Incarcerated Retroverted Gravid Uterus with Anterior Sacculation

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A young patient P.R.N. aged 22 years was admitted on 2-2-94 with H/o 8 months' amenorrhoea, loss of foetal movements and breathlessness since 5 days. Obstetric history revealed that she had a full term normal vaginal delivery 1 year back and now she had conceived during lactational period. Past history suggested that she had acute retension of urine 2 months prior to admission and the retention was relieved by catheterisation at the Primary Health Centre. The catheter was subsequently removed, though she continued to have difficulty in passing urine.

On examination she was an averagely built patient, pallor was present, pulse was 100/min., B.P. 140/80 mmHg. There was tachypnoea and respiratory rate was 48/min. Respiratory and cardiovascular systems were otherwise normal.

On per abdominal examination a mass of about 28 weeks gestation size, cystic in consistency arising from pelvis was felt. There was slight tenderness over the mass. Though the patient had a history of 8 months' amenorrhoea the consistency of the mass did not appear like a pregnant uterus.

Per vaginal examination revealed a cervix which was soft, patulous and high up in vagina just behind the symphysis pubis. The vagina appeared to be elongated. A bulge was felt involving the whole of the post vaginal wall and the contents of the bulge appeared like? foetal parts.

Catherisation was done, 3000 cc of high coloured urine was drained with terminal pyuria. After emptying the bladder, the abdominal mass reduced in size to 24 weeks but still the consistency differed from the pregnant uterus. With provisional diagnosis of ? secondary abdominal pregnancy? incarcerated retroverted gravid uterus was made. The patient was investigated. Hb – 7 gms%, urine alb. – trace, sugar – nil, Blood urea – 80 mg%, Sr. Creatinine 1 mg%, TLC – 15,000 per cumm, DLC – 87, 13, 0, 0. The blood urea was raised and marked leucocytosis was present.

Ultrasonography revealed a nonviable foetal shadow in the pelvis. A Plain X-ray abdomen revealed a very faint shadow of skull occupying the sacral hollow.

Patient was given I.V. fluids, antibiotics and blood transfusion. An indwelling catheter was inserted. Patient was taken for exploratory laparotomy on 3-2-94 with provisional diagnosis of "incarcerated retroverted gravid uterus". On opening the abdomen the peritoneum was thick; it was incised. The bladder which was very much hypertrophied, oedematous, stretched upto the umbilicus. It was separated from the uterus and adherent to the anterior surface of the uterus. Only a small portion of the anterior uterine wall could be visualised which was stretched and thinned out. The diagnosis of incarcerated gravid uterus was confirmed. The fundus of the pregnant uterus was impacted into the pelvis. It was impossible to dislodge the uterus from the pelvis hence a hysterotomy was done through the ant. wall which was accessible and thinned out. After emptying the uterus, fundus could be easily brought out of the sacral hollow and the uterus quickly regained its shape and was closed in layers. There was marked hydro-ureter and hydronephrosis. Postoperatively patient was put on higher antibiotics, and I.V. fluids etc. She made considerable recovery for 2 days but on 3rd postoperative day she developed sudden

hypotension with all signs of septicaemia and subsequently died on 5th post-operative day. The cause of death was septicaemia due to chronic pyelonephritis and cystitis.

In this case a retroverted gravid uterus did not rectify itself after 12 weeks of gestation. Patient had retention of urine for which she was catheterised and then the catheter was removed immediately, and hence she continued to have retention with overflow. Chronic retention might have prevented the spontaneous correction of the uterus. Subsequently the uterus continued to grow into the sacral hallow leading to incarceration after 14 weeks of gestation. Patient continued to have chronic retention of urine with pyelonephritis and cystitis. The uterus continued to grow in the sacral hollow and later there was anterior wall sacculation.

Incarceration usually becomes symptomatic after 16 weeks. Retention with overflow is the usual symptom and if unattended it might lead to incarceration.

The best treatment to avoid incarceration is to correct retroversion before 14 weeks by lifting the uterus P.V. through post fx. or per rectum as suggested by Hunter. If incarceration cannot be corrected the only alternative is laparotomy.