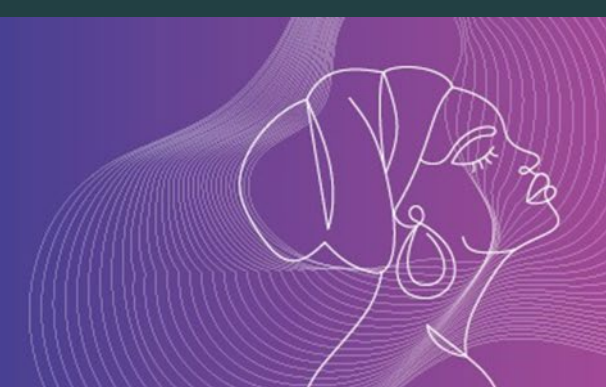




An interesting case of acute presentation of Nonpuerperal Uterine Inversion (NPUI)

Dr Shweta Sonthalia, Dr. Julia Lord, Dr Alice Clarke, Dr. Radha Venkatakrishnan, Dr. Helen Jefferis
Oxford University Hospitals NHS Foundation Trust, United Kingdom

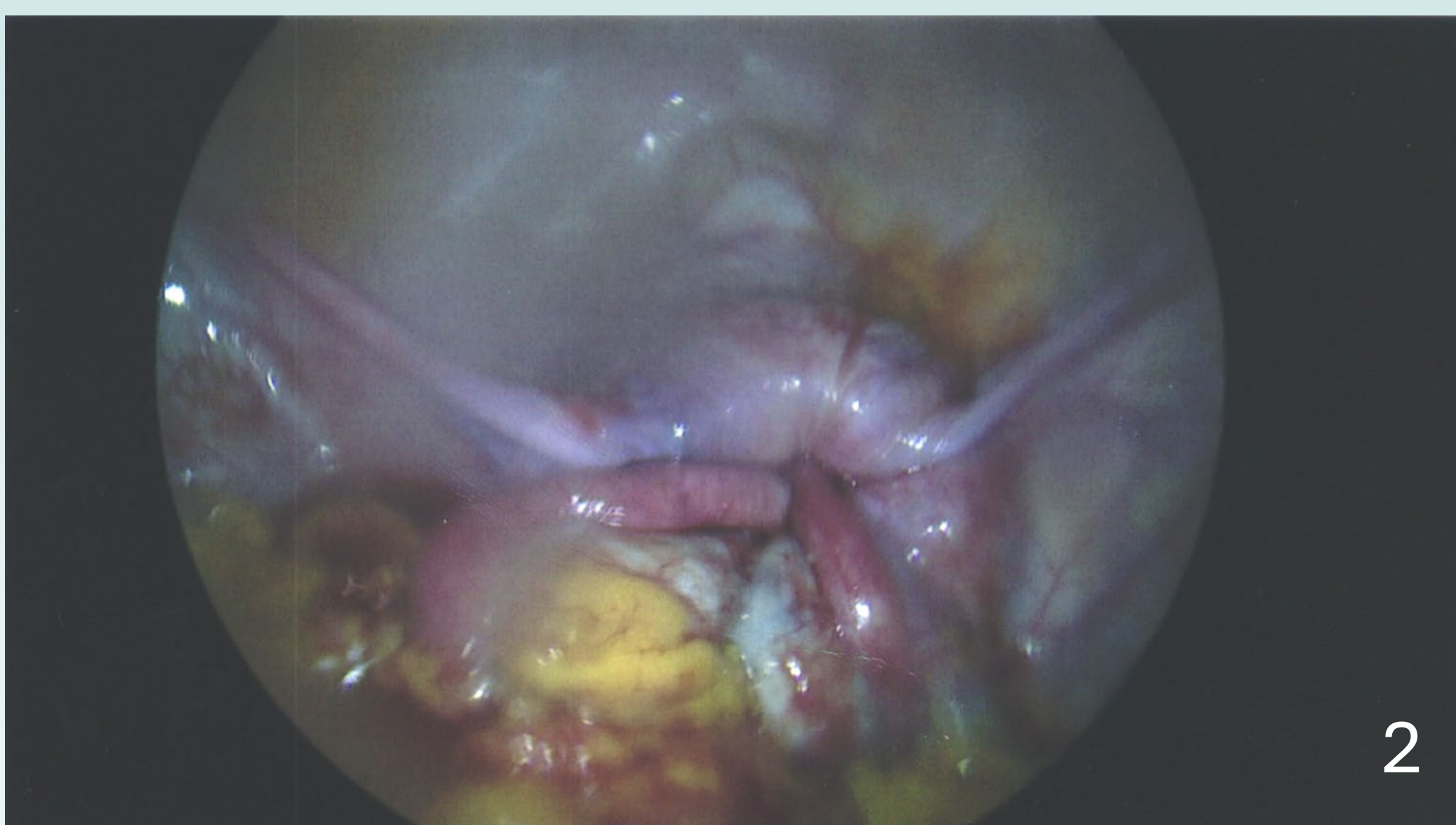
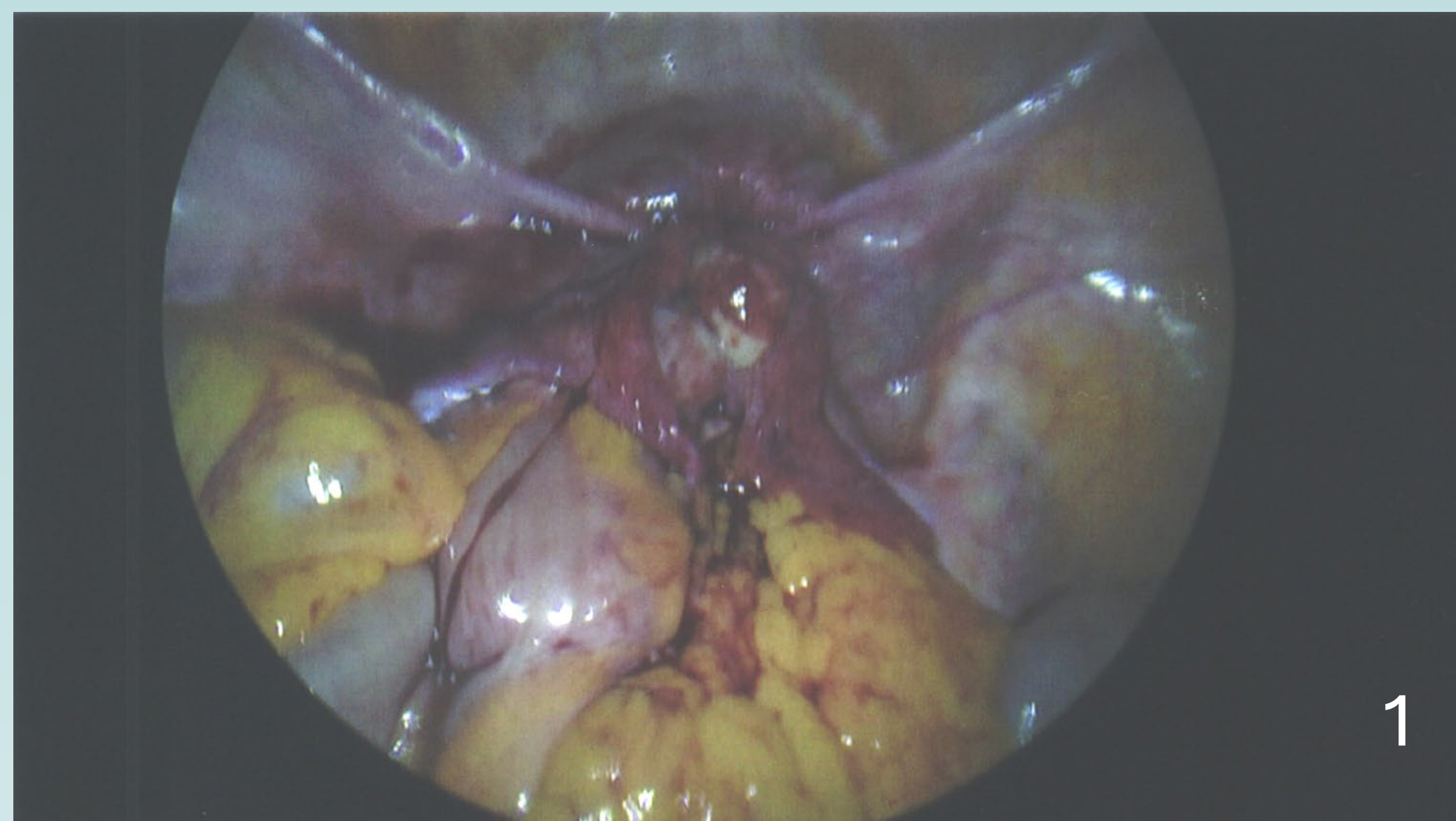
Objectives

Nonpuerperal uterine inversion (NPUI) is rare, and actual incidence is not known. Most of the literature on NPUI is in the form of case reports. We report a case of huge fibroid prolapsing from the cervix to the introitus and diagnosed as complete uterine inversion intraoperatively.

Case report

A 43-year-old female presented with heavy menstrual bleeding and pelvic pain for more than a year not improving with medical management. On evaluation, she was found to have a large fibroid polyp in the endometrial cavity, distending the cavity and descending completely through the cervical canal, measuring 90 x 40 x 50 mm. Her symptoms gradually worsened, and she presented to the emergency department with continuous bleeding, foul smelling discharge, severe abdominal pain, nausea, rectal pressure for two days and urinary retention for 12 hours. She was planned for hysteroscopy and transcervical resection of fibroid with Mirena insertion on the next day.

Intraoperatively, after vaginal fibroid polypectomy, an unexpected complete inversion of uterus was found which was treated with reversion of uterus by laparotomy. The uterus was re-positioned vaginally, and during the process a uterine perforation was sustained which was sutured once it was returned to the correct position. The Fallopian tubes had sustained a tear with possible effect for future fertility, and the tissues within the pelvic area were swollen due to both inversion and re-positioning. The patient recovered well but required intravenous antibiotics for a post-operative collection and psychological support following discharge.



Discussion

Leiomyomas are the commonest cause of NPUI, although a considerable proportion are due to malignancies. Most women present with foul-smelling vaginal discharge or irregular vaginal bleeding, worsening dysmenorrhoea, and acute urinary retention.

Ultrasound is the first line investigation, with emerging evidence for a combination of 3D power doppler and USS for diagnosis of inversion. Surgery is the mainstay of treatment of NPUI, focusing on the repositioning of the uterus. According to literature, Haultain procedure seems to be the most successful method of repositioning the uterus, however most women will need hysterectomy. In our case we used abdominal approach and Huntington procedure to reposition the uterus.

Figures

1 & 2: intra-operative of uterus during laparoscopy

3: MRI demonstrating large submucosal polyp expanding the endometrium and extending into the cervical canal (maximum diameter 90 mm).

Conclusions

It is prudent to keep a diagnosis of uterine inversion as a differential in a case of large uterine fundal fibroid polyp presenting acutely unwell. The diagnosis is said to be difficult and high index of suspicion is needed. Further evaluation, investigation and detailed discussion of treatment options including hysterectomy is imperative. Leiomyoma being the most common cause of NPUI, large fundal fibroid polyp should be prioritised in surgical list to avoid such complications.

References

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