



CHRONIC UTERINE INVERSION-A RARE CASE REPORT

Gynaecology

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ABSTRACT

Introduction: Inversion of uterus is an unusual entity¹⁻⁴ encountered as an obstetric emergency. Nonpuerperal inversion is often chronic, although Das⁵ has reported 8.6% of nonpuerperal inversion as sudden onset.

Case presentation: 33-year-old nullipara admitted with complaints of lower abdominal pain, a protrusion from vulva, and foul smelling vaginal discharge since 2 weeks. speculum examination: 5×4cm firm globular mass filling the vagina and protruding through introitus. The cervix could be neither seen nor palpated. Ultrasonography shows a hypoechoic lesion 4×8cm in lower segment of uterus- suggestive of a myoma or uterine inversion with right ovarian cyst. MRI shows a large heterogeneous mass lesion in endometrial cavity extending into cervical canal. Uterine inversion noted. Haultain procedure was done and fundal fibroid of 6×7cm was removed. Histopathology showed uterine leiomyoma.

Conclusion: preoperative diagnosis and histology especially in chronic uterine inversion would aid in planning proper treatment.

KEYWORDS

INTRODUCTION

Inversion of the uterus is an unusual entity¹⁻⁴ and may be classified as puerperal or obstetric and nonpuerperal or gynecologic inversion. It is a rare clinical problem encountered as an obstetric emergency and a diagnostic challenge in gynecology. Nonpuerperal inversion is often chronic, although Das⁵ has reported 8.6% of nonpuerperal inversion as sudden onset.

CASE PRESENTATION

The Case: We are reporting a case of 33-year-old nullipara admitted to the hospital with complaints of lower abdominal pain, a protrusion from the vulva, and foul smelling vaginal discharge since 2 weeks. On examination, her general condition was fair and she was afebrile. She had pallor and was anicteric. Vitals were stable. Systemic examination was within normal limits. Abdominal examination: soft, tenderness in lower abdomen, speculum examination: there was a 5 × 4cm firm globular mass filling the vagina and protruding through introitus. The cervix could be neither seen nor palpated.



Figure1- INVERSION OF UTERUS

Investigations: An ultrasonography performed revealed a normal-size uterus with a hypoechoic lesion 4 × 8cm in lower segment of uterus suggestive of a myoma or uterine inversion with right ovarian cyst.

MRI shows a large heterogeneous mass lesion in endometrial cavity extending into cervical Canal.

Treatment: Anemia was corrected by blood transfusion. Prophylactic IV antibiotics were given. Laparotomy was performed. Intra operatively it was found to be chronic uterine inversion. Haultain procedure was done and anterior fundal of 6×7cm foul smelling fibroid was removed. Right ovarian cyst of 6×4cm noted and cystectomy was done. The postoperative period was uneventful and afebrile. Histopathology showed uterine leiomyoma.

DISCUSSION

Most cases of uterine inversion are puerperal, and nonpuerperal inversions are extremely rare. To date 88 cases of uterine inversion were reported, 15 accounting for only one-sixth of all cases were non puerperal inversions (16.35% versus 85.8%). Takano et al summarized 88 reported cases of nonpuerperal uterine inversion; 81 (92%) of these were associated with uterine tumors, of which 20% were malignant. This emphasizes the need to perform biopsies prior to definitive treatment.⁶ All cases of nonpuerperal inversions are usually chronic but 8.6% are presented as sudden onset. The present case was a nonpuerperal uterine inversion due to a growing submucous myoma. This is rare and diagnosis is often difficult. Symptoms associated with nonpuerperal uterine inversion is vaginal discharge, vaginal tumor, and lower abdominal pain. MRI can examine the characteristic image of uterine inversion. Lewin et al reported that in T2-weighted MRI scans, a U-shaped uterine cavity and a thickened and inverted uterine fundus on a sagittal image and a "bulls-eye" configuration on an axial image are signs indicative of uterine inversion.³ Considering the short duration in which the size had increased, malignancy was considered to be the first differential diagnosis and was ruled out with a biopsy from the mass.

CONCLUSION

In the presence of a tumor protruding from vagina or vulva, we must consider uterine inversion. Non puerperal uterine inversion may be due to malignancies, therefore preoperative diagnosis and histology especially in chronic uterine inversion would aid in planning proper treatment.

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