HERNIATION OF RETROVERTED GRAVID UTERUS THROUGH THE POUCH OF DOUGLAS

(A Case Report)

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A retroverted gravid uterus is not an infrequent clinical entity. Usually it undergoes spontaneous rectification at or soon after the 12th week of gestation without causing any symptoms and the condition passes unnoticed. Rarely, it fails to do so resulting in incarceration which is indeed a serious and even fatal complication.

This condition was first described by Sir William Hunter in 1754 (cited by Moir, 1956)—the specimen of his historical case is preserved in his museum. Gregoire and Kilmann (cited by Moir, 1956) have also independently referred to this condition.

The symptoms of incarceration usually arise after the 14th week of gestation. Apart from pelvic discomfort and low sacral pain, the bladder symptoms predominate. They are—frequency, dysuria, retention with overflow incontinence, and if the condition is unrelieved the bladder becomes enormously distended with thick bladder walls. Infection soon supervenes resulting in gross cystitis which may lead to sloughing of the mucous membrane of the bladder, and even gangrene and rupture of the bladder have been reported. The obstruction and infection lead to pyelonephritis, hydronephrosis and pyonephrosis, resulting in uraemia. In fact Berge (cited by Moir, 1956) is of the opinion that 80% of the deaths in such cases are due to urinary complications.

Constipation is often very persistent. A fatal case was reported by Treub in which the post-mortem examination revealed a compressed gangrenous colon. In Hunter's historic case (supra), there was pronounced obstruction of the rectum.

Very rarely, the incarcerated uterus may burrow between the vagina and the rectum, opening up the recto-vaginal space and finally protrude through one of the two canals. Barnes (1886) quoted a case where the fundus of the incarcerated retroverted gravid uterus buldged into the vagina and Brandao Fillio (1932) reported a case in which a five months' gravid uterus forced its way through the anus.

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The last complication appears to be extremely rare and search of the available literature failed to produce any reported cases, except the two cases quoted by Chasser Moir in Munro Kerr's "Operative Obstetrics". Such rarity of the condition prompted us to report the following case where the incarcerated retroverted gravid uterus burrowed through the posterior vaginal wall and was lying outside the vulva.

Case Report

Smt. D., aged 24 years, 4th gravida, 3 children alive and healthy, last delivery 2½ years ago, was admitted on 7-3-1969 in Sir Sunder Lal Hospital, Banaras Hindu University, with the complaints of amenorrhoea 4 months and something coming out of the vagina since one day. The patient had constipation for which she had to strain during defaecation. She often used to have difficulty in micturation but that was not very prominent. One day while she was straining at stool, something protuded through the vagina. She called a dai who tried to put a small bag of sand in the vagina to replace the mass but was unsuccessful. Thereafter, she was taken to a nearby doctor who advised her to come to this Hospital.

On general examination, the patient was extremely dehydrated and ill. She was thin, emaciated and anaemic. Pulse was 100/mt., B.P.-140/60 mm., and surprisingly, she was not in shock. The lower abdomen was soft and empty. A mass was protuding through the vagina which was covered with rags and was foul-smelling. After cleaning the part, examination revealed that it was the uterus with tubes and ovaries lying outsides the vulva (Fig. 1 and 2).

The mass was very oedematous and infected and at places it was gangrenous. A catheter was put in the bladder, but the urine was small in quantity, high coloured and infected. After giving her two bottles of intravenous fluids to overcome the dehydration and arranging for a blood transfusion she was taken up for operation. Meanwhile, the routine investigations carried out were as follows:—

Total leucocyte count—10,550/cmm.

Diff. count: P—69%, L—27%, E—4%. Urine was turbid and showed albumin—one plus, few R.B.C.S. and pus cells.

Under general anaesthesia, a proper examination was carried out, which showed a rent in the posterior vaginal wall through which the whole of the gravid uterus was protruding out with its appendages. As the uterus was oedematous and gangrenous it could not be replaced through the rent; therefore, through a fundal vertical incision the products of conception were evacuated and the size of the uterus reduced; even then an effort to replace the uterus was unsuccessful. Therefore, the abdomen was opened by a midline subumbilical incision and by bimanual efforts the uterus was brought to its normal position. In view of the gross infection and gangrene of the uterus it was decided to perform a hysterectomy. A total hysterectomy with bilateral salpingo-oophorectomy was done in the usual way without any difficulty. Having removed the uterus the vagina was explored properly and a transverse rent of about 3" was found in the posterior vaginal wall, about 1½ from the introitus, which was stitched with interrupted catgut sutures. Rectal examination revealed the rectum to be intact. Pelvic peritonisation was done and the abdomen closed in layers. The patient was given one bottle of blood, along with 3 bottles of glucose and saline. She stood the operation well. Post-operative period was afebrile and uneventfull. An indwelling catheter was kept for 6 days in anticipation of bladder injury or bruising due to pressure. She was given chloramphenicol, 250 mg. 6 hourly. On the eighth day the abdominal stitches were removed. Speculum examination revealed healthy vaginal sutures, although the vagina was very lax. The patient was discharged from the Hospital on the eleventh day in a fit condition.

Comments

Barns (1947) quotes the incidence of uncomplicated retroversion during pregnancy as 5.7% (5.5% in primi-

paras and 6.5% in multiparous). Jeffecoate (1962) puts the incidence of retroversion during the early weeks of pregnancy at 10%.

The capacity of the uterus to correct its position is remarkable even in the presence of adhesions, which presumably soften and stretch in pregnancy, so that spontaneous correction occurs nearly in all cases. Very occasionally the fundus of the uterus fails to clear the sacral promontary and becomes impacted in the pelvis at the twelfth to fourteenth week. The growing uterus then fills the pelvis displacing the fundus of the bladder upwards and the base of the bladder forwards, resulting in urinary symptoms. Impaction is most likely to occur when the pelvis is small and has an overhanging sacral promontary.

In the case stated above the fundus of the uterus burrowed between the rectum and vagina opening up the rectovaginal space for quite some length. It gradually separated the rectum from the vagina in its middle third, thereby leading to constipation and finally protruded through the vagina after tearing the posterior vaginal wall.

Since the bladder symptoms were not predominant, which usually bring the patient to the hospital, the patient evaded medical aid till the uterus entered the rectovaginal space. The clean cut tear in the vaginal wall without any sloughing is difficult to explain, since presumably the vagina was torn as a result of pressure necrosis by the growing uterine fundus. The entire gravid uterus with the tubes and ovaries was lying outside the vulva upside down without any shock to the patient, nor was there any history of shock at its onset —a remarkable feature indeed.

Regarding the management we feel that no better treatment could have been carried out than what was done in this case. Search of the literature did not help us and we shall be indeed grateful if any of our colleagues can cite some references or forward some comments.

Summary

1. A case of herniation of retroverted gravid uterus through the pouch of Douglas has been described.
2. Literature on retroverted gravid uterus and its complications has been briefly reviewed.
3. More references and comments in connection with similar cases are requested.

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See Figs. on Art Paper VII