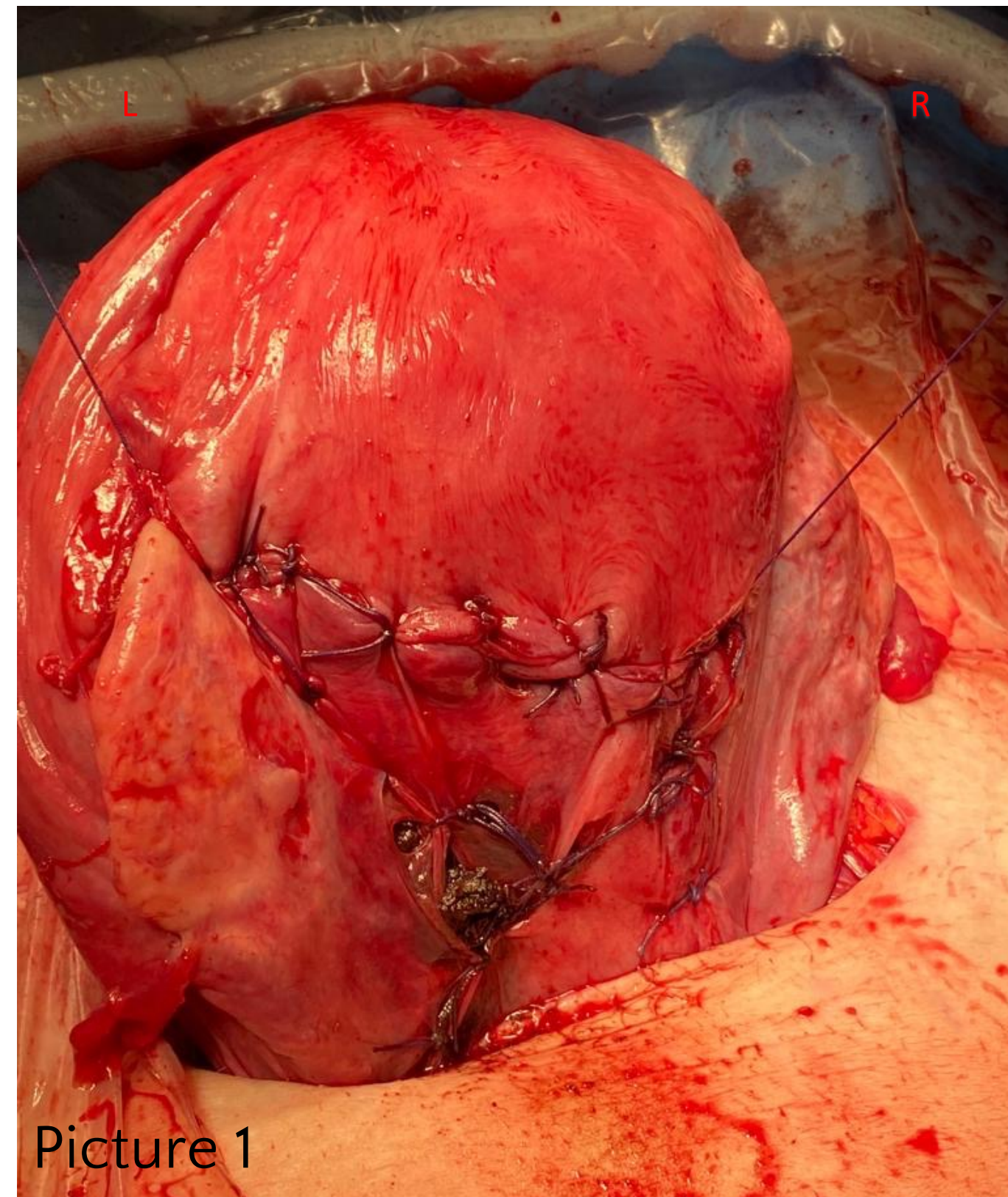
