

## A Rare Case Series of Uterine Inversions.



### Medical Science

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### ABSTRACT

*Uterine inversion is a very rare but potentially life threatening obstetric emergency due to severe post partum hemorrhage and shock. The incidence of inversion varies considerably in literature. Maternal mortality is as high as 15%1. Immediate recognition and prompt treatment is vital in management. We present a case series of 2 cases of inversion of uterus that were referred to our secondary care hospital.*

#### Introduction:

Uterine inversion in the acute post partum period is a rare complication. The incidence varies from 1 in 2000 to 1 in 50,000 births<sup>2</sup>. The diagnosis is based on clinical signs and symptoms. Treatment options are quite varied, from manual to surgical and pharmacological for correction of an inversion; the best amongst these has still not been established. Early diagnosis and prompt treatment can prevent maternal morbidity and mortality.

#### Cases:

Two cases of uterine inversion were referred to our hospital on the very same day, by the same hospital.

The first patient was a P1L1, delivered at a rural hospital where after delivering the placenta there was massive post partum hemorrhage, due to inversion of the uterus. The patient came to our casualty in a state of shock, unconscious, cold, clammy, with severe pallor, with pulse rate of 140bpm and BP was 60 systolic. The patient was directly received in the ICU and was intubated by the intensivists and was put on inotropic support. On examination, there was complete inversion of the uterine fundus. The investigations sent on admission showed hemoglobin of 3.7gm% wbc 20000 platelets of 3lakh. The uterus was repositioned manually and confirmed on ultrasound. The patient was given 3units of packed RBCs, and was transferred on ventilator support to a tertiary care hospital for intensive care and blood products. There the patient was on ventilator in ICU for 6 days and eventually died of DIC and multi organ failure.

The other patient, P2L2, delivered at the same previous hospital, 4 hrs later came with a very similar clinical picture. She too was in shock, unconscious, deathly pale, with pulse and BP not recordable. She was shifted to ICU, put on ventilator support on inotropic drugs. The hemoglobin was 1.7gm%, wbc 24000 platelets 2lakh. This uterus also could be manually repositioned. This patient was also given 2packed RBCs, and was transferred on ventilator support to a tertiary care hospital. She survived for 3 days but died due to complications of DIC and renal shutdown.

#### Discussion:

Uterine inversion is displacement of the fundus of the uterus mostly seen in the third stage of labour. It may be complete where the fundus passes through the cervix or incomplete where it remains above this level<sup>3</sup>. It is associated with placenta previa, fundal implantation of the placenta, use of vigorous cord traction to deliver the placenta, and the use of magnesium sulphate antepartum<sup>3,4</sup>. The classical presentation is that of an obviously inverted fundus while delivering the placenta, with massive post partum haemorrhage, and shock. Brar and colleagues reviewed 56 cases of inversion and estimated blood loss upto 2500ml.<sup>5</sup>

Management has two main components, immediate treatment of shock and replacement of the inverted uterus. Resuscitation should start immediately while attempts are made to replace the uterus. The chances of successful immediate reduction are as high as 40%<sup>5,6,7</sup>. If it is not possible to replace the uterus, then one should wait till patient is hemodynamically stable. Placenta should be left in situ to avoid further blood loss. The contraction of the cervix may require relaxation with tocolytic agents like terbutaline, ritodrine, nitroglycerine or magnesium sulphate or anaesthetic agent like halothane<sup>8</sup>. Severe cases may require laparotomy, the most commonly used being the Huntington and Haultain procedures.

#### Conclusion:

Uterine inversion is a potentially life threatening complication. If this is not recognized in time, it will lead to massive haemorrhage and shock leading to maternal death. It can occur in any setup and so trained personnel must be present at the time of delivery. Manual manipulation with tocolytic agents or halogenated anaesthetic agents is useful. In more resistant cases, patient may require surgical correction. Blood and blood products must be easily available to treat such cases. Early diagnosis and prompt treatment is crucial for patients' survival.

### REFERENCE

- Lewin JS, Bryan PJ. MR imaging of uterine inversion. Jcomput assist Tomogr.1989;13:357-9
- Momani AW, Hassan A. Treatment of puerperal uterine inversion by the hydrostatic method: reports of five cases. Eur J Obstet Gynaecol Reprod Biol.1989;32:281-5
- Still DK. Post partum haemorrhage and other problems of third stage. In:James DK, Streer PJ, Weiner CP, Gonik B, eds. High Risk Pregnancy Management Options:WB Saunders Company Ltd.1994;1175-7
- Shah-Hosseini R, Edward JR. Puerperal uterine inversion. Obstet gynaecol. 1989;73:567-70
- Brar HS, Greenpool JS, Platt LD, Paul RH. Acute Puerperal Inversion. New Approaches to Management. JRepro Med.1989;34:173-7
- Platt LD, Druzin ML. Acute puerperal inversion of the uterus. Am J Obstet Gynaecol. 1981;141:187-90
- Abouliesh E, Ali V, Joumaa B, LopezM, Gupta D. Anaesthetic management of acute puerperal inversion. Br J Anaesth. 1995; 75: 486-7
- Catanzarite VA, Moffitt KD, Baker ML, Adwalla SG, Argubright KF, Perkins RP. New approaches to the management of acute puerperal uterine inversion. Obstet Gynaecol. 1986; 68:7S-10S