UTERINE TORSION IN PREGNANCY

(A Case Report)

by

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Torsion of gravid uterus, not associated with congenital anomalies in pregnancy is very rare and is a serious obstetrical complication. Nesbit and Corner (1956) reviewed literature and could collect only 107 cases. Corr (1943) reported that, repeated torsion in first and second pregnancy may occur due to a large soft fibroid in the left wall of uterus. Myoma could also lead to this condition (Punjabi *et al*, 1965; Giri 1968; Kawatheker *et al*, 1975). There are many other predisposing factors like ovarian cyst, pendulus abdomen with diastosis of recti/transverse lie. In most of the instances, congenital anomalies lead to torsion of the gravid uterus. In our 17 years of experience in Manipur, we have come across only the present case of uterine torsion during pregnancy with definite symptomatology. As this condition is very rare and this patient had some interesting features, this case is reported.

CASE REPORT

Mrs. Y. I. D., Hindu female, aged 32 years, primigravida, was admitted in the Regional Medical College Hospital, Imphal, Manipur on 28-11-77 with history of amenorrhoea for 6 months. pain in abdomen since 7 days and feeling of feverishness for the same duration.

Her menstrual history was normal—menarche at 14 years of age with average flow for 4-5 days in 28-30 days cycle. She never had any history of menorrhagia or dysmenorrhoea. LMP—2/6/77 making her 25 weeks and 4 days on the day of admission. She was married for the last 3 years and had one curettage an year prior to this pregnancy.

Clinical Examination

The patient was of average built with no apparent signs of malnutrition. Height 5'-1", weight 52 kgs., B.P. 120/80 mm Hg. Breast and thyroid were normal. There was no edema of feet, cyanosis, juandice or anaemia. Other findings were normal.

Abdominal examination revealed 22 to 24 weeks size uterus in mid-line, well relaxed and with restricted mobility, but tender on deep palpation. F.H.S. was heard distinctly with normal rate. A firm mass, 12 cm x 14 cm size was palpable in the right lumbar region. It was tender with restricted mobility. No free fluid in the peritoneal cavity was present. Liver and Spleen were not palpable.

Vaginal examination also revealed 22 weeks uterus. Left fornix was clear but in the right fornix high up, the abdominal mass was felt which was tender with restricted movement.

She was admitted with provisional diagnosis of twisted ovarian cyst complicating pregnancy. However, the possibility of an appendicular lump or a myoma with torsion or red degeneration were also kept in mind.

Investigation

All the clinical laboratory investigations including X-ray did not provide any clue to the

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Introduction

diagnosis. Surgical opinion excluded possibility of appendicular lump. She was kept in complete bed rest with sedatives (morphine 1st dose ¼ gr. followed by phenobarbitone 30 mg. t.d.s.). duvadilan (Isoxsuprin) and antibiotics.

Treatment

Laparotomy was performed after 1 week on 6-12-77 as she was not responding to the conservative line of treatment.

On opening the abdomen the uterus was found 22 weeks pregnant size with a subserous cornual fibroid of 10 cm x 12 cm on the right side of the abdomen. On further examination the fibroid was found attached to the left cornu with a short and thick pedicle (about 2 cm) making the gravid uterus to undergo torsion by more than 180° on its axis at the cervico-vaginal junction. Myomectomy was completed and torsion corrected gently. Ovaries. tubes and rest of the graviduterus were found normal.

She recovered well but Duvadilan was continued till another 4 weeks. After her discharge from the hospital, she continued antenatal check up till term. She was re-admitted on 31-3-78 in labour having 3 weeks overdue of the expected date as she refused admission earlier. On examination, everything was found satisfactory and she was allowed to go for a normal vaginal delivery under strict observation.

She delivered normally a ma'e child weighing 3 kg. after episiotomy at 9 hrs. of labour. Her labour and delivery were quite normal and she was discharged from the hospital on the 6th day of puerperium.

Discussion

This case presented herself with some diagnostic problem in the first ins'ance. The possibility of torsion of the gravid uterus was not initially thought of. Diagnosis was difficult as no clue was obtained by any laboratory and X-ray examination. Palpation of the round ligament was difficult due to tenderness and no spiralling noticed. There could have been many complications in th:s case if laparotomy was not dont as planned, because she was a subfertile elderly primigravida with 3 weeks postdate and the condition could escape our attention.

References

1. Corr, J. E.: Am. J. Obstet Gynaec. 46: 749, 1943.
2. Giri. A. K.: J. Obstet. Gynaec. India. 18: 582, 1968.
3. Kawathekar, P., Ansuya, S. R. and Tanga, M. R.: J. Obstet Gynaec. India. 25: 702, 1975.
4. Nesbit, R. E. and Cornor. C. W.: Obstet. Gynaec. Surv. 11: 311, 1956.
5. Punjabi, M. D., Mehtaji, S. and Aptekar, J. Obstet. Gynaec. India. 15: 497, 1965.