ACUTE TORSION OF A GRAVID UTERUS

(A RARE CASE OF UTERUS DIDELPHYS WITH SEPTATE VAGINA)

(A Case Report)

by

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Dextro-deviation and a small degree torsion of the gravid uterus are frequently met with during caesarean sections and are symptomless, but, a marked degree of torsion of the gravid uterus causing acute abdominal pain is an uncommon complication. Not more than 130 cases have been published in the literature so far. Torsion in a gravid double uterus is still rarer. The following is the case report of torsion of a gravid uterus in a case of uterus didelphys with complete septate vagina.

Case Report

Mrs. U. B., aged 18 years, a second gravida, was admitted into the Assam Medical College Hospital, Dibrugarh, on 22nd March 1968, at 4.30 a.m. for confinement.

She was seven months' pregnant. Her last menstrual date was on the 20th August, 1967. This was her second pregnancy. Her first was a tubal pregnancy and a left salpingectomy was done in March 1966 at a district hospital. No record of any congenital abnormality was made.

Two days ago while attempting to lift up something from the ground, she had an attack of sudden pain in the whole abdomen. Immediatly a village dai was called in. She fastened a cloth tightly over her gravid uterus. The pain began to increase and, therefore, she was sent to the nearest hospital. From that hospital, she was again referred to this institution for treatment.

At the time of admission, she was conscious of her surroundings but was restless with pain in the abdomen. Her build and nutrition were average, with marked pallor. There was no cyanosis. Pulse was 160 per minute, thready and almost imperceptible. Blood pressure was 60 systolic and the diastolic could not be recorded. Temperature was 96°F. The abdomen was extremely tender and rigid. Foetal parts could not be palpated and there were no foetal heart sounds. The size of the uterus could not be determined.

On vaginal examination, there was no bleeding per vaginam. A complete antero-posterior septum divided the whole length of the vagina into two halves and both were well-developed. Cervix was felt through the right half of the vagina very high up. It was closed and elongated. The possibility of another cervix in the left half of vagina was not in our mind and hence this was missed.

A diagnosis of a severe degree of concealed accidental haemorrhage was made and a decision was made to do a laparotomy when her condition improved. Later, a laparotomy was done under general anaesthesia. There was no blood in the peritoneal cavity. On further exploring, double uteri were found. The right uterus was pregnant to the size of 32 weeks of gestation and rotated clock-wise for 180 degrees, so that the posterior surface was

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anterior. It was completely tarry black in colour, except for a small area anteriorly. The uterus was very soft in consistency. This rotation was corrected easily. The right tube was markedly elongated and also distended. It also appeared black. The ovary was enormously enlarged and could be mistaken easily for a big old blood clot. The tube and overy were extremely friable to touch and seemed to give way easily at some points. They were found to lie in the left-hand corner of the abdominal cavity. The other uterus was slightly bulky, about eight-weeks' size of gestation. This uterus had the stump of the previous salpingectomy operation and a normal healthy ovary.

After correction of the gravid uterus, there was no change in its colour which persisted till the end of the operation (Fig. 1). A longitudinal incision was made on the anterior wall; there was no distinction between the upper and the lower segments of the uterus, nor could the vesical peritoneum be demarcated which was very friable, soft and thin. The amniotic sac was clear. A normal male dead foetus was removed from the uterus. The whole placenta and the membranes were similarly removed. The placenta was implanted in the upper segment and there were no retroplacental blood clots. The uterus started bleeding freely after the placenta was removed. The blood loss was heavy without any control in spite of the usual measures. The uterus did not retract. Subtotal hysterectomy of the right uterus and right salpingo-oophorectomy was performed. After closing the abdomen, the patient was put in the lithotomy position and the two vaginae and two cervices were clearly visualised.

Her post-operative stay in the hospital was uneventful.

Discussion

Torsion in this case may have been precipitated by the sudden movement while lifting something from the ground and was aggravated by the treatment meted out to her by the village dai. This condition grew serious by transporting her from one clinic to another. Torsion of the uterus for more than 72 hours led to infarction of the tissues distal to the site of strangulation. To what extent the non-gravid uterus played its part is not clear and it may have been the prime mover of the process.

The case was wrongly diagnosed as concealed accidental haemorrhage. The clinical picture was typical of this condition. Similar mistakes have been made by many previous authors. If labour starts and delivery occurs vaginally, these cases remain undiagnosed. Diagnosis is mostly made at laparotomy. Torsion has been reported without symptoms (Rabbiner, 1935; Hanley, 1939; Dillon, 1965). Imrae (1966) suggested that inability to correct the foetal lie by external manipulation despite the laxity of the abdominal muscles and a history of previous easy versions in the antenatal period may suggest torsion.

Uterine abnormality and growths in the pelvis, especially uterine fibroids, are well-known mechanical factors causing torsion of the uterus. Malpresentations, particularly transverse presentation, is commonly met with. The cases reported recently by Imrae (1966) and Sankari (1967) had transverse presentations. This may be the result of torsion and not the precipitating factor, because the longitudinal axis in the uterus is markedly reduced by torsion and that probably favours a transverse lie. As quoted by Imrae (1966), it is rather the external cephalic version which may induce torsion.

Corr (1943) reported recurrent torsions successively in both the first and second pregnancies. Caesarean

sections were done in both the cases. But this is very unusual.

Handerson (1960) reported successful correction of torsion by external manipulation. Often it may aggravate the situation.

Whatever may be the factor or factors responsible for torsion, if it is of short duration, the damage is not permanent and simple correction at laparotomy followed by caesarean section is the procedure usually adopted. But, if the damage is significant, because of the long duration of torsion, the condition may not be reversible and caesarean hysterectomy may be the unfortunate result, as in our case.

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Fig. on Art Paper V