OPERATIVE TREATMENT OF CHRONIC INVERSION OF THE UTERUS: VAGINAL HYSTERECTOMY FOR INVERSION

by

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SUMMARY

Chronic inversion of the uterus is an extremely rare but interesting type of gynaecological condition. Haultain's operation is often performed for puerperal chronic inversion. Vaginal hysterectomy is the treatment of choice for most non-puerperal cases. However, the steps of the latter operation has not been described in any book or literature. As such detailed steps of vaginal hysterectomy for chronic inversion based on personal experience has been described in this article.

Three interesting cases of chronic inversion with important diagnostic points, anatomical and other interesting features have also been reported here.

Introduction

Inversion of the uterus means the uterus turns inside out the fundus prolapsing through the cervix. It is a rare, interesting but dangerous condition. Acute puerperal inversion is relatively more common than chronic inversion but is more dangerous needing urgent reposition of the uterus with resuscitative measures (Chaudhuri, 1964). In Calcutta Medical College Hospital there were 12 cases of acute inversion among 58,897 deliveries from 1976 to 1982 with an incidence of 1 in 4,900 deliveries whereas only one case of chronic inversion was admitted over there in the last 10 years during which period about 50,000 gynaecological operations were performed.

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Chronic inversion may be puerperal, when it is detected after 4 to 6 weeks of delivery, or nonpuerperal which happens in women in their forties and fifties mostly. In chronic puerperal inversion, if reposition fails Haultain's operation is preferred by most surgeons which has been well described by Bonney (1952). Spinelli's operation (MacLeod and Read, 1955) performed vaginally is not well accepted. Chronic non-puerperal inversion mostly needs vaginal hysterectomy, the steps of which are completely different from the usual ones. However, this operation has not been described in any book of gynaecological surgery or in any literature which puts gynaecologists into lot of mental tension and difficulty if they have to perform the operation out of the blue. As such the author describes in this article the detailed steps of vaginal hysterectomy for chronic inversion based on personal experience. Three cases of

chronic inversion which were treated surgically by the author in the last 25 years of practice are also reported here for their interesting features and for further information about this rare type of clinical condition.

Case Reports

Case 1

Mrs. X, aged 26 years, Para 4 + 1 was admitted in B.C. Hospital, Burdwan, on 3-5-1961 with the complaints of irregular haemorrhage and foul smelling discharge per vaginum since her home delivery conducted by her relatives 2 months ago, and something coming down and occasional fever since then. She had brisk haemorrhage during delivery. She did not attend any hospital or gynaecological clinic earlier. On examination, she was found to be severely anaemic and her body temperature was 100.8°F. A filthy foul smelling haemorrhagic mass was found protruding through the vaginal outlet. Her lower abdomen was tender and resistant. On vaginal examination, a cervical rim of 1.5 cm length could be felt through which the mass was protruding. The uterine body could not be properly felt. Provisional diagnosis was ? fibroid polyp ? chronic inversion. Her haemoglobin was 7 gm% and she had leucocytosis (112,000/cu.mm.) with pleocytosis (80%).

After controlling infection and after pre-operative transfusion of one unit of blood she was examined under anaesthesia and operated after 7 days of admission preparing her both for abdominal and vaginal surgery. Under anaesthesia an attempt was made to pass an uterine sound into the uterine cavity by the side of the mass which could not be done. The body of the uterus could not be felt by abdomino-rectal examination, instead a rim like structure could be felt. The case was then diagnosed as a case of chronic inversion. A hard attempt was made to repose the uterine body through the cervix manually but it failed. The abdomen was then opened. The uterus was found to be inverted drawing in parts of the tube and round ligament. Fimbrial ends of the tubes and ovaries were present above the uterine cup formed by the peritoneal surface of the uterus. The bladder was found in normal position. Light adhesions with the intestines were separated, an incision was made in the middle of the posterior side of the cup involving cervix and uterine body. With the help of volsella and fingers the uterine body was pulled up with fair amount of difficulty. The incision on the uterus was repaired with catgut in two layers and ligation of the tubes was performed. There was brisk haemorrhage and one unit of blood, which could be procured with difficulty, was transfused. The patient had uneventful recovery and was discharged on the 10th post-operative day.

