INVERSION OF THE UTERUS

by

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Inversion of the uterus is a very rare clinical entity, so much so that many of us are deprived from seeing such a case throughout our career. The present case, occurred as an acute inversion after home delivery and was seen by us as a chronic case after two years of its occurrence.

Case Report

Mrs. M. K., 22 years, Para 1, was admitted in S.V.B.P. Hospital Meerut, first in the medical wards as a case of severe anaemia. History revealed irregular bleeding per vaginam for the last two years following delivery. Two years back she had a full term delivery at home in a village. There was history of removal of placenta by a village midwife as it was retained. She went into shock following these manipulations and somehow survived this hazardous delivery. The child died after 4 months of delivery. The patient continued to bleed off and on since delivery.

On admission, her haemoglobin was 2.5 gms, per cent. She was referred to us for vaginal bleeding. On examination, no mass was palpable per abdomen. Local examination did not reveal any mass outside the vagina. Per speculum examination revealed a fleshy congested mass with a raw surface inside the vagina. On vaginal examination there was bleeding from the mass which was soft and of size of a small orange. The fundus of uterus and vaginal portion of the cervix were not felt and the upper margins of the mass were continuous with the vagina suggesting the diagnosis of complete inversion of the uterus. There was no possibility of passing a uterine sound as the cervix was neither felt nor seen. On rectal examination a cup-shaped depression was felt in place of uterus confirming the diagnosis of inversion of the uterus.

She was given antianaemic treatment along with six bottles of blood transfusion to treat her anaemia. Her general condition improved and her haemoglobin rose to 10 Gms per cent. She was kept for abdominal operation on 20-5-70 with the consent for hysterectomy if needed. Haultain's operation was performed keeping in view her young age and the desire for children, which was successful though with difficulty. The posterior cervical ring had to be cut about 1.5 inches before complete replacement could be obtained with the help of Allis's forceps. After replacement the incision was stitched. Postoperative recovery was uneventful and the patient was discharged on 2-6-1970. There was no vaginal bleeding and she was having regular periods till last check up on 30-8-70.

Comments

Acute inversion is one of the rarest complication of labour. Jardine has reported its incidence to be 1 in 17,000 deliveries, Zangiemeister puts it as 1 in 40,000, McCullagh (1925) as 1 in 23,000, Harer and Sharkey (1940) as 1 in 16,240 and Das (1940) as 1 in 23,127 deliveries.

Inversion of uterus may be puerperal or non-puerperal. Each of these varieties is usually subdivided into acute and chronic. The distinction between acute and chronic in puerperal variety is determined by the interval between the time of

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occurrence of the accident and the commencement of the treatment, which for acute is limited to 30 days.

Symptoms

In chronic cases history of shock at the time of delivery followed by irregular bleeding and discharge per vaginam is suggestive of inversion of uterus. Useful aids in preoperative diagnosis are examinations under anaesthesia, per rectum and per vaginam to feel the absence of body of uterus above and passing a sound into the uterine cavity to note the shorter length. Diagnosis becomes really difficult in incomplete chronic inversion of the uterus associated with a tumour as an aetiological factor. Cupping of the fundus of the uterus in these cases is diagnostic.

Treatment

The treatment of chronic inversion depends upon the age of the patient, parity, presence of infection, degree of inversion and the associated tumour, if present. In elderly women treatment is easy as we can resort to vaginal or abdominal hysterectomy. In young patients desirous of children surgical correction can be done, either by vaginal approach in which the anterior part of the cervical ring is divided (Spinelli's technique) or the posterior part of the ring is divided (Kustner's procedure), or by abdominal route either by Haultain's operation in which the posterior part of the constriction ring is incised or Dobbin's method where the anterior part of the ring is cut.

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