Torsion Of Pregnant Uterus In Case Of Uterus Didelphys Bicollis

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INTRODUCTION

Uterine torsion is defined as a rotation of uterus of more than 45 degrees on its long axis. Rotation of uterus less than 45 degrees is common finding in late pregnancy. Torsion of uterus is an unusual complication of pregnancy. It ranges from 45 degrees to 720 degrees. When uterus rotates on its long axis, the blood supply is altered at first veins then arteries. This results in abdominal pain, fetal distress and abruptio placenta in more severe cases¹,⁴. In most cases, it is associated with uterine myomas, uterine developmental anomalies, fetal malpresentation, adnexal mass, kyphotic pelvis and traumatic injuries. Preoperative diagnosis is difficult to establish. In most cases, diagnosis is made intraoperative. It can be detected by MRI if equipment is available in emergency departments²,³. Here we report a very rare case of acute uterine torsion during pregnancy in case of uterus didelphys bicornis.

CASE REPORT

Mrs. X, 23 year old woman, referred from private hospital as an emergency case with 34 weeks pregnancy and acute lower abdominal pain and absent fetal movement since 1 day and spotting PV since 2 hours. On admission to our hospital, she was severely pale and cold with pulse 140/min, low volume and BP 100/60 mm of Hg. On per abdominal examination, size of uterus was more than period of amenorrhea, tense, tender and fetal heart sound could not be located with stethoscope and CTG. Fetal parts could not be palpated. On per speculum examination, vertical vaginal septum found. Brownish vaginal discharge found coming from right cervix. On per vaginal examination from the right side of the septum, cervix found to be higher up and external os closed. On per vaginal examination from the left side of the septum, cervix external os closed. Urgent decision was taken for emergency caesarean section in view of abruptio placenta with intrauterine fetal death. Her haemoglobin was 4.7 gm%, total count 17800/cumm, platelet count 3.1 lac/cumm, RFT, LFT and coagulation profile were within normal limit. Urgently 3 units of PCV issued. After opening of the abdomen, uterus was bluish in colour and congested, round ligament could not be visualised in normal position. Uterovesical fold of peritoneum was not identifiable. After palpation of the lower uterine segment, torsion of uterus up to 360 degree towards left side (levorotation)

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was found. Lower segment was ballooned up. Nick was kept over the lower uterine segment and approximately 250 cc blood stained, dark amniotic fluid was drained out. Untwisting of the torsion of the uterus was done. Nick was extended bilaterally over anterior surface of lower uterine segment and baby delivered and found fresh still birth. Uterus was delivered out of abdominal cavity and found to be uterus didelphys, with pregnancy in right sided uterus.

Figure 1 : uterus didelphys

Uterus didelphys: pregnant horn is towards right side which was derotated and non pregnant horn was towards left side. Right ovary was gangrenous. Left side of the uterus was 12 weeks pregnant size with normal ovary and fallopian tube. Pregnant uterus was flabby and atonic. All medical measures for atonic postpartum haemorrhage were tried, but still uterus was atonic.

Figure 2 : atonic uterus

Atonic uterus: after all medical measures pregnant horn remained flabby and hysterectomy of same was performed. Her pulse was 180/min, blood pressure was 60 systolic. So, decision for obstetrics hysterectomy was taken after consent of her relatives to save her life. Right sided subtotal hysterectomy with right sided salpingo-oophorectomy was performed, specimen was sent for histopathological examination.

Figure 3 : septated vagina

Septated vagina: per-speculum examination under anaesthesia was performed that revealed two vaginal opening with cervix in each opening. Patient was kept in critical care unit for 2 days. Her postoperative period was uneventful. Sutures were removed on 8th postoperative day. Patient was discharged with follow up advice.

DISCUSSION

Torsion of uterus is an unusual complication of pregnancy. Uterine torsion is defined as a rotation of uterus of more than 45 degrees on its long axis. In most cases, degree of torsion is approx. 180 degree, but can ranges from 45 degrees to 720 degrees. Torsion of gravid uterus is extremely rare but more common than non-gravid uterus. Causes of torsion of gravid uterus includes Uterine myomas, Uterine anomalies, specially bicornuate uterus, Pelvic adhesion, Abnormal presentation or fetal anomalies, Abnormalities in spine or pelvis Various presenting symptoms of torsion of gravid uterus are Pain (95%), Shock, Intestinal obstruction, Urinary symptoms, Bleeding, Obstructed labour Various differential diagnosis of torsion uterus are Ectopic pregnancy, abdominal haemorrhage, torsion of pelvic tumour, peritonitis, obstructed labour, placental abruption, tonic uterine contraction, degenerating fibromyomata, acute hydramnios. Torsion of uterus should be suspected when 1.Round ligament palpably stretch across abdomen 2. Uterine artery pulsating anteriorly on vaginal examination. 3. Twisting of vagina, cervix or rectum. Pre-operative diagnosis is difficult to establish and diagnosis is usually made intraoperatively. Various treatment options are: Detorsion, Hysterotomy- posterior transverse cesarean hysterotomy, Hysterectomy. It is associated with poor maternal and perinatal outcome.
CONCLUSION
Uterine torsion is a rare complication of pregnancy and obstetricians should have this complication in mind while performing a caesarean section during acute abdominal pain. So, early diagnosis can improve maternal and fetal outcome. Also, anatomical landmarks should always be defined prior to uterine incision to check for the torsion.

REFERENCES