ACUTE TORSION OF FULL TERM GRAVID UTERUS

by

A. N. GUPTA*, M.D., D.G.O. (Madras)

Acute torsion of a gravid uterus is a relatively rare accident of pregnancy and is often diagnosed as accidental haemorrhage or other intra-abdominal catastrophy. Pre-operative diagnosis is seldom made because of its rarity. Till 1956, 108 cases had been reported in the literature (Nesbitt and Corner, 1956) and a few more must have been added since then. The present case of an advanced degree of torsion, predisposed by a uterine malformation, is reported because of its rarity and difficulties in diagnosis.

CASE HISTORY

Mrs. S aged 25 years, married since four years, para 1+0+0+0, was admitted as an emergency on 9-2-1969 at 9.30 A.M. She complained of amenorrhoea of about nine months and pain in the abdomen followed by vomiting for the last twelve hours. The pain in the abdomen was described by her as that similar to labour pains. She also gave a history of having had 6-7 loose motions. There was no history of vaginal discharge or bleeding. She was examined by a local 'dai' and referred to this hospital.

In the past medical and surgical histories there was nothing contributory. Her menses were regular, painless, the flow lasting for 3-4 days. The exact date of her last menstrual period was not known.

In her past obstetrical history she was admitted in this hospital 1½ years ago as a case of obstructed labour due to shoulder presentation. She was delivered after decapitation, and exploration of the uterus at the end of the operation revealed no rent. The puerperium was morbid and she was discharged on the seventh day.

On examination she was found to be restless, tossing with pain, looking pale, pulse, 140/mt. poor in volume and tension, and B.P. was 80/60 mm. Hg. The temperature was normal and respiratory rate was 24/mt; heart and lungs did not reveal any abnormality.

Abdominal examination revealed the uterine ovoid as transversally oval, foetal lie was oblique. The head was felt in the left lumbar region and breech in the right iliac fossa. Foetal heart was not heard. There was no tenseness or tenderness over the uterus. There was no free fluid in the abdomen. Bowel sounds were normal and there was no tenderness or rigidity of the abdomen. Vaginal examination revealed a cervix, which was tightly closed and the presenting part was very high above the pelvic brim. There was no bleeding or discharge per vaginam.

The resident on duty in view of her past history of difficult labour made a provisional diagnosis of rupture of uterus. The physical finding were against the diagnosis of either rupture of uterus or concealed accidental haemorrhage, but the cause of her shock remained to be explained.

Investigations And Progress

Hb. 8 gms.%; urine—N.A.D.; E.C.G. revealed sinus tachycardia; serum electrolytes, Na 130 Meq/L, K 5-5 Meq/L Cl, 91 Meq/L. Her blood group was B, Rh positive. With mephentine and I. V. fluids (one litre) given rapidly her B. P. improved to 100/70 mm. Hg., but again at 11 A.M., i.e. 1½ hours after admission it dropped to 85 mm. Hg. systolic.

*Asso. Prof. of Obst. & Gynec., Postgraduate Institute of Medical Education and Research, Chandigarh.

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As shock could not be explained and in view of her past obstetrical history of a difficult labour, and incomplete rupture of the uterus, specially of the posterior wall, could not be ruled out with certainity, even though there was nothing to support it clinically. A laparotomy was decided at this time and done at 11.20 A.M., i.e. 2 hours after admission.

Findings at Laparotomy

The uterus was found to be bicornuate and intact, but discoloured. There was no free fluid or blood in the peritoneal cavity. The lower segment was found to be abnormally narrow with tortuous veins over it. A classical caesarean section was done as the baby was in the transverse lie and a fresh stillborn foetus, weighing 3000 gms., was delivered. The placenta (weight 500 gms.) was delivered entire with its membranes. There were no retro-placental clots. The uterus remained flabby in spite of oxytocics. It was just like an empty gunny bag as one has seen in a few cases of concealed accidental haemorrhage. On further exploration, the uterus was found to be sub-septate and had undergone torsion through 135° to the right. The incision on uterus was actually on the posterior wall, 2½" lateral to the attachment of left round ligament. As the uterus failed to retract even though the torsion was corrected and classical incision closed as usual, a quick subtotal hysterectomy was done to arrest the atonic post-partum haemorrhage (Figs. 1 and 2). A total of 3 units (1300 cc) of compatible blood was given during operation. Her B.P. at the end of operation was 90/60 mm. Hg. and pulse 116/mt. Her post-operative period was uneventful and she was discharged on the 13th post-operative day, i.e. on 22nd February 1969.

Comments

Torsion of the uterus is more common in animals (Cows) as compared to human beings. Torsion of the uterus, if pronounced, is associated with acute abdominal symptoms. In the early months it simulates an ectopic pregnancy, but in later months it is more likely to be mistaken for concealed accidental haemorrhage. If torsion is associated with uterine or ovarian tumours, as is often the case, the abdominal disturbances are attributed to complications of the tumour itself. In human beings, in 80% of cases there are associated uterine anomalies or pathologic lesions in the pelvis, e.g., myomas, ovarian tumours, adhesions, uterine anomalies previous uterine suspension or abnormalities of the spine or pelvis. Of the reported cases, in 30% there was a uterine myoma and in 15% there was a bicornuate uterus.

In the present case there was a uterus bicornis leading to a recurrent transverse lie and acute torsion of the uterus through 135°. The clinical findings did not quite fit in with the preoperative diagnosis of either rupture of the uterus or accidental haemorrhage. The cause of acute abdomen and shock remained unexplained and a laparotomy was decided upon without any delay.

The narrow lower uterine segment with tortuous veins over it necessitating a classical caesarean section, should have pointed to diagnosis along with the position of the round ligaments. Because of its rarity, the dark and flabby look of the uterus was mistaken for concealed accidental haemorrhage. A hysterectomy had to be done as the uterus failed to retract in spite of detortion, oxytocics warm packs and blood replacement. It was considered as almost a life saving procedure in this young patient in profound shock, caused by atonic postpartum haemorrhage.

Summary and Conclusions

1. A case of advanced degree of acute torsion of a full term gravid

uterus, predisposed by an uterine anomaly, requiring caesarean hysterectomy, is described.

2. A plea is made to keep this rare possibility in mind in the differential diagnosis of an unexplained acute abdomen and shock during pregnancy and labour.

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See Figs. on Art Paper VIII