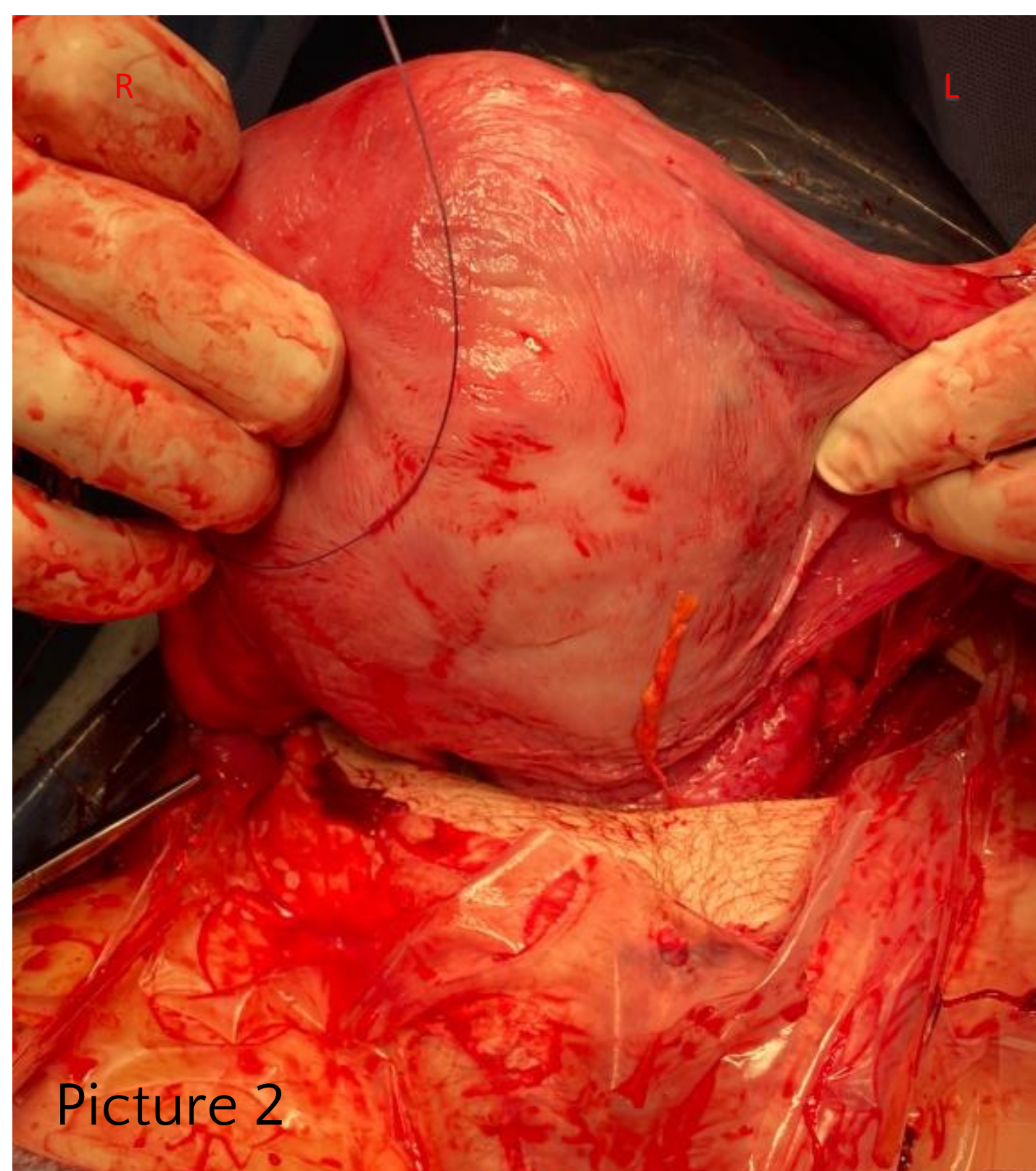


