Original Research Paper

Volume : 5 | Issue : 8 | August 2016 • ISSN No 2277 - 8179 | IF : 3.508 | IC Value : 69.48

# Chronic Non Puerperal Uterine Inversion : A Case Report

Medical Science

KEYWORDS :

| | |
|---|---|
| **Dr.Geeta samota** | Govt medical college kota. |
| **Dr.Santosh** | Govt medical college kota. |
| **Dr Mamta sharma** | Govt medical college kota |

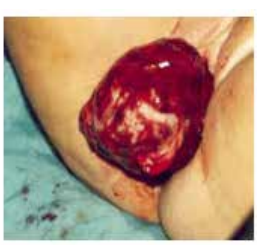
## ABSTRACT

*A case of non puerperal chronic uterine inversion secondary to submucus fibroid in a 55 years old women is presented there was complete uterine inversion of incarcerated inverted uterus protruding through the vagina beyond the vulva.The submucus fibroid was attached to fundus.At laparotomy uterus was found inverted,TAH with BSO done.Histopathology examination of speciman following hysterectomy confirmed.*

**Inrtoduction**:- Chronic non puerperal uterine inversion (CNPUI) is an extremely rare clinical situation on emerge a gynaecologist may out see one case in their entire life. Due to diversity of underlying causes and presentation of this condition , assessment and treatment need to be tailors individually.Most of the surgical methods disscused for treating CNPUI invoved reinverting the uterus before repairing the inversion made or proceeding to hysterectomy[1]. Vaginal hysterectomy for CNPUI without reinverting the uterus,poses unique challenge to surgen.

Case report:-A 55 year old multipara women presented in gynae emergency with complain of bleeding per vagina since 2 days. There was a history of mass protruding outside the vagina since 6 month with foul smelling discharge 4 month with spotting per vagina since 1 month.The mass was presented inside the vagina for the last 5 years but had not caused any problem.

General examination reveals:- She was average nourished , well hydrated and pale. BP was 130/80 mmHg,pulse 76/min.On vaginal examination a soft fleshy mass of 10 x 6 cm seen probably arising from the anterior lip of cervix.Per rectal examination uterus could not be felt.



On pelvic ultrasound examination :- Cervix showing a growth of 6.5 cm x 4.5 cm in it with peripheral vascularity with calcific foci suggesting of cervical fibroid with thickened endometrium.

CT finding :-Well defined lobulated soft tissue density lesion of 48 x 54 mm,seen within cervix, not significantly enhanced after contrast,predominantly seen in left posterolateral cervix wall.No exophytic component seen .Periuterine fat planes are clear – benign pathology ? Polyp ? Submucus fibroid.

Management :- 2 units blood transfusion done and 7 days injectable antibiotic course and then vaginal myomectomy was planned but uterine sound test was negative, so decision of laparotomy was made.On laparotomy uterus was not seen and fimbrial end of tubes were seen above the constriction ring than the diagnosis of complete chronic inversion of uterus was confimed. During surgery bilateral round and infundibulo pelvic ligaments clamped,cut and transfixed with bilateral uterine artery clamped and ligated.Incision was made on constriction ring and uterus was tries to pulled up and uterus was delivered with fundal submucosal fibroid polyp insitu and sent for histopathological examination. HPE reports show :Uterine fibroid show degenerative changes and senile atrophic changes of endometrium with cervicitis.

Discussion:-Chronic non puerperal uterine inersion is a very rare uterine leiomyoma,leiomyosarcoma,rhabdomyosarcoma,endometrial polyp,endometrial carcinoma and uterovaginal prolapse have been described as possible preceeding factor[2-8].Uterine leiomyoma were known to cause uterine inversion in 78.8 – 85% of cases.The classical diagnosis of chronic inversion depends on finding a mass coming through cervix,without definite margins of cervix and the absence of the uterine body during bimanual or rectal examination.Many surgical method have been described to treat CNPUI.Huntington abdominal approach involve grasping the round ligament and the uterus below the area of inversion and slowly pulling up repeatedly until the uterus is reinverted.

