VAGINAL DELIVERY AFTER HAULTAIN'S OPERATION

(A case report)

by

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Acute puerperal inversion of the uterus is seldom encountered. Its incidence reported by different authors varies widely. Mccullagh (1925) reported an incidence of 1 in 23000 deliveries; Jardine from Glasgow gave an incidence of 1 in 17000; Herer and Sharkey reported 1 in 16240. Zangmeister from Germany gave the incidence of 1 in 4000,000. From India, Das (1940) gave the incidence as 1 in 23, 127. Chronic inversion of the uterus is even rarer, because most of the cases of acute inversion are immediately treated as and when they are noticed.

Miller (1927) reported 42 deliveries following post-partum inversion of the uterus. Chandra and Rathe (1964), Heera and Pinto Rosario (1966) Agarwal *et al* (1966) reported one case each of normal delivery after a previous Haultain's operation for chronic inversion of the uterus. Because of the rarity of this condition it was thought worth while to report this case.

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Case Report

N. R., 22 years, 2nd para, reported to the Govt. Hospital on 19-1-66 with complaints of excessive blood-stained discharge per vaginam and retention of urine with overflow for the last 18 days. She delivered a normal live child at home 18 days ago. She had profuse bleeding for about two days after delivery. On general physical examination she was moderately built but poorly nourished and was severely anaemic.

Abdominal examination showed bladder distended upto the umbilicus. She was catheterised and twenty ounces of clear urine were removed. Vaginal examination revealed a mass lying in the vagina, which was about 3½" x 2½" in size coming through the cervix. The cervical rim was felt all round the mass. Body of the uterus could not be felt on bimanual examination. There was tenderness in the fornices. Per speculum examination revealed a reddish mass lying in the vagina which was bleeding on touch. Foul-smelling discharge was present. She was diagnosed as a case of inversion of the uterus.

Investigations: haemoglobin 2 gm%, total leucocyte count 9200, differential leucocyte count, poly 73%, lympho 24%, eosinophil 3%. Urine examination, albumin was present in traces. Microscopically, many pus cells were seen per high power field. Urine culture revealed a growth of E. Coli sensitive to Furadantin. She was given a packed cell blood transfusion on the day of admission; in all she was given 4 blood transfusions and the urinary infection was treated by Furadantin. Haemoglobin came

upto 9.8 grams and the patient was cleared of her urinary infection when she left the hospital against medical advice. She again reported to the hospital after about a month with the history of continuous bleeding per vaginam which was more profuse for the last five days. On general physical examination she was severely anaemic. Vaginal examination findings were the same and there was profuse bleeding per vaginam. Haemoglobin was only 5 grams%. She was built up by repeated blood transfusions.

On 11-4-66 she was operated under general anaesthesia. A mid-line subumbilical incision was made. Fundus of the uterus was invaginated; both tubes and ovaries were partly pulled into the depression caused by the inversion. There was a fibrous constriction at the inverted margin; the ring was cut posteriorly and the inversion was corrected. Incision in the uterus was stitched by interrupted stitches in two layers with chromic catgut and the round ligaments were plicated. Post-operative period was uneventful and she was discharged on 28-4-66. She again reported in August, 1967, with amenorrhoea of 7 months' duration. On examination height of the fundus was about 30 weeks pregnancy, presentation was vertex, position was L.O.A., foetal heart sounds were good. She was advised to attend the antenatal clinic regularly and was advised admission about 4 weeks before the delivery. She was admitted on 28-10-67 with amenorrhoea of 9 months and vaginal discharge since the previous night. She went into labour on 31-10-67. Vaginal examination at 6 A.M. showed cervix about three fingers dilated and partially taken up. Vertex was below the level of ischial spines. She delivered a live male child at 11 A.M. There was no post-partum haemorrhage. Puerperium was uneventful and she left the hospital on 5-11-67.

Comments

There were 10 cases of inversion of the uterus in our hospital in the last eight years. In six cases Haultain's operation with plication of round ligaments was done. In 4 cases modified Haultain's operation and modified Gilliam's were carried out. In the first 4 cases the constriction ring was cut anteriorly, as in Dobbin's operation, and the scar was on the anterior uterine wall. Three cases out of these ten have reported with pregnancy. In one case a lower segment caesarean section was done in 1966, because of the fear that the scar may rupture during labour. In the present case we decided to allow her a vaginal delivery. The third case is 7 months pregnant.

Of the various operations for chronic inversion of the uterus, Spinelli's and Haultain's are the most popular. Samarrae (1965) considers Spinelli's operation to be better because it does not affect future pregnancies and normal deliveries. In the present case as well as in the cases reported by Chandra and Rathe (1964), Heera and Pinto Rosario (1966), Agarwal *et al* (1966), Haultain's operation was also found to be quite satisfactory as these cases conceived and delivered normally.

There is a definite danger of rupture of the uterus in subsequent pregnancy or labour as the scar is situated in the upper uterine segement, and there is a 40% chance that the placenta may get implanted over it causing erosion of the scar. Miller reported an increased incidence of subsequent adherent placenta in 38% of his cases. Recurrence of inversion has been reported after manual reposition but not after surgery.

Post-operative adhesions may interfere with the proper function of the uterus in labour and with retraction in the third stage. Because of these complications a pregnant woman

after a previous Haultain's operation needs a very careful watch during pregnancy and labour and these cases should be admitted to the hospital 4 to 6 weeks before delivery.

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