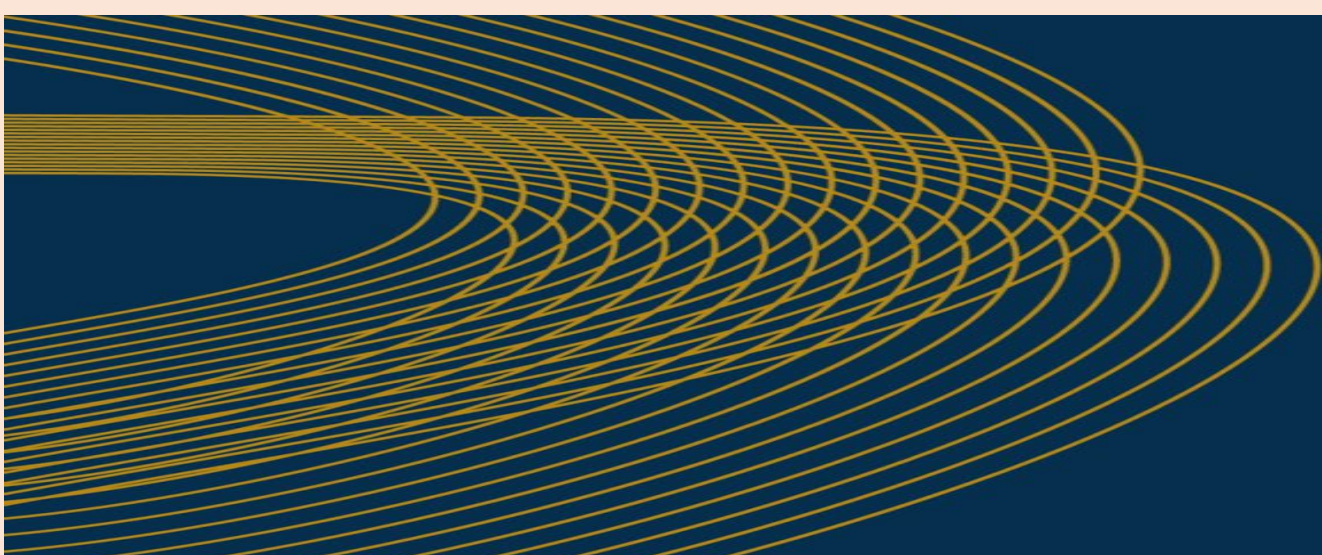


Complete uterine inversion during a caesarean section delivery

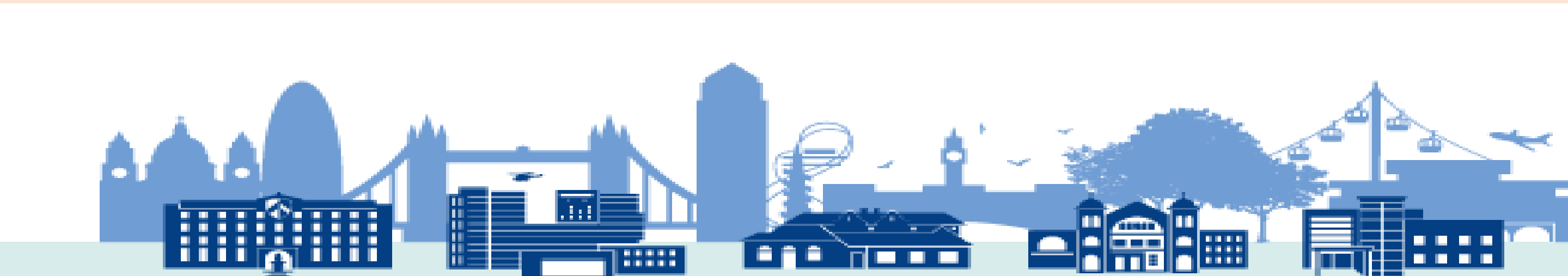
- An Obstetric Emergency

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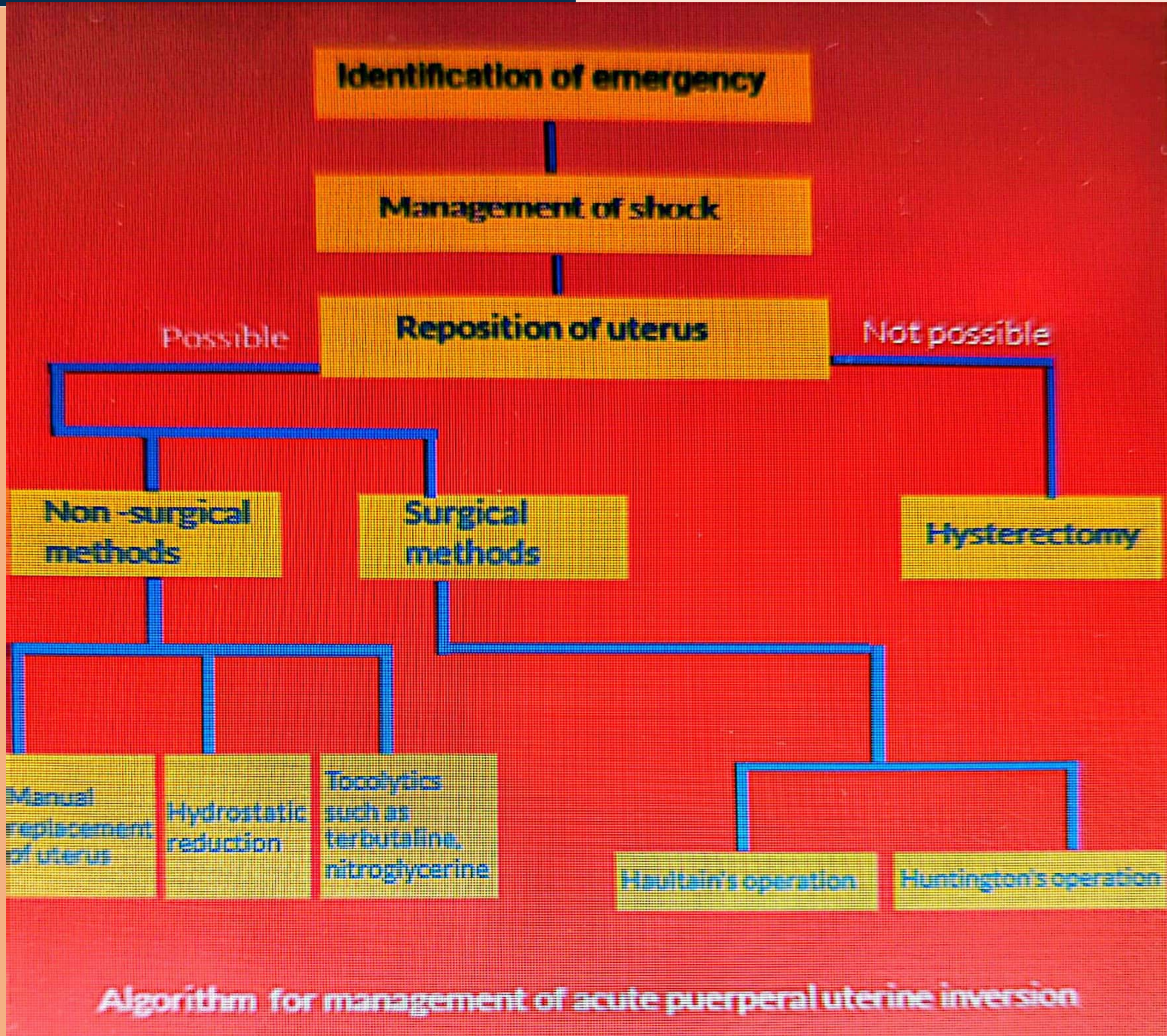
Introduction

Background

Puerperal uterine inversion is defined as the “turning inside out of the fundus into the uterine cavity”. (1) Though rare, it has grave implications, as it can lead to major haemorrhage, development of shock and even death. (2) If present, it usually occurs after vaginal delivery, but may rarely follow delivery via caesarean section.

Objective

This is to present a case of spontaneous uterine inversion noted during a caesarean section delivery, in our department, at Newham University Hospital, which was successfully managed.



Discussion

Acute inversion of the uterus following delivery is a life-threatening event. The incidence in caesarean deliveries between 1 in 2000 to 1 in 23,000 pregnancies. (1) In this case, some attributing factors could have been uterine atony, fundal attachment of morbidly adherent placenta, and umbilical cord traction, syntocinon bolus and uterine musculature weakness. It is important to **call for help** and then manually reduce the uterine inversion first, such as with Johnson’s manoeuvre, before attempting delivery of the placenta. If corrected, then myometrial contraction is induced with uterotonics. If manual correction is impossible, and massive obstetric haemorrhage is declared, then hysterectomy needs to be considered. (3) Bakri balloon use is also beneficial to control bleeding. (4) Surgical interventions include Haultain’s and Huntington’s procedures, uterine repositioning, either with cervical incisions or via laparoscopic methods.

Conclusion

Uterine inversion is a **recognised obstetric emergency**.

Awareness, diagnosis, experienced staff involvement, escalation and teamwork are essential for managing such a complication post-delivery.

Case Report

A 40-year-old para three (three previous caesarean sections) lady was booked for an elective caesarean section for which she had an uncomplicated delivery of a healthy infant. 5 units bolus of syntocinon was administered after, and slight umbilical cord traction was applied to deliver the placenta. Uterine exteriorisation occurred with inversion noted having the ongoing bleeding placenta still attached to the fundus.

Recognising the situation, an obstetric emergency was declared. **Immediate escalation** to the on-call LW consultant occurred for further support. The Consultant Obstetrician manually replaced the uterine inversion **before the development of a prominent contraction ring**, which could have made correction more challenging. The placenta was removed with gentle traction. Massive obstetric haemorrhage was anticipated. She received 40 units syntocinon infusion, ergometrine 250 mcg and carboprost 250 mcg to better uterine tone and achieve haemostasis. Misoprostol 800mcg was administered per rectally post vaginal toileting.



References

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- (5). [Acute puerperal uterine inversion | SpringerLink](#)