(2) Hanltain procedure is where vagino-cervical ring is incised posteriorly and carried up the posterior wall of the uterus until it can be reinverted to its normal anatomy.

(3) Kustner and Spinelli procedure are commonly used vagional approach ,kustner procedure is entering the pouch of dougles vaginaly and splitting the posterior aspect of uterus and the cervix and reinverting the uterus.In Spinelli operation incision is made on anterior aspect of the cervix and then the uterus is reinverted. After both the procedure the uterine incision needs to be repaired after repositioning of fertility is wished or otherwise can be proceeded for routine vaginal hysterectomy,subtotal vaginal hysterectomy[9] or vagional hysterectomy without reinversion of uterus has to be described to treat the CNPUI.Mayadeo et al. in 2003 described case of incomplete lateral inversion of uterus, diagnosed with laparoscopy and tied with vaginal hysterectomy without reinversion of the uterus.

Pulling anterior possible loops of bowel in an inverted uterus and finding a normal ureteric course in IVP was sufficient before proceding to myomectomy.Leiomyoma whenever present better to excised before proceding to hys-

terectomy as attempts to reposite the uterus may be more successful after myomectomy and hysterectomy is much easier when it is reposited rather than inverted Such reposition also avoids delay in reinversion procedure and sares valuable time in patient with high risk of anaesthesia.

Conclusion:-Cronic uterine inversion is a rare condition that is difficult to manage even for the experienced gynaecologist.USG and MRI usually leads to definitive diagnosis and the treatment is surgical[10] that include both abdominal and vagional approach.However need for preservation of fertility and excluding possible malignancy might be important in selected cases.

Repositioning of uterus may not be possible in all cases,leaving vaginal hysterectomy the only option.Performing myomectomy helps to relieve traction and at least partially reposite uterus which make vagional hysterectomy with reinversion much easier and without complication.

**References**

1. Mwinyoglee J, Simelela N, and Marivate M. Non-puerperal uterine inversions. A two case report and review of literature. Cent Afr J Med 1997;43(9) : 268-71.
2. Lupovitch A England ER, and Chen R. and Chen R. Non-puerperal uterine inversion in association with uterime sarcoma: case report in a 26-year-old and review of the literature *Gynecol Oncol* 2005;97(3):938-41.
3. Gomez-Lobo V, Burch W, and Khanna PC. Nonpuerperal uterinc inversion associated with an immature teratoma of the uterus in an adolescent. *Obstel Gynecol* 2007; 100(2 Pt2):491-3.
4. Eigbefoh JO, Okogbenin SA, Omorogbe F, and Mebayoje PS. Chronic uterine inversion secondary to submucous fibroid: a case report *Niger J Clin Pract* 2009; 12(1): 106-7.
5. Oguri H, Maeda N, Yamamoto Y, Wakatsuki A, and Fukaya T. Non-puerperal uterine inversion associated with endometrial carcinoma--a case report *Gynecol Oncol* 2005;97(3):521-3.
6. Rocconi R, Huh WK, and Chiang S. Postmenopausal uterine inversion associated with endometrial polyps. *Obstel Gynecol* 2003; 102(3): 521-3.
7. Tjalma WA, Naik R, Monaghan JM, and De Barros Lopes A. Uterine inversion by a mixed mullerian tumor of the copus. *Int J Gynecol Cancer* 2003; 13(6):894-7.
8. Mayadeo NM and Tank PD. Non-puerperal incompletc lateral uterine inversion with submucous leiomyoma: a case report *J Obstel Gynacecol Res* 2003; 29(4): 243-5.
9. Simms-Stewart D, Frederick S, Fletcher H, Char G, and Mitchell S. Postmenopausal uterine inversion treated by subtotal hysterectomy. *J Obstet Gynaecol* 2008; 28(1): 116-7.
10. Lascarides E and Cohen M. Surgical management of nonpuerperal inversion of the uterus. *Obstet Gynecol* 1968;32(3): 376-81.