

## Case Reports

# Acute Non Puerperal Uterine Inversion

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### Abstract

Inversion of uterus is very uncommon, more so, when it is not associated with puerperium or third stage of labour.

A rare case of non puerperal uterine inversion caused by a large fundal leiomyoma in a 45 year menopausal woman is reported.

### Introduction

Uterine inversion occurring in puerperal period, are postulated to be caused by mismanagement of third stage of labour. The acute inversions are associated with shock. Non puerperal uterine inversions are associated with myoma or even sarcoma of the uterine fundus.

### Case Summary

A 45 year old woman, P6L6, menopausal since a year was admitted to the hospital with complaints of something coming out per vaginum suddenly while passing stools in the morning. No history of constipation or chronic cough. The mass could not be repositioned back in the vagina

On admission her pulse was 90/min, BP 100/80 mmHg. She was pale. Per abdominal examination revealed no abnormality. A large mass 8 cm by 10 cm seen protruding from introitus, solid in consistency. On per rectal examination uterus not felt.

Investigation revealed Hb-7.5 gm%

USG of pelvis showed part of uterus with descended endometrial cavity. USG of prolapsed mass revealed a fibroid. Hence diagnosis of fibroid causing uterine inversion made.

Patient was taken up for exploratory laparotomy after giving two units of packed cell. Pfannenstiel incision taken. Presence of uterine inversion

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confirmed. Patient given lithotomy position. Pitressin injected and incision taken over the mass. A fibroid 8 cm by 8 cm removed easily from the uterine fundus. Uterine inversion corrected by pushing from below and pulling on cornual ends of uterus with vulsellum from above. Total abdominal hysterectomy with bilateral salpingo-oophorectomy done. Histopath showed submucous leiomyoma. Uterus, cervix, tubes and ovary revealed normal histopathological findings.

### Discussion

Inversion of uterus is a rare clinical problem. In puerperium, it is an emergency, while in gynaecology it is a diagnostic dilemma. Takano *et al* summarized 88 reported cases of non puerperal uterine inversion. 81(92%) were associated with uterine tumour, of which 20% were malignant.<sup>1</sup>

Symptoms associated with nonpuerperal uterine inversion are vaginal bleeding, vaginal tumour, lower abdominal pain, menorrhagia and urinary disturbances.

Uterine inversion is suspected when tumour is palpable in vagina or seen out of introitus, as seen in our case, but when uterine fundus is not palpable by a pelvic examination, MRI has been shown to be a useful diagnostic tool since it can examine characteristic image of uterine inversion.<sup>2</sup>

In our case, the woman was menopausal



Figs. 1 and 2 : Myoma causing uterine inversion



Fig. 3 : Intra operative confirmation of uterine inversion.



Fig. 4 : Separation of myoma from uterine fundus.

so after correcting the inversion total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. In case of chronic inversion uterine integrity is restored by Spinelli technique or Kustner operation.

#### Conclusion

Non puerperal uterine inversion is extremely rare. Thus when encountered, it has to be managed with no previous experience. With tumour protruding from vagina or vulva we must consider uterine inversion. Non puerperal inversions may be

malignant so preoperative histology (biopsies) is essential.<sup>3</sup>

#### References

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2. Lewin JS, Bryan PJ. MR imaging of uterine inversion. *J Comput Assist Tomog* 1989; 13 : 357-9.
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