

An Unusual Case of Uterine Inversion: A Case Report

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ABSTRACT

Acute puerperal uterine inversion is a rare but potentially fatal obstetric emergency. A prompt recognition will enable

the immediate repositioning of the uterus before it becomes edematous and incarcerated by a constriction ring which requires surgical intervention.

Key Words: Primipara, Uterine inversion, Postpartum hemorrhage

KEY MESSAGE

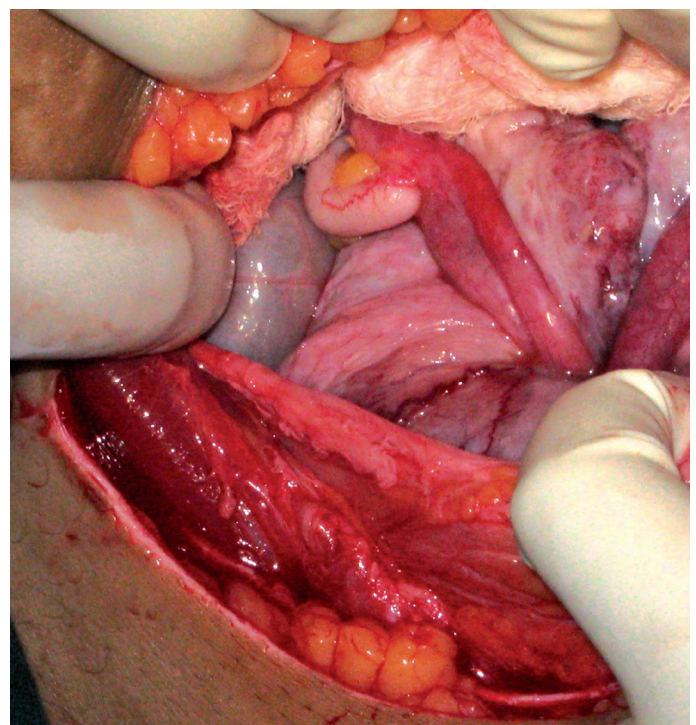
- Bimanual method of correction of uterine inversion at laparotomy is a new technique and is less traumatic than other laparotomy techniques described.

CASE STUDY

A 23-year old primipara was referred to our hospital with neurogenic shock. She had a vaginal delivery, 21 hours prior in a peripheral hospital and had given birth to a healthy male baby, weighing 3.1 kg. The uterus inverted soon after the delivery of the placenta, and it was repositioned. On arrival to our hospital, the patient was pale and in pain, her pulse rate was 155 bpm, her BP was 78/56 mm Hg and her uterus was palpable, just above the pubic symphysis. Her per speculum examination revealed a fleshy mass (inverted uterus). Her abdominal ultrasound was inconclusive. Antishock measures and antibiotic therapy were instituted. Manual reposition was attempted under controlled general anaesthesia, without success. On laparotomy, the cup of the uterine inversion was identified [Table/Fig-1]. Traction on the round ligaments was avoided, as it invariably gets torn. The bimanual reposition was successful in spite of oedema, with the vaginal surgeon attempting to reduce the uppermost part of inverted uterus, first on one side and then on the other side. The uterus was pale and flabby, oxytocics were given and Hayman's suture (the suture was placed through and through in the lower uterine segment and it was braced over the fundus. The same was repeated on the opposite side) was applied to aid tonicity and to prevent reinversion. The patient was observed in the intensive care unit for a few hours, antibiotics were given and breast feeding was initiated the next day. The patient was discharged after 5 days. This case is unusual in the sense that it recurred after correction and was recorrected at laparotomy, without putting an incision in the uterus.

The exact aetiology of uterine inversion remains unclear, but the most common and likely cause is mismanagement of the third stage of labour. The incidence of uterine inversion is 1 in 8537 (India), 1 in 23127 (US) and 1 in 27902 (Britain) [1]. The risk factors for spontaneous uterine inversion are primiparity, oxytocin use, the fundal insertion of the placenta, a short umbilical cord, macrosomia and uterine abnormality. The most common clinical presentation is pain, vaginal bleeding and shock.

The treatment requires the immediate implementation of shock therapy, uterine repositioning and antibiotic therapy. The nonsurgical methods are manual repositioning (Johnson's maneuver) and hydrostatic reduction (O'Sullivan). The surgical methods include the incision of the constriction ring vaginally (Spinelli), upward traction on the round ligaments with the assistant applying upward pressure from the vagina (Huntington) and incising the constriction ring posteriorly at laparotomy (Haultain). The newer methods include laparoscopic reduction [2], the use of obstetric ventouse at laparotomy [3], and application of cephalad traction on the deepest visible part of the posterior uterus [4].



[Table/Fig-1]: Cup of uterine inversion seen at laparotomy

Patient was severely shocked and the inverted uterus was edematous. Laparotomy helped us to achieve successful repositioning, and we saved her life. The bimanual method for the correction of uterine inversion at laparotomy is a new technique and it is less traumatic than other laparotomy techniques which have been described.

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