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TORSION OF TERM GRAVID UTERUS - AN INCIDENTAL FINDING DURING CESAAREAN SECTION: A RARE CASE REPORT

KEY WORDS: Uterine Torsion, Uterus, Cesaarean Section

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ABSTRACT

Uterine torsion is rotation of the uterus around its long axis greater than 45 degrees. This is a rare case of 22 year old G2P1L1, 40 weeks of gestational age with previous normal vaginal delivery admitted for safe institutional delivery. Growth scan was done, AFI of 4.5 cm with estimated fetal weight 2.8 kg. After counselling about risk of oligohydramnios explained the mode of delivery, taken consent of trial of labour and induction. As there was non reassuring CTG, with nonprogression of labour, patient was taken for emergency LSCS under spinal anesthesia, intraoperatively there was an axial rotation of uterus to 180 degrees observed, as there was difficulty to derotate the full term gravid uterus with stiff abdomen low transverse incision is given on the posterior surface of uterus and delivered an alive male baby. Derotation of uterus done and sutured. Uterine torsion although rare should be kept in mind while performing cesaarean section.

INTRODUCTION

Uterine torsion is defined as rotation of the uterus around its long axis greater than 45 degrees. Uterine torsion is rare and its incidence is not well known. 300 cases reported over 150 years, but IUFD is common, in our case mother carried alive baby. Majority of cases of uterine torsion are associated with pregnancy, often asymptomatic and only found during cesarean section. The condition can occur in all ages, any parity, and in any trimester of pregnancy.

Case Report

A 22 year old pregnant lady, G2P1L1, 40 weeks of gestational age with previous normal vaginal delivery admitted on estimated date of delivery, with no complaints for safe institutional delivery. Growth scan was done on admission and it shows AFI of 4.5 cm with EFW of 2.8kg with placenta in upper segment anterior surface. We have counselled her about the risk of severe oligohydramnios, explained about the mode of delivery and taken consent. On examination vitals were stable, CTG was reassuring, uterus relaxed and on pervaginal examination cervix was unfavourable. Induction of labour was done and FHR monitoring done. As there was non reassuring CTG, decided to do Emergency LSCS under spinal anaesthesia. Consent was given for emergency Cesaarean Section.

Intraoperative Findings

Intraoperatively there was an axial rotation of uterus to 180 degrees observed. As there was difficulty to derotate the full term gravid uterus with stiff abdomen with inadequate relaxation, low transverse incision given on posterior surface of the uterus and delivered an alive male baby of weight 2.6 kg, cry present, APGAR 9 at 1 min, placenta and membranes removed completely. De-rotation of uterus done and posterior surface of uterus closed in 2 layers. B/L tubes and ovaries normal. Patient vitals were stable through out the procedure. Post operative period was uneventful.

DISCUSSION

Uterine Torsion is considered rare and has been referred to as an "obstetrician's" once in a lifetime diagnosis.



Figure1: Image showing Posterior surface of uterus sutured

after Detorsion. No signs of ischemia were seen.

Pregnancy exaggerates the congenital and physiological rotations and obliquities of the uterus making the gravid uterus prone for Uterine torsion, though cases have been reported in non gravid uterus. Recently cases have been reported with no associated pelvic factors. Most cases present with abdominal pain but signs and symptoms may vary and about 11% of patients remain asymptomatic. Risk factors include Asymmetry due to fibroids, Mullerian anomalies, Fetal malpresentation, Pelvic adhesions, Abdominal or ligament laxity, External cephalic version, Maternal trauma, Abdominal massage, Ehler danler syndrome, Oligohydramnios, Idiopathic. In this case oligohydramnios is assumed riskfactor. In oligohydramnios the distance between the uterine wall and fetus is less and any maternal abrupt movements will cause painful stimuli to fetus, which performs strong reflexive movements that can cause rotation of the uterus.

Management

About 11% of patients remain asymptomatic. All asymptomatic cases had Uterine torsion not more than 180, found during cesarean section. Uterine torsion presenting in labour may manifest by failure of cervical dilatation despite uterine contraction or fetal distress due to reduction in uterine blood flow. Preoperative diagnosis of Uterine Torsion is difficult to establish. In most cases, the diagnosis is made intraoperatively. A severe torsion of the uterus with acute abdomen can be diagnosed with USG, abdominal MRI. Uterine Torsion if detected remote from term then urgent laparotomy and rotation of uterus into its normal anatomical position may give chance for normal course of pregnancy. Uterine Torsion is a potentially dangerous complication of pregnancy both to the mother and to the fetus. During laparotomy where correction of UT is not possible, a deliberate posterior hysterotomy can be done for delivery of fetus. Both vertical and transverse posterior uterine incision have been described. The risk of rupture of posterior transverse incision is theoretically less than a posterior vertical incision, although exact risk is not known because of the rarity of this condition. After delivery manual correction can be easily performed and associated pathologies like adhesions, fibroids or ovarian cysts should be removed to prevent recurrence. Bilateral plication of the round ligaments can be done to prevent immediate postpartum recurrence of UT. This keeps the uterus in anteversion, prevents posterior uterine adhesions and future dyspareunia. Bilateral plication of uterosacral ligaments has also been described

CONCLUSION

Uterine torsion although rare should be kept in mind while performing Cesarean Section, associated myomas, ovarian tumours, malpresentations of fetus.

Clinical symptoms may be absent or or nonspecific and diagnosis may be intraoperative.

Anatomical landmarks should always be defined prior to uterine incision during a cesarean section to prevent damage to uterine vessels and vital organs. Early diagnosis and laparotomy may help to reduce maternal mortality and morbidity.

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