

## Case Report

# Torsion of gravid uterus near term - a rare complication

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### Introduction

Torsion of the gravid uterus is a rare entity and is defined as rotation of more than 45 degrees around the long axis of the uterus<sup>1</sup>. Its diagnosis is difficult to make preoperatively<sup>2</sup>. The most usual symptoms of uterine torsion are birth obstruction, abdominal pain, vaginal bleeding, shock and urinary and intestinal symptoms<sup>1</sup>.

### Case report

A 23-year-old G<sub>3</sub>P<sub>2</sub> with two previous cesarean deliveries was admitted on 11<sup>th</sup> December 2004, with a history of 8½ months amenorrhea and pain in the abdomen since 8 hours. She was hospitalized previously for similar pains in the 6<sup>th</sup> and 7<sup>th</sup> months and treated with tocolytics. Abruptio-placenta was ruled out. There was no history of leaking or bleeding per vaginum. Her EDD expected date of delivery was 7 February 2005. On examination her vitals were stable. The uterus was of 36 weeks size with transverse lie and generalized vague tenderness. FHS were good and

regular. There was no tenderness over the cesarean scar. On vaginal examination the cervix was neither dilated nor effaced. Sonography showed a single viable fetus of 36 weeks gestation in transverse lie with fundus posterior placenta.

She was taken for emergency cesarean section under spinal anaesthesia. The abdomen was opened by paramedian subumbilical incision. Omentum was adherent to the anterior abdominal wall, adhesions were separated and lower part of the uterus had engorged, dilated bunch of blood vessels. Urinary bladder could not be identified anteriorly and right fallopian tube and ovary were present anteriorly near the left pelvic wall. The uterus had undergone 180 degree rotation (torsion). Urinary bladder was identified towards left postero lateral position. Derotation was tried but failed. J shaped incision was given on posterior uterine wall, which was facing anteriorly and a live male baby of 2.9 kg was extracted by breech, with apgar score of 8/10 at 1min. Placenta was adherent to anterior uterine wall and removed in pieces. Uterus was closed in layers and derotation was done. The patient had atonic PPH. All conservative measures were tried and the uterine arteries on both the sides were ligated. Since the patient was developing hypotension, internal iliac artery ligation was not attempted and a subtotal hysterectomy was performed. The post operative period was uneventful and the mother and the baby were discharged in good condition.

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## **Discussion**

Pathological torsion of gravid uterus is unusual and deceptive in human beings. Crona and Buchrach<sup>1</sup> state that 113 cases of torsion of the pregnant uterus are documented since 1863. Recently cases of uterine torsion during pregnancy have been reported by Picone et al<sup>2</sup>, Cook and Jenkins<sup>3</sup>, and Rich and Stokes<sup>4</sup>. Dasari and Vijaya<sup>6</sup>, and Singh and Gulati<sup>6</sup> have recently reported cases from India.

According to Jensen<sup>7</sup> malpresentations, fibroids and uterine malformations are the common causes.

At cesarean section the absence of utero vesical fold of peritoneum and grossly engorged veins at the lower segment should make one suspect that it may be the posterior uterine wall presenting anteriorly. A lower segment vertical or transverse incision can be taken on the posterior uterine wall for delivering the baby, though it may not be the first option. But for technical feasibility and safety we opted for that.

Cesarean hysterectomy is not indicated unless gangrene of the uterus is present. As such cesarean hysterectomy is becoming relatively infrequent day by day, but it still remains a necessary tool for the obstetrician in some cases.

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