

CASE REPORT

Torsion of Gravid Uterus Managed by Obstetric Hysterectomy with the Fetus In Situ

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Introduction

Torsion of gravid uterus is very rare. The earliest report of this condition was made by an Italian veterinarian [1], Columbi in 1662. In 1863, Virchow reported the first case [2] in a human in postmortem examination. In 1876 [3], Labbe described this abnormality for the first time in a living woman. Another instance of this unusual entity is what we record from our obstetric practice.

Case Report

Mrs. DBG, aged 23 years, resident of Makarpura, G1 P0 A0 with amenorrhea of 28 weeks, presented to the emergency unit of our hospital on July 3, 2011, Sunday, at 2.30 pm with complaints of acute lower abdominal pain, perspiration, and uneasiness since 2 h. Her general condition was drowsy, with pulse 120/min, blood pressure 100/60 mm Hg, and temperature normal. Pallor was present, grade II. Respiratory and Cardiovascular systems were normal. On per abdomen examination, uterus was of 30 weeks size, tense with breech presentation of the fetus. Fetal heart sounds were absent on auscultation. Per vaginal examination revealed cervix to be non-dilated and non-effaced. Hemogram showed Hemoglobin—7 g%, Total count—10,200 cells/cu mm,

DC—88/10/01/01/00, and Platelet count—227,000. Among other investigations, the observations were B. urea—27 mg/dl, S. creatinine—0.8 mg/dl, Blood group—A positive, BT—2'15", CT—4'30", PT (T)—16 s (C)—11.8 s, INR—1.35, aPTT (T)—28.5 s (C)—28.0 s, and D-dimer—905 ng/ml. Ultrasonography was suggestive of single intra-uterine fetus with breech presentation with the maturity of 28 weeks and cardiac activity being absent. Placenta was fundal with separation of edge with small line of clots. In view of deteriorating, general condition of patient and unfavorable cervix, decision of LSCS was taken. Three blood transfusions were arranged for, and the patient was taken to Operation Theatre. General anesthesia was given, and abdomen was opened in Pfannenstiel incision. On opening the peritoneal cavity, uterus was of 30 weeks size, with levorotation of more than 180° on its own longitudinal axis, at the level of junction of cervix and the corpus (Figs. 1, 2).

Manual untwisting of the uterus was done in the direction opposite to that of the torsion (Figs. 3, 4).

Considering the hyper vascularity and congestion of tissues and the deteriorating condition of the patient, decision was taken to avoid an incision on the uterus that could have caused torrential bleeding, and hence a quick obstetric hysterectomy was undertaken. Pedicles were clamped, cut, and ligated in order, and hysterectomy was performed with fetus in situ (Fig. 5).

Vault was closed with interrupted sutures and hemostasis ensured. A left-sided small rudimentary horn of the uterus was found (Fig. 6).

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Fig. 1 Shows twisted gravid uterus

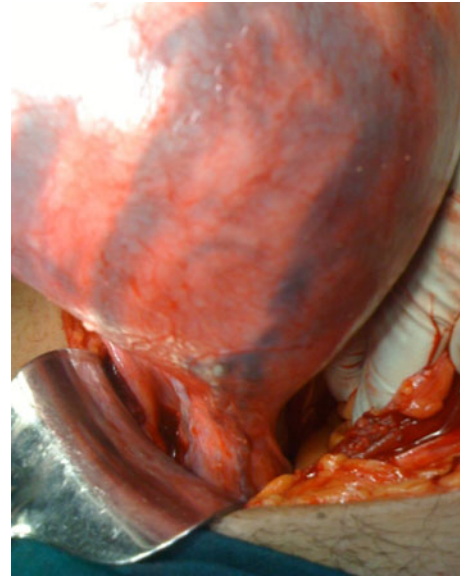


Fig. 3 Shows untwisted gravid uterus

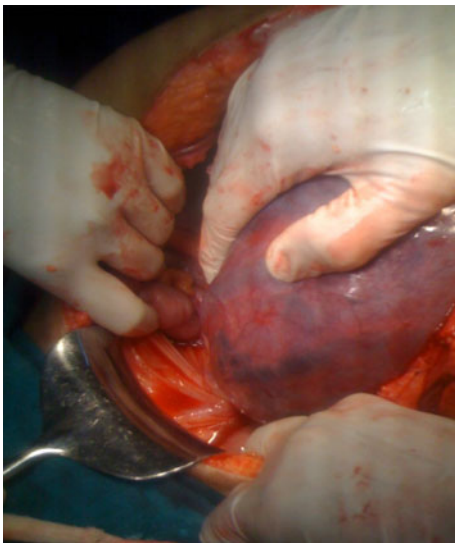


Fig. 2 Shows twisted uterus



Fig. 4 Shows untwisted gravid uterus

Specimen of uterus was cut open and dead fetus retrieved (Fig. 7).

Placenta showed a large clot adjacent to the fetal surface justifying venous congestion and venous leak due to torsion (Fig. 8).

Postoperative period was uneventful. Patient was discharged after suture removal on the 7th day.

Discussion

Rotation of the gravid uterus is a normal finding in the third trimester of pregnancy. However, a pathologic rotation of

the uterus beyond 45°—torsion of the entire uterus—is rarely seen in obstetrical practice. In approximately 20 % of cases of uterine torsion, no causative factor is apparent. The predisposing factors found in the other 80 % of cases include malpresentation (particularly transverse lie), myomas, uterine anomalies, pelvic adhesions, ovarian cyst, uterine suspension, abnormal pelvis, and placenta.

Acute torsion results in interference with uterine circulation. The main clinical features are pain, shock, intestinal, and urinary symptoms, obstructed labor, and secondary



Fig. 5 Shows specimen of uterus with fetus



Fig. 7 Shows the fetus



Fig. 6 Shows rudimentary horn



Fig. 8 Shows placenta clots

vaginal bleeding. The main condition that must be distinguished from is abruptio placentae. In many cases, the clinical features exacerbate progressively, resulting in a diagnosis of “acute abdomen.” Only at the time of laparotomy is the definitive diagnosis made. Maternal mortality in uterine torsion is about 10–20 %. Perinatal mortality is about 30 %. Establishing clinical diagnosis of this condition is difficult, but very important for reducing maternal and fetal morbidity and mortality. Clinical symptoms are either absent or nonspecific, and the diagnosis is usually made at laparotomy. Uterine torsion is an infrequently reported and potentially dangerous complication of pregnancy that occurs mainly in the third trimester with adverse

maternal and neonatal consequences. It is necessary to have in mind the possibility of uterine torsion in all cases of abdominal pain during pregnancy and dystocia.

References

1. Pilot D, Gluck M, Oxorn H, Ottawa, Torsion of the gravid uterus. *CMA J.* 1973;109.
2. Koh KS, Bradford CR. Uterine torsion during pregnancy. *Can Med Assoc J.* 1977;117(5):501.
3. Wilson D, Mahalingham A, Ross S. Third trimester uterine torsion: case report. *J Obstet Gynaecol Can.* 2006;28(6):531–5.