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VAGINAL HYSTERECTOMY FOR A CHRONIC NON PUERPERAL INVERSION WITH POST MENOPAUSAL BLEEDING – A CASE REPORT

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ABSTRACT:

Chronic non puerperal uterine inversion is a rare clinical entity with diagnostic and surgical challenges. It is usually secondary to a tumor implanted in the endometrial surface of the fundal region of the uterus. Here we present a 65 year old multiparous lady with vaginal mass, postmenopausal bleeding and foul smelling discharge .Vaginal myomectomy was done followed by vaginal hysterectomy following a failed abdominal approach in this case.

Key words: Non puerperal, uterine inversion, fibroid

Introduction:

Chronic non puerperal uterine inversion (CNPUI) is an extremely rare clinical condition with diagnostic and surgical challenges. It is mostly associated with uterine tumors. Abdominal reposition with repair and vaginal reposition with abdominal repair are usually done followed by abdominal hysterectomy. Vaginal hysterectomy is rarely done. Vaginal hysterectomy for chronic non

puerperal inversion poses unique challenge to the surgeon. We report a 65 year old multiparous lady with postmenopausal bleeding and chronic uterine inversion who underwent vaginal hysterectomy.

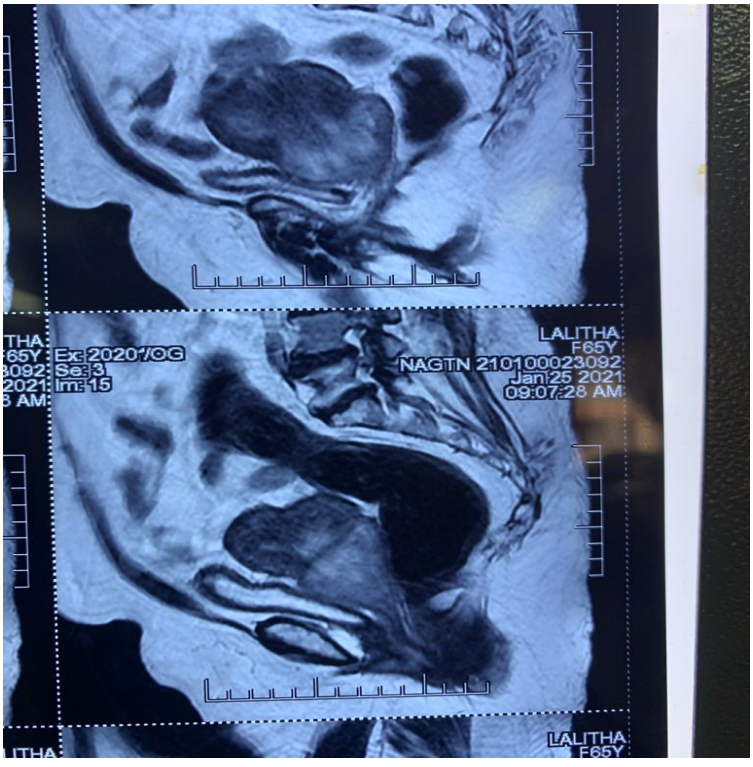
CASE REPORT:

A 65 year old P4L4 postmenopausal lady with history of psychiatric disorder for 7 years on treatment presented in our gynaec OPD with history of postmenopausal bleeding for 3 years and foul smelling vaginal discharge for 2 years. She was admitted and further evaluated.

She had already presented with the same complaints to Regional Cancer Centre eighteen months back where cervical punch biopsy and Pipelle sampling were done - both of which were negative for neoplasm. On admission, her Haemoglobin was 7.5 g/dl. Hence 3 units of packed cells were transfused. Patient was obese (110 kg). Blood pressure and blood sugar were within normal limits. She had foul smelling vaginal discharge and intermittent vaginal bleeding. Hence she was started on higher antibiotics. Betadine vaginal douche was also given.

USG showed mass occupying the uterine cavity. MRI pelvis showed lobulated T2 hyperintense lesions involving both lips of cervix with extension to lower uterine segment, upper 1/3 rd of vagina, hypointense rim of cervix is maintained. No myometrial invasion.

