CHRONIC INVERSION OF THE UTERUS

(Report of 2 cases associated with fibromyomate uteri)

by

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Inversion of a puerperal uterus is a rare entity and for such a condition to occur in a non-puerperal uterus is considered almost a gynaecologic curiosity. Das (1940) states that inversion of a non-puerperal uterus is so rare that many medical men in the course of their professional career never see one. It is for this reason that we report two cases of chronic inversion due to fibromyoma of uterus, who presented with identical picture.

Case 1.

Mrs. A.S., aged 40 years, para 2, was admitted as an emergency in Medical College Hospital, Aurangabad on 15.6.1973 with complaints of irregular bleeding per vaginam with foul smelling discharge for the last 10 months, something coming out of vagina since 2 months and inability to walk since 15 days. Her menstrual periods were regular 10 months back. For the last 10 months cycles were disturbed in the form of irregular bleeding per vaginam. There was no history of previous menorrhagia. She had 2 term normal deliveries, the last one 8 years back.

On examination, the patient was ill looking and severely anaemic with haemoglobin 3 gm%. B.P. 100/60 mm. Hg. and pulse 90/min. Rest of the systemic examination did not reveal any abnormality.

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On local examination, part of the vagina with the whole uterus and myoma was hanging outside the introitius. (Photograph 1). The size of myoma was 4 to 6 inches. The whole mass was necrotic and foul smelling. There was no bleeding from the mass which was lying outside. Cervical rim was not felt. The clinical diagnosis of chronic inversion due to fundal fibroid was made. As general condition of the patient was poor, she was given 300 ml. blood transfusion on 2nd day of admission.

Excision of fibroid under local anaesthesia was carried out on 23.6.1973. After excision, the uterus was replaced in position easily (Photograph 2) patient improved with supportive line of treatment and three pints of blood transfusion. Infection was controlled by antibiotics. Sloughed vagina was completely healed, patient was subjected to vaginal hysterectomy on 19.7.1973. Post-operatively she did well except slight local sepsis of the wound. She was discharged on 8.8.1973. Histopathology of fibroid was benign leiomyoma. The uterus after hysterectomy showed evidence of fibroid by a small fibrosed area at fundus. There was no other pathology in the uterus.

Case 2.

Mrs. S.S., aged 40 years, para 8, was admitted as an emergency in Medical College, Aurangabad, on 8.4.1975 with complaints of something coming out of vagina since 1 year, difficulty in passing urine since 4 months, irregular vaginal bleeding since 3 months, foul smelling discharge since 1 month and retention of urine with overflow since 8 days. Patient gave history of something coming out of vagina since 1 year but she did not pay importance till the urinary symptoms appeared. She had 8 term normal deliveries the last 9 years back.

On examination, the patient was ill looking and severely anaemic with Hb. 4.5 g%, B.P. 120/70 mm. Hg. and pulse—90/min. Systemic examination, did not reveal any abnormality, on examination, part of the vagina with the whole uterus with myoma was hanging out side the introitus (Photograph 3). The myoma was about 4" in diameter. The whole mass was necrotic and there was slight bleeding from the myoma with marked sloughing. Cervical rim was felt higher up. The clinical diagnosis of chronic inversion due to fundal fibroid was made. She had associated mild diabetes which was controlled with crystalline insulin preoperatively. She received 300 cc. of blood.

Excision of myoma was done under I.V. Calmpose 5 mg. on 14.4.1975. Patient improved with supportive line of treatment and 900 cc. of blood transfusion before operation. Diabetes was under control. Vaginal hysterectomy was performed on 5.5.1975. Post-operative period was uneventful. Histopathology of fibroid was benign leiomyoma. Gross specimen of uterus revealed the stump at the upper part of body of uterus. There was no pathology in the uterus (Photograph 4).

Comments

Practically all instances of nonpuerperal inversion are caused by myomatous tumours. Myomas producing inversion are generally submucous and are either sessile or have a short thick pedical.

In our two cases reported the inversion was due to the fundal submucous sessile fibromyoma which was markedly infected. Inversion was due to the infection of submucous myoma leading to weakening of uterine wall and the weight of the tumour. This was also observed in our series.

The general condition of the patient is usually very poor due to marked infection and anaemia. Unless one treats infection and anaemia the patient cannot be subjected to major surgery. We advocate two stage surgery for rapid recovery of the patient. Firstly, excision of infected myoma which will be followed by rapid recovery due to the removal of infected mass. In our series we did two stage surgery. Excision of infected myoma was done under local anaesthesia followed subsequently by hysterectomy as the patients were nearing menopause. Vaginal hysterectomy even can be easily and successfully done because of complete control of infection.

Acknowledgement

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References

1. Das, P. C.: J. Obst. & Gynec. Brit. Emp., 47: 525, 1940.

See Figs. on Art Paper V