have been reported. Rupture of the operation scar has not been seen, but it is advised that the case should be managed as previous classical scar for subsequent delivery. There appears to be an increased incidence of adherent placenta. Recurrence however, has not been reported after operative repair.

REFERENCE 1. Hussain M, Jabeen T, Liaquat N, et al; Acute puerperal uterine inversion. J Coll Physicians Surg Pak. 2004 Apr;14(4):215-7. | 2. Anderson JM, Etches D; Prevention and management of postpartum hemorrhage. Am Fam Physician. 2007 Mar 15;75(6):875-82. | 3. Livingston SL, Booker C, Kramer P, et al; Chronic uterine inversion at 14 weeks postpartum. Obstet Gynecol. 2007 Feb;109(2 Pt2):555-7 | 4. Dali SM, Rajbhandadari S, Shrestha S. Puerperal inversion of the uterus in Nepal: case reports and review of literature. J Obstet Gynaecol Res 1997; 23:319-25. | 5. Pistorius LR, Hartman CR; Sonographic diagnosis of subacute puerperal uterine inversion. J Obstet Gynaecol. 1998 Sep;18(5):483 | 6. Momin AA, Saifi SG, Pethani NR, et al; Sonography of postpartum uterine inversion from acute to chronic stage. J Clin Ultrasound. 2009 Jan;37(1):53-6. | 7. Rocconi RH, Warner K, Chiang S. Postmenopausal uterine inversion associated with endometrial polyps. Obstetrics & gynaecology 2003; 102: 521-3. |