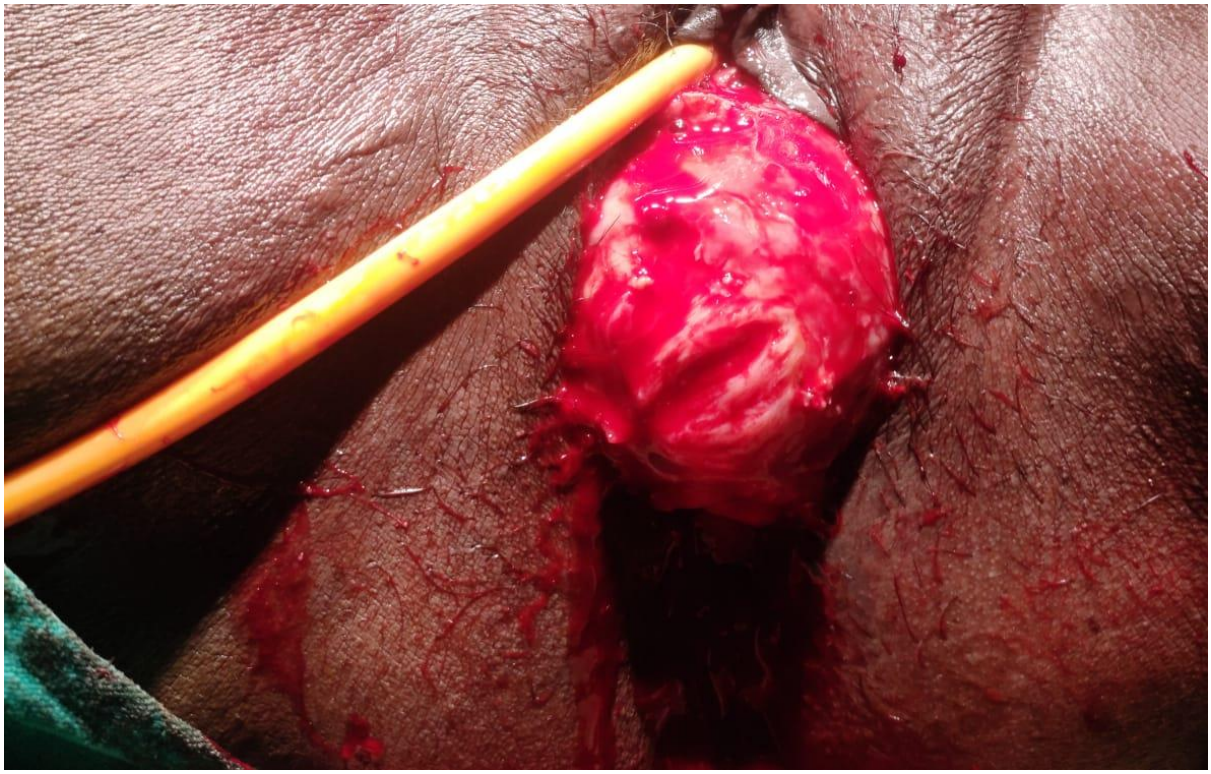
Picture 1: MRI picture of the patient



Examination under anaesthesia was done. Anterior lip of the rim of the cervix could only be felt and was drawn up. Cervix could not be visualised with speculum examination. A boggy necrotic mass could be felt behind the anterior lip of the cervix . Only upto 1 cm of uterine sound can be introduced behind the anterior lip of the cervix. Biopsy was taken from anterior lip of cervix and the boggy mass. So a differential diagnosis of uterine mass protruding through the cervical canal and a cervical mass were made.HPE came as necrosed material.

Few days later, the uterus was found completely inside out and could be fully visualised outside the vaginal introitus. Two fibroid polyps were seen one near the fundus and other near the lower anterior portion of the uterus.

