

■ Case Report

Chronic uterine inversion secondary to submucous fibroid

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Abstract

Nonpuerperal uterine inversion is a rare condition. We describe a case report of chronic inversion secondary to submucous fibroid. A 37 years lady presented with acute retention of urine with submucous fibroid. Diagnosis of partial inversion was made intra operatively and she underwent abdominal hysterectomy.

Introduction

Uterine inversion refers to descent of the uterine fundus to or through the cervix, so that the uterus is turned inside out. Uterine inversion is a rare condition that occurs usually as a complication of deliveries.¹ Non-puerperal inversion is extremely rare representing about one sixth of all inversion.² Chronic non puerperal uterine inversion is often associated with uterine pathology. Prolapsed fibroids tend to be the most common inciting factors with occasional report of inversion associated with uterine neoplasm and endometrial polyp. Three contributing factors proposed for uterine inversion are (1) sudden emptying of the uterus which was previously distended by a tumor (2) thinning of the uterine walls due to an intrauterine tumor and (3) dilatation of cervix.³⁻⁶ We present a report of a case who presented with acute urinary retention due to large fundal fibroid and was found to have chronic inversion of uterus at the time of hysterectomy.

Case Report

A 37 year old unmarried lady presented to the gynaecological outpatient with history of acute retention of urine. She was apparently well 7 days prior to the presentation when she had pain in the suprapubic region associated with burning micturition. She also

had history of incomplete voiding of urine for 1-2 days followed by acute retention of urine. She was catheterized by plain rubber catheter at her home by local health care provider. Catheterization was needed for 6-7 times before she decided to go to the nearby health post where she was catheterized with Foleys catheter and was kept for continuous drainage. Then she was referred to BPKIHS.

She never had fever. There was no history of discharge per vaginum. No history of mass coming out of vagina. She had regular cycle with her LMP 10 days back with average flow but severe dysmenorrhea. She had menorrhagia 6 months back but did not seek any medical advice. No significant past medical history. On examination the patient was pale. She was afebrile and her vitals were stable. Her abdomen was soft but had around 14-16 weeks size immobile nontender mass in the suprapubic region. Foleys catheter was in situ. On per speculum examination, cervix was not visualized. Mass of 6X6 cm with smooth surface was seen in the vagina. No bleeding or discharge was seen. On per vaginal examination, cervical rim was felt with thick pedicle coming through the uterine cavity. Diagnosis of submucous fibroid polyp was made and she was admitted for investigations and management. Her haemoglobin was 5g/dl and her USG shows intramural fibroid with bilateral normal ovaries. She was planned for abdominal hysterectomy. She received 5 units of blood transfusion before surgery. After her pre-anaesthetic clearance, she was posted for abdominal hysterectomy. Intra-operatively the

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diagnosis of partial uterine inversion was made with submucous fibroid polyp (Fig 1). She underwent abdominal hysterectomy through midline below umbilicus vertical incision. During hysterectomy, bilateral round ligaments, infundibulopelvic ligaments and uterine were clamped and ligated as usual. Then the submucous fibroid polyp was removed abdominally through incision made on anterior surface of the uterus (Fig 2). After that rest of the steps were as usual.



Fig 1: Partial Inversion of the Uterus



Fig 2: Specimen of the Fibroid

Discussion

Uterine inversion can be classified into four stages as stage 1: the inverted uterus remains in the uterine cavity, stage 2: complete inversion of the fundus through the cervix, stage 3: the inverted fundus protrudes through vulva and stage 4: inversion of the uterus and vaginal wall through the vulva.⁹ Inversion can also be classified as acute and chronic. Acute uterine inversion causes severe pain and haemorrhage whereas chronic inversion is insidious and characterized by pelvic discomfort, vaginal discharge, irregular vaginal bleeding and anemia. The diagnosis is easier with stage 3 and 4 disease. In other cases, the diagnosis can be difficult and the use of ultrasound or computer tomography can be

used.⁹ In acute inversion the uterus can be generally reverted by intravaginal manipulation. Many surgical methods have been described to treat chronic non puerperal uterine inversion. The efficacy of the nonsurgical methods is not clear. Huntington and Haultain are commonly used abdominal approaches. Kustner and Spinelli procedures are the commonly used vaginal approaches.^{7,8}

Conclusion

Chronic uterine inversion is a rare condition that is difficult to manage even for the experienced gynaecologists. Uterine inversion has a good prognosis when managed in timely correct manner. The treatment for chronic uterine inversion is surgical that includes both abdominal and vaginal approaches. However, need for preservation of fertility excluding malignancy might be important in selected cases.

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