ACUTE INVERSION OF THE UTERUS

(A Case Report)

by

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Acute inversion of the uterus is one of the most serious but luckily one of the rarest complications in obstetrics. The incidence has been variously reported between 1 in 17,000 and 1 in 200,000 deliveries. Das in his review of the subject gave its incidence in India as 1 in 23,127.

There are three degrees of inversion. The first degree which is likely to be missed is that in which the fundus is turning itself inside out but does not however, herniate through the internal os. In the second degree, the fundus passes through the cervix but lies within the vagina and in the third degree the entire uterus is turned inside out and hangs outside the vulva taking much of the vagina with it. It is the third variety which is the rarest.

Case Report

Mrs. K.K., 20 years old, primipara, was admitted in the Hospital on 14-9-68 at 9.00 A.M. with labour pains. She delivered normally a female child at 12.15 P.M. on the same day, but during the third stage of labour along with the placenta there was complete inversion of the uterus. The placenta was attached at the fundus. Bleeding per vaginam was slight. There was no history of any manipulation like cord traction or abdominal pressure, but during the delivery of the baby the cord was found encircling the leg twice and the neck once. The patient was in a moderate degree of shock, with a pulse rate of 120 per minute, blood pressure 70 m.m. Hg. systolic, and a cold clammy skin.

Immediate replacement of the protruding mass into the vagina was done, i.e. the third degree inversion was converted into a second degree and during this procedure the placenta got completely detached. Bleeding was moderate.

It was decided to replace the uterus under general anesthesia and the patient was given injection morphia ¼ grain and injection atropin 1/100th grain. The blood was taken for grouping and cross matching (transfusion, however, was not required later). Intravenous 5% glucose drip was started. Replacement of the uterus was not difficult but during the procedure the blood pressure fell further, but came up again to 100 m.m. systolic no sooner the replacement was completed. The uterus contracted well after giving one injection of Methergin intravenously.

Discussion

In large percentage of cases, in about 4/5th of the total, the responsible factor for inversion according to Donald, (1964), is some error of management of labour. But there also exists a separate entity of spontaneous inversion which can be caused by certain precipitating factors even in the absence of any error in the management of the labour.

These precipitating factors are: 1. Fundal attachment of the placenta,

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2. short cord either itself or becoming short due to winding round the baby's body, and 3. atony of the uterus as a whole or localised atony in the region of placental attachment.

A short cord or cord becoming short by winding round the baby's body will start pulling on the unseparated placenta even in the second stage of labour as the foetus continues to descend. This pull will be more if the placenta is attached at the fundus, and if the superadded factor of localised atony at the site is there, inversion is more likely to occur.

Besides these causes, few others like precipitate delivery in the erect position, a sharp rise in intra abdominal pressure like, voilent bearing down efforts, severe coughing, and improper method of Crede's expression of the placenta can also cause acute inversion, more so if the precipitating factors are also present.

Summary

A case of acute third degree inversion, a rare entity is presented. Importance of the precipitating factors in causing spontaneous inversion has been discussed.

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References

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