ACUTE INVERSION OF THE UTERUS

(Report of a Case)

by

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Acute inversion of the uterus is a catastrophy which no obstetrician would like his patient to develope. Occurrence of acute inversion gives an impression of a badly managed third stage of labour. Owing to its rarity that many obstetrician hardly ever see a case. The average incidence of the condition is about 1 in 30,000. Das (1940) has reported that the average incidence in Great Britain was 1 in 27,992; in American hospitals 1 in 23,127; in Indian hospitals 1 in 8,537. In Wadia Maternity Hospital, Bombay, (1961-66) it was 1 in 11,400.

The object of this paper is to report this case of acute inversion of the uterus in a booked case, a primigravida who had a spontaneous delivery in the hospital before the expulsion of the placenta.

Case Report:

Mrs. S., primigravida, was admitted in the Zenana hospital, Jaipur, on 23-7-68 at 9.15 A.M. with 9 months' amenorrhoea and labour pains since 6 A.M. the same day. General and systemic examinations did not reveal any thing in particular. On abdominal examination the uterus was 40 weeks' size, was contracting mildly. Vertex was engaged and the position was L.O.A. Foetal heart sounds, regular with good tone. Her labour went on smoothly and membranes ruptured at 1.30 A.M. on 24-7-68 and she delivered a living male child weighing 6¼ pounds after episiotomy at 1.45 A.M. on 24-7-68. Just after the delivery the patient complained of severe pain in the lower abdomen and became restless, started profuse vaginal bleeding and collapsed, the systolic blood pressure was 60 and pulse was a 160/min and low in volume. On abdominal examination uterus was not felt and the placenta was seen at the introitus and was adherent to the inverted uterus. Resuscitative measures were taken at once and blood transfusion was arranged and in the meantime it was decided to replace the uterus under general anaesthesia. The placenta was removed manually before reduction and the uterus was pushed into the vagina and the inversion was reduced by 'O' Sullivan's hydrostatic method and the hydrostatic, pressure was maintained for one hour. Uterus was felt per abdomen but it was flabby. So intravenous methergin 0.25 mgm was given and 10 units syntocinon were put in the drip. The uterus and vagina were packed by roller gauze. Blood pressure improved immediately after reduction and it was 110/70 mm Hg at 3 A.M. Two units of blood were given after the reduction. Blood pressure was maintained after reduction. The pack was removed 24 hours later after starting the syntocinon drip. The patient was allowed to move about on the seventh day of reposition. Her Hb was 50% after delivery, for which she was given antianaemic treatment. She had an uneventful recovery thereafter. The mother and baby were discharged in good condition on the fourteenth day.

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Discussion

Varying etiological factors are mentioned by different workers. These include congenital malformation of the uterus, localised atony of the uterus in association with sudden rise in intra-abdominal pressure, asymmetrical uterine contractions, postpartum mismanagement of the third stage of labour, manual removal of adherent placenta, and lastly fundal attachement of the placenta;. Orisini (1929) reported only 3% cases had fundal insertion of placenta hence low incidence of inversion of the uterus. The symptoms of the accident are not always well defined. In McCullagh series shock was present in 50% of the cases. In all cases of obstetric shock of obscure origin a simple vaginal examination should be made to rule out partial inversion and if found correction should be done immediately.

In the management of inversion prophylaxis is important. It has been advocated that treatment of shock should precede the treatment of inversion. If, however, the patient does not rally round in spite of usual resuscitative measures within a reasonable length of time one should not hesitative to correct the inversion. In these cases reposition of the inverted uterus might itself bring the patient out of shock as it is the tension on the neurovascular bundle in the broad ligament which is responsible for the shock. Reduction can be done by manual reposition or by hydraulic pressure.

It is a controversy whether the adherent placenta associated with the inverted uterus should be removed before or after reposition of the inverted uterus. Cosgrove (1939) & Loizeaux *et al* (1955) are in favour of removing the adherent placenta before replacement. According to Munro Kerr replacement is done with the placenta still attached to it as a protection against infection but with modern antibiotics that can be prevented, but if the replacement cannot be so accomplished the placenta should be removed.

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