

ACUTE PUERPERAL INVERSION OF THE UTERUS

BEJOYLAKSHMI GOSWAMI • ASHIS MONDAL

SUMMARY

Seven cases of this serious and life threatening complication were treated in our institution during a period of 2 years, among 19010 confinements. Four of them came from outside following home delivery and 3 developed this condition in our hospital. After resuscitation, manual reposition was possible in all of them but we lost one mother among outside cases. Factors responsible for this complication and the remedial measures including training of the personnel conducting delivery have been discussed.

INTRODUCTION

Acute inversion of the uterus following childbirth is a very serious complication. Unless diagnosed early and managed efficiently, it can be life threatening. Inevitable bloodloss is usually severe but often underestimated. The associated shock is also disproportionate to the quantity of haemorrhage.

MATERIAL

Seven cases of acute puerperal inver-

sion have been treated in Chitta Ranjan Seva Sadan, Calcutta, during last two years (August, 1991 to July, 1993) among 19010 deliveries - an incidence of 1 in 2715. Four of them were admitted following home delivery by traditional birth attendants (T.B.A.) in semiurban areas and 3 cases (booked) developed this condition in our hospital. The age and parity distribution are shown in Table I.

OBSERVATION AND MANAGEMENT

Among hospital cases, a primigravida (case 4) had moderate PPH which was controlled, the uterus being well con-

Dept. of Obst. & Gyn. Chitta Ranjan Seva Sadan, Calcutta.

Accepted for Publication on 18.01.1994.

Table I

Showing particulars of the cases

Case No.	Admission	Age	Parity	Delivery	Del-Diag Interval	Diag-Reposition Interval	Blood Trans.	Outcome
* 1	14.08.91	28 yrs	2 + 0	home	7 hrs	14 hrs	2 bottles	uneventful
2	05.12.91	23	1 + 1	home	6 hrs	5 ½ hrs	4 "	"
3	06.03.92	32	3 + 0	home	2 ½ hrs	1 ½ hrs	2 "	"
4	11.04.92	19	0 + 0	hospital	4 ½ hrs	9 hrs	2 "	"
5	15.11.92	22	1 + 1	hospital	4 hrs	1 ½ hrs	2 "	hightemp.
6	08.01.93	26	0 + 0	hospital	15 mins.	5 mins.	nil	uneventful
* 7	25.03.93	2	3 + 0	home	1 ½ hrs	1 hr.	3 "	expired

*Placenta remaining attached

tracted but after 4½ hours, her rising pulse rate made the accoucheur suspicious who got the diagnosis confirmed. Another case (case 5) developed shock after 4 hours of delivery and on internal examination revealed the entity. The third one could be diagnosed within 15 minutes and reposition done immediately under deep sedation. The outside cases came after an interval of 1½ to 7 hours and were in severe shock with placenta remaining attached in 2. The placenta had to be removed before reposition and there was no morbid adhesion. Case No. 7 (Table I) came to us early with H/O massive PPH. She had severe pallor and a systolic BP of 40 mm of Hg. There was no appreciable improvement by one hour and reposition had to be undertaken under deep sedation. Blood was available only after one hour of reposition and transfusion of 3 bottles could not save her as she went into irreversible shock by then. She expired after 8 hours of reposition.

It was complete inversion in all the cases, manual reposition could be done

in all of them (5 cases under G.A.) and none needed O'Sullivan's hydrostatic pressure or laparotomy for division of the ring.

DISCUSSION

Complete inversion after delivery is mostly due to strong traction on the cord, the placenta having fundal implantation and a tough cord not yielding to tear is a contributing factor. All the home delivered cases were attended by TBAs and controlled cord traction is unknown to them who resort to some sort of Crede's fundal pressure, may be on a relaxed uterus. So mismanagement of 3rd stage is operative here.

The incidence in our series is 1 in 2715 deliveries. It varies widely depending upon the quality of intrapartum care and in some recent series, we find it to be 1 in 3615 (Goswami et al, 1979), 1 in 2148 (Platt & Druzin, 1981), and 1 in 6666 deliveries (Prativa et al, 1990). Unfortunately it happened in 3 cases delivered in our hospital. Prolonged labour in a primigravida (case 4) may be

responsible for uterine atony and slowly progressing inversion detected after 4½ hours. Primiparity itself is stated to be an important causative factor as the duration of 3rd stage in them is more, where premature attempt to remove the placenta may be responsible. Parenteral Mag. Sulph. used in PIH is also held responsible (Platt & Druzin, 1981).

Incomplete inversion is occasionally noted during caesarean section due to cord traction in presence of uterine atony where the placenta is not adherent and the inversion can be corrected promptly. Routine exploration of the uterus following vaginal delivery as advocated by Bruce (1984) has not found favour. In experience of the personal conducting delivery is the most important causative factor (Pitchard, 1982). Proper training of the

rural birth attendants is essential to make them conversant with the signs of placental separation and the technique of its removal.

ACKNOWLEDGEMENT

We are thankful to the Principal and Superintendent of our Institution for her kind permission to publish the hospital records.

REFERENCES

1. Bruce A.H. : *Clin. Obstet. Gynec.* : 27:134:1984.
2. Goswami B.K., Mukhopadhyaya B., Mukherjee K. : *J. Obstet. Gynec. India* : 29:889:1979.
3. Pitchard J.A. : *Am. J. Obstet. & Gynec.* : 143:725:1982.
4. Platt L.D., Druzin M.L. : *Am. J. Obstet. Gynec.* : 141:187:1981.
5. Prativa D., Gobardhani M., Sundari Krishna : P.T. : *J. Obstet. Gynec. India* : 40:548:1990.