

Spontaneous Uterine Inversion

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We report a case of acute uterine inversion which occurred in a young primigravida after forceps delivery for prolonged second stage of labour.

A 19-year old primigravida was admitted to the hospital for induction of labour due to postdates. Her pregnancy was categorised as low risk. She had a forceps delivery due to a prolonged second stage and maternal exhaustion. Placenta was delivered by controlled cord traction 10 minutes after delivery of the baby. Following placental delivery, the woman had a primary postpartum haemorrhage (PPH). After initial medical management for primary PPH the woman was transferred to theatre for examination under anaesthesia in view of persistent heavy bleeding, severe lower abdominal pain and hypovolemia shock. Following induction of general anaesthesia, an immediate diagnosis of acute complete uterine inversion was made and the uterotonics was stopped instantaneously. Management involved multidisciplinary team including obstetricians, anaesthetists, midwives and blood bank services. Manual replacement of uterus was done followed by insertion of Bakri ballon and syntocinon infusion. Postnatal recovery was unremarkable, and the woman discharged 4 days after the delivery.

Uterine inversion is one of the rare and serious obstetrics emergencies. Based on timing of occurrence, it can be classified into acute (within 24 hours of delivery), subacute (> 24 hours but < 4 weeks) or chronic (>1 month postpartum)^{1,2}. If not immediately identified will lead to massive and often underestimated blood loss which may results in hypovolemic shock and maternal death that can reach 15% in some cases¹. Risk factors include mismanagement of 3rd stage of labour, primiparity, fatal macrosomia, excessive fundal pressure, abnormal placenta localization uterine hypotonia, short umbilical cord and ligament laxity¹. The initial approach of the management of uterine inversion is to try to reverse the uterus with manual pressure on the fundus through the vagina called Johnson manoeuvre. Hydrostatic pressure is another method used if manual reduction failed, which involves inserting a balloon vaginally to increase the pressure on the uterine fundus to push the uterus to its initial position⁴. There are two main surgical techniques described as Huntington and Haultaim. In the Huntington technique, the round ligament is grasped by clamps, near to its insertion in the uterus, and slowly pulling up repeatedly until uterus is re-inverted³. In Haultaim technique an incision is made in the posterior part of the ring formed by the cervix in order to increase the size of the cervical ring and thus reposition the uterus³.

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