Introduction

Uterine torsion is a term used to describe when the rotation of the uterus is more than 45° and its presentation can vary from asymptomatic to life-threatening.^[1] Here, we report a case of incidental finding of asymptomatic uterine torsion at elective Caesarean Section.



Picture 1. Sutures at the Posterior hysterotomy site

Picture 2. Anterior surface of the uterus

Case Report

A 27-year-old, G2P1 lady underwent ELCS at 39 weeks. She had a previous emergency Caesarean Section due to concealed breech presentation. Her antenatal history for the current pregnancy included intermittent lower abdominal and pelvic pain that was controlled with simple analgesia.

On abdominal entry, due to the presence of dense adhesions, the anatomy was inconspicuous and the lower segment of the uterus looked bulky. There was also some difficulty with reflecting the bladder. When the uterus was noted to be rotated to 180°, a second consultant was consulted. However, attempts to de-rotate the uterus was unsuccessful. Therefore, a joint decision was made to deliver the baby through the posterior uterine wall. After delivery of the baby, the uterus rotated back to its anatomical position and the posterior wall was repaired while making sure that extension to the important structures has not occurred,.

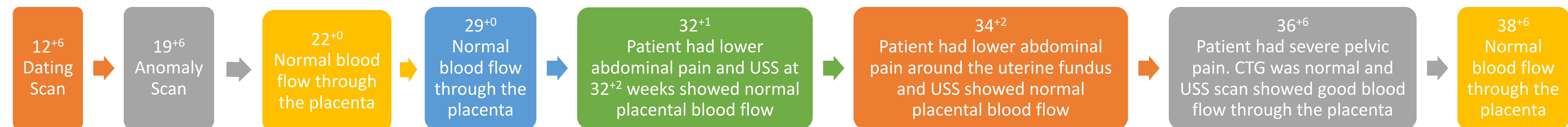
The baby was born in a good condition and weighed 3434g. The uterus was detorted back to its anatomical position, and the estimated blood loss was 800mL. Consequently, both the mother and the neonate were discharged home the next day.

Discussion

As uterine torsion is an uncommon phenomenon, there has not been any clear causes identified but there are many predisposing risk factors, which include, uterine asymmetry, fibroids, and pelvic adhesions.^[1] In our case, the only risk factor present for the rotation is the dense adhesions.

In addition, clinical presentation for uterine torsion can be vague and variable.^[1] In this case, the patient has had lower abdominal pain at 26⁺³, 32⁺¹ and 34⁺² weeks as well as pelvic pain at 36⁺⁶ weeks. Any of these events could have been possibly attributed to intermittent uterine torsion with spontaneous resolution. However, there has not been any foetal compromise during the pregnancy.

Although ultrasound scans have been shown to be useful at diagnosing uterine torsion^[1], the lady had 8 ultrasound scans from 12⁺⁶ to 38⁺⁶ weeks, but it did not show any evidence of uterine abnormalities. In addition, all the Doppler Ultrasound Scans done at the time of presentation with abdominal or pelvic pain showed normal placental blood flow. The flow chart below summarises the timings of presentation with pain and ultrasound results.



Conclusion

Although, uterine torsion is an uncommon disorder encountered by obstetricians and gynaecologists, it can be associated with high perinatal mortality and possible maternal mortality. To the best of our knowledge, our case is the first 180° uterine torsion with no mortality and a hospital stay of one day post-delivery. Hence, in such rare cases, expertise of clinicians and prompt clinical decision making can play an important role.

Key Messages

- ✓ Clinicians to consider the possible diagnosis of uterine torsion when a patient presents with abdominal pain.
- ✓ Identifying the torsion intraoperatively is important as failure to do so can lead to severe consequences due to distorted anatomy.
- ✓ Dual-consultant operations are recommended for future cases of uterine torsion whenever possible.

References

1. Liang R, Gandhi J, Rahmani B, Khan SA. Uterine torsion: A review with critical considerations for the obstetrician and gynecologist. Translational Research in Anatomy. 2020 Nov 1;21:100084.