Case 2

Mrs. X, aged 47 years, Para 10 + 3 with all normal deliveries was admitted N.R.S. Medical College, Calcutta, on 15-5-1976. Her last child was 12 years old. Her menstruation was normal until 7 months ago. She had menorrhagia and dysmenorrhoea for the last 7 months. A mass came out vaginally and she had brisk haemorrhage 5 days earlier. She stayed at home for 3 days and tried to replace the mass with the help of relatives but without any success. By this time, she developed foul smelling discharge and was having slight bleeding. She got admitted in a peripheral hospital from where after two days she was transferred to N.R.S. Medical College Hospital, Calcutta. She had no urinary trouble and was not running temperature. She was slightly anaemic. Local examination showed a partly gangrenous stinky fibroid of 10 cm in diameter with a broad pedicle of 2.5 cm width, and oedematous haemorrhagic endometrial surface of the uterus with no cervical lip. Abdominorectal examination could not find uterine body in position. The diagnosis was chronic inversion of the uterus with fibroid. Her Hb. was 9 g% and she had mild leucocytosis (10,000/cu.mm) with pleocytosis (75%). After preliminary treatment with vaginal douche and antibiotics for 2 days she was put up for operation. No blood could be procured for her.

Vaginal hysterectomy was performed following the steps described hereafter. Fibroid was enucleated first without difficulty. The bladder and ovaries were not drawn inside the uterine cup. There was no difficulty nor any unusual haemorrhage. Post-operatively she had mild degree urinary infection and was discharged on the 10th post-operative day.

Case 3

Mrs. X, aged 55 years, Para 2 + 0 was admitted in Medical College Hospital, Culcutta, on 4-6-1985. Her deliveries were normal and she had menopause 7 years ago. The patient had something coming down for 7 years which did not bother her much. But for the last two months she was having irregular bleeding and the mass had come out completely outside causing difficulty in walking. Local examination showed completely inverted uterus, looking like congested eroded elongated cervix, without any cervical lip with an attached small fibroid polyp of 2 cm in diameter and moderate degree cystocele. Her blood and urine examinations showed no abnormality except slightly low Hb. level of 10.5 g%.

Vaginal hysterectomy for chronic inversion as described hereafter with repair of cystocele was performed. There was no need of removing the small fibroid prior to removal of the uterus.

Post-operative period was uneventful and she was discharged on the 12th post-operative day.

Steps of Vaginal Hysterectomy for Chronic Inversion

Under general anaesthesia preliminnary vaginal and abdominorectal examinations are made to confirm diagnosis of chronic inversion. A metal catheter is introduced to note the position of the bladder particularly to see if it has been drawn into the uterine cup. Usually it is not drawn in as was found in all the 3 cases reported here. If there is a fibroid and it hinders progress of operation it should be removed as was done in Case 2, otherwise it helps traction of the inverted uterus. A vertical incision is made (Fig. 1) along the entire length of the anterior wall of the inverted uterus which is cut open so as to expose the uterine cup formed by the peritoneal surface of the inverted uterus. The uterine cup is explored to note its contents; usually it contains the uterine tubes, part of round and ovarian ligaments. The ovaries are usually present above the upper edge of the cup. A horizontal incision is now made at the cervicovaginal junction, vaginal wall is carefully cut and the base of the bladder is separated. The uterovesical pouch of peritoneum is carefully dissected aided by a finger pushed up through the uterine opening. The horizontal and vertical incisions are joined together so as to expose the uterine cup fully in the upper part.

Vaginal hysterectomy is now performed in a reversed way. By means of a vaginal retractor the bladder is drawn up. The broad ligament, fallopian tube, ovarian and round ligaments are clamped below the level of the upper edge of the cup, cut and ligatured on each side (Fig. 2). The uterine vessels cross just over the edge of the uterine cup where they are clamped by Kocher's forceps cut and ligatured on each side. There is no fear of injuring the ureters as they are never drawn in and are held up by the anterior vaginal retractor. The lateral and posterior vaginal walls are now clamped (Fig. 3), cut and tied. The specimen is removed. After closing the peritoneal cavity by a purse string suture the broad ligament stumps are sutured together. Anterior colporrhaphy is now performed if there is cystocele as was done in Case 3. The vaginal wall is closed by a continuous locking type of stich with catgut. Colpoperinorrhaphy may also be performed in the usual way if there is rectocele.

See Figs. on Are Paper II