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Case Report

Asymptomatic Torsioned Term Gravida Uterus

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Abstract

Torsion of gravid uterus is very rare condition. Dextrorotation of gravida uterus can be a normal finding, however rotation greater than 45 degrees along the longitudinal axis of the uterus described as a rare pathological condition in obstetrical. A 29 years old, gravida 2 para 1 mother with gestational age of 39 weeks, presented for elective cesarean delivery for indication of term pregnancy and declined vbac to our MCH clinic. Intraoperatively there was 180 gravida uterus torsion, detorsion was failed and delivered by posterior hysterotomy. Laparotomy inevitable to decrease maternal and neonatal morbidity and mortality.

Keywords: *Torsioned; Gravida Uterus*

Introduction

Uterine torsion during pregnancy is defined as rotation of the gravid uterus more than 45 degrees along longitudinal axis of uterus. Rotation is common towards the right than the left side due to recto-sigmoid colon in left side. Certain group proposed that maternal irregular body movements, external cephalic version, myoma, adhesion, posture, positions, soft thin-walled lower uterine segment, laxity of the supporting ligaments and abdominal wall, in combination can predisposed to gravida uterus torsion [1,5,7].

Torsion of uterus presented as asymptomatic or with non-specific sign and symptoms. Rotation of gravid uterus can be presented with lower abdominal pain, mild abdominal discomfort, acute abdomen with shock, failure of cervical dilatation, vaginal bleeding, uterine tenderness, twisted vaginal canal and urethral displacement may be seen. It can causes uterine venous obstruction will lead to decrease placenta perfusion, placenta abruption, IUGR, fetal distress and can end up with shock.

Management of tensioned gravida is uterus admission and giving analgesia, bed rest and laparotomy should be done. De-torsion should be done during preterm pregnancy hoping that to continuous the pregnancy. Near term cesarean section should be done after detorsion [2,3] but some times de-torsion is difficult and Posterior hysterotomy is required for delivery. This is Significantly associated torsioned uterus with fetal and maternal mortality and morbidity depend upon gestational age and degree of torsion. The perinatal mortality and the maternal morbidity is around 12% and13% respectively [1,8].

A 29 years old, gravida 2 para 1 mother with gestational age of 39 weeks, presented for antenatal care follow up to our MCH clinic. She had one previous c/s delivery two years back for the indication of failed induction. She had no compliant during antenatal care follow up. Blood pressure 110/60 mm Hg, pulse 112/min and temperature was in normal range. Pink conjunctiva, Respiratory and Cardiovascular systems were normal. Abdomen examination was term size gravida uterus, longitudinal lie, cephalic and fetal heart beat was in normal range. Vaginal examination finding was cervix closed, posterior and uneffaced. Routine urine and blood laboratory tests were in normal range. She was admitted for elective caesarean section with diagnosis of full term pregnancy and declined VBAC after informed consent was taken. There was mild resistant during catheterization.

She was operated under spinal anesthesia. Abdomen was entered through pfannenstiel incision.

Bladder was not visible. There was mild adhesion of uterus with abdominal wall. There was 180 gravida uterus torsion; Round ligament, fallopian tube and utero-ovarian vessels were crossing from the right to the left. detorsion was tried and was not successful. Posterior lower uterine segment hysterotomy was done to deliver female neonate 3400 gm with good APGAR score. Placenta was delivered by cord traction. Uterus sutured with two layers and replaced after derotation. After haemostat secured abdomen closed layer by layers.

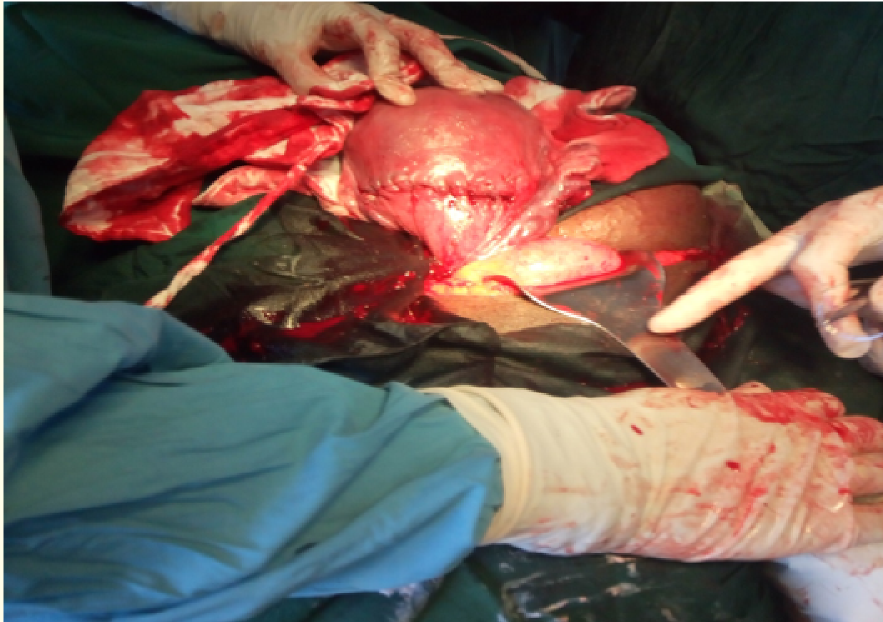

Figure 1: *Shows posterior hysterotomy during delivery of torsioned gravida uterus.*

Discussion

Slight rotation of gravid uterus not exceeding of 45 degree is common during the pregnancy but uterine torsion is one of the rare complication of pregnancy. It range from