ACUTE INVERSION OF UTERUS—A DIRE EMERGENCY

(A Report of 5 Cases)

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Introduction

Acute inversion of uterus is not an uncommon complication in obstetrics in developing countries. There were 14,373 deliveries conducted in Smt. Shardaben Hospital, Ahmedabad in the period of 1981 to 1983 including 2 cases of acute inversion of uterus. The incidence varies widely from place to place. z

In India, Das (1940) reported a frequency of in 23,127 and Ghosh and Das (1972), 1 in 40,000, Sengupta and Duttagupta (1976) reported 5 cases in 21,693 deliveries and Palanichamy (1976) reported 5 cases in 12,302 deliveries.

We are presenting 5 cases of actute inverssion of uterus managed at Smt. Shardaben Hospital, out of which 2 delivered in this institute, the incidence being 1 in 7,185, while 3 cases were referred from outside.

CASE REPORTS

Case 1:

Mrs. K.D., a primipara, 25 years old was admitted as an emergency for vaginal bleeding and breathlessness. She had a normal delivery of a live female child at some private nursing home 2 hours ago. This was followed by post-partum haemorrhage and she was transferred in a moribund and unconscious condition. On examination pulse and blood pressure were not recordable. She was extremely pale and cold. There was occasional gasping and irregular feeble heart sounds. There was marked vaginal bleeding. Immediately resuscitative measures were given. However patient died within ten minutes of admission. Abdominal examination after death showed absence of fundus of the uterus and vaginal examination showed inversion of the uterus.

Case 2:

Mrs. N.K., a primipara, 19 years old was admitted as an emergency for post-partum haemorrhage and in shocked condition. She had normal delivery of a live female child at a private nursing home at 2.45 a.m. There was inversion of uterus. Immediatetly resuscitative measures were given. Reposition of uterus was done and vagina was packed. Intubation was done and patient was put on artificial respirator. Weak radial pulse could be palpated but blood pressure was not recordable even after four hours. After reposition there was no active bleeding and uterus was well contracted. E.C.G. showed sinus tachycardia. She died of irreversible shock.

Case 3:

Mrs. S.M.., aged 20 years, second gravida with first normal delivery was booked for confinement. Her pregnancy was uneventful. She had a normal vaginal delivery on 29-9-1983 at 12.50 p.m. a healthy male child of 2.800 kg., was delivered. After 10 minutes placenta was found at introitus, still it was partially separated and there was a gush of bleeding. On

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examination patient was conscious, pulse was 90 per minute, blood pressure 100/70 mm of Hg and respiration normal. Abdominal examination showed absence of fundus of the uterus. Vaginal examination showed fundus of the uterus in vagina and placenta attached to it, partially separated. Reposition of uterus was done easily under general anaesthesia, placenta was separated and delivered. Intravenous methergin was given. She was discharged on 10th day, mother and baby both being well.

Case 4:

Mrs. M. M., a primigravida, aged 19 years was booked at this hospital. Her pregnancy was uneventful and had a normal vaginal delivery of female child weighing 2.400 kg., with an episiotomy. The delivery was conducted by a resident. After clamping and cutting the cord resident doctor found something coming out of vagina with placenta. It was found to be complete inversion of the uterus lying outside the vagina with fundal insertion of the placenta. There was no vaginal bleeding. There was tachycardia of 120/minute and blood pressure 110/70 mm. of Hg. Immediately resuscitative measures were undertaken. After 10 minutes she developed post-partum haemorrhage with tachycardia and fall in B.P. 90/70 mm. of Hg. After one blood-transfusion under general anaesthesia reposition of inverted uterus was done in operation theatre. Most of the placenta was separated and delivered. However, there was still some adherent placental tissue and membrances left attached to fundus of the uterus which could not be separated. She was given 5 units of blood transfusion. Puerperium was uneventful. She was discharged on 10-10-1983.

Case 5:

Mrs. L.R., a primigravida, aged 19 years was admitted. She had a normal delivery of female child at home. She was transferred to the hospital in a moribund condition with inversion of uterus. Her pulse was feeble, blood-pressure 90/60 mm. of Hg., she was very anaemic. There was complete inversion of uterus. She was resuscitated. After combating the shock inversion was corrected under general anaesthesia, first manually then by hydrostatic method with warm saline. Injection Methergin 1 ampule was given, uterus was packed with sterile roller gauze. Uterus was well contracted. She was put on a course of injection Garamycin. Pack was removed after 24 hours. There was no further bleeding. Her post operative recovery was uneventful apart from anaemia. She had 5 units of blood-transfusion in toto. Her haemoglobin level came up to 8.5 gm.% on 9-11-1983. She was discharged on 8th day.

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