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RESEARCH ARTICLE

ACUTE INVERSION OF UTERUS.

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uterine inversion, AMTSL, Shock, hysterectomy.

Abstract

Complete inversion of uterus after delivery of the baby is always the consequence of strong traction on umbilical cord attached to the placenta implanted in the fundus. With AMTSL the incidence is decreasing. In this article we discuss about a 21 yrs primi who was referred as uterine inversion to our tertiary care centre in a state of shock. The prompt resuscitative measures with hysterectomy done at appropriate time saved the patient's life.

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Case Report:-

A 21yrs primipara delivered an alive term female baby of birth wt - 2.9kg by labour natural on 15.09.11 at 9.00pm at PHC. Referred from peripheral hospital as inversion of uterus at 9.50pm. Patient was received on 16.09.11 at 1.30am – 4 1/2hrs after delivery. Patient was in a state of shock. On examination patient was unconscious with peripheral pulses absent, BP not recordable, carotid felt, heart sounds muffled. P/A – Uterus was not palpable per abdomen. L/E – entire uterus with placenta lying outside the introitus, bluish black in color. Simultaneous resuscitation with Nasal O_2 , IV crystalloids, O+ve blood transfusion, Dopamine drip and Endotracheal intubation done in labour ward. Under GA in OT repositioning of uterus done after removing placenta. Endometrium blackish color. 20 units synto drip, iv methergine, im prostadin given. Uterus was atonic. Decision for Laparotomy was taken. Uterus was flabby intraoperatively. Conservative surgical management failed. Proceeded with hysterectomy. 3 units of whole blood and 2 units FFP transfused. Patient shifted to IRCU for ventilatory support. Post operatively one unit FFP given. Treated with Inj. Piperacillin + Tazobactam 4.5g iv tds. Suture removal done on 8th POD. Wound healthy. Discharged on 28/9/11. Investigations revealed normal LFTs, Blood sugar, urea and creatinine.

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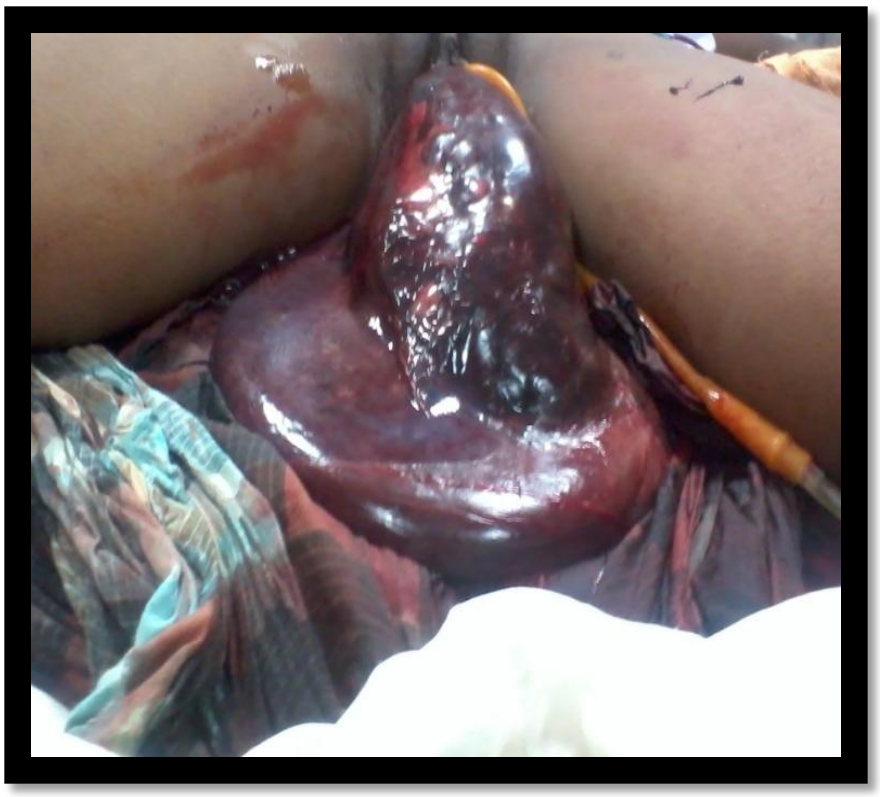

Discussion:-

Govt. Rajaji Hospital, Madurai Statistics:-

YEAR	2001	2002	2003	2004	2005	2006	2007	2008	2009
INCIDENCE	5	1	4	6	5	2	3	1	4

Totally 32 cases reported – all were referral cases. There was an average of 12000 deliveries per year in this period of observation. Incidence of MMR depend on the time interval between delivery/inversion and resuscitation with repositioning. Between 2009-2010 - 3 cases of death occurred. 2 cases died due to neurogenic shock, 1 case cause of death was uremic encephalopathy. Patient died after 40 days. This case of acute inversion of uterus is presented as unique in the sense that after 4 hrs of delivery and inversion, patient survived.

Contributing factors for uterine inversion are uterine atony ,improperly applied pressure over fundus, traction of umbilical cord, placenta accreta , parenteral $MgSO_4$ in women with PIH. Uterine inversion is most often associated with shock disproportionate to the blood loss. It is fatal without prompt treatment and delay in treatment increases mortality. The degrees of inversion are 1^o – Dimpling of the fundus, 2^o – Fundus passes through internal os, 3^o – Uterus at introitus. Simultaneous resuscitation with two intravenous infusion system,iv fluids and cross matched blood and if placenta is attached, it can be removed and then repositioning of the uterus done. Portion of the cervical canal that is the last to come down is to be replaced first and the fundal portion the last. Simultaneous oxytocics to contract the uterus should be given. Conservative methods used are Huntington, Kellog and Haultain method. When conservative management fails hysterectomy is done as life saving procedure as in this case.

Conclusion:-

AMTSL is preventive against acute inversion of the uterus. Training to VHN, Maternity assistants and Staff nurses should be given about proper care in the conduct of 3^{rd} stage of labour and to avoid injudicious traction on the cord, applying pressure over fundus, forcible expression of non-separated placenta. Thus uterine inversion is an obstetric complication that, due to its gravity, requires a rapid diagnosis and immediate clinical action. Its low incidence leads to scarce experience in solving this kind of situation. Regardless of the treatment, vaginal or surgical approach, the best prognosis occurs in situations when the diagnosis and maneuvers for uterine reversal are made early.

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