So we concluded that partial inversion had become complete inversion . Complete bladder drainage was done. Consent for abdominal and vaginal hysterectomy were obtained . Abdomen was opened by suprapubic transverse incision .With difficulty we saw the cervical rim. Our traction at round ligaments failed. We could not grasp any portion of the uterus .The cervical rim was very narrow.Then we decided to proceed vaginally. Initially the two fibroids were coagulated and cut at the base. Both had broad bases. Bleeders were cauterised . Fundal submucosal fibroid was 12x 11 cm and the other was 6 x 5 cm. Vaginal hysterectomy was proceeded by making a vertical incision on anterior vaginal wall. Then the round ligament , fallopian tube and ovarian ligaments were clamped, cut and ligated. Bladder was identified by giving traction on the foley's bulb. Transverse incision made over the cervico vaginal junction. Then the UV fold of peritoneum was found with difficulty , cut and pushed up. Anterior cut edges of vagina held with Alley's forceps . Then uterine vessels, Mackenrodts and uterosacrals were clamped, cut and ligated. Lateral and posterior vaginal walls were then clamped and cut . The specimen was removed and sent for HPE. Vault was sutured. Clear urine drained at the end of the procedure. Then the abdomen was closed in layers after checking for complete haemostasis. Postoperative period was uneventful.HPE came as degenerated fibroid.



Picture 2: After vaginal myomectomy

DISCUSSION:

Non puerperal uterine inversion is an uncommon presentation seen often in association with leiomyoma, uterine sarcomas and endometrial carcinomas [1, 2]. Our first diagnosis was uterine tumor with malignant changes but it turned out to be leiomyoma with degenerative changes. Surgical intervention is usually necessary in chronic uterine inversion as uterine walls have very little elasticity to be reposited manually[3]. Haultain's abdominal operation and the two vaginal surgeries- Spinelli's and Kustner's are the available surgeries for chronic uterine inversion.

Based on the degree of inversion, some authors describe four distinct stages as follows[4]

Stage 1 – Inversion of the uterus is intrauterine or incomplete. The fundus remains within the cavity

Stage 2 – Compete inversion of the uterine fundus through the fibromuscular cervix

Stage 3 – total inversion, where by the fundus protrudes through the vulva.

Stage 4 – vagina is also involved with complete inversion through the vulva along with an inverted uterus[5].

The clinical diagnosis of chronic uterine inversion is difficult. MRI is also helpful in the diagnosis. U shaped uterine cavity, a thickened and inverted uterine fundus on a sagittal section and a bulls eye configuration on an axial image are the described MRI findings of uterine inversion [1].

Most of the case reports reviewed the difficulties of clinical diagnosis and emphasized the interpretation of USG [6]. To overcome this, examining under anaesthesia and histological sampling of vaginal mass have been suggested [6].Again this did not help in our case as the HPE turned out to be necrosed tissue. Demonstrating the endometrium on the surface of the mass will be confirmatory of diagnosis. Histological evaluation of the mass is justifiable before the definitive surgery, unless the causative pathology of a fibroid is obvious. If the tubal ostia are seen,it is conclusive of uterine inversion but if the mass is infected or sloughing,ostia may not be seen easily [7].

Mwinyoglee et al report a NPUI which was treated with vaginal hysterectomy without repositioning the uterus[8]. Herath et al reported a case where they performed a vaginal hysterectomy under direct observation with a laparotomy[9].

Vaginal hysterectomy for complete CNPUI could be dangerous when there is no access through the abdomen. Bisecting the uterus can damage the contents like the bowel. In our case, we were not able to reposition the uterus abdominally. Hence we approached vaginally after ruling out bowel inside the inverted uterus. It also helped us to check haemostasis from the pedicles.

CONCLUSION:

Nonpuerperal uterine inversion is a rare clinical entity even for an experienced gynaecologist. Due to different presentations and low incidence it can be misdiagnosed on initial assessment. Fibroid polyps are the commonest cause of uterine inversion. Abdominal repositioning may not be possible in all cases, leaving the vaginal hysterectomy as the only option. Abdominal access helps in

confirming the haemostasis and contents of inverted uterus. It also helped in checking bladder integrity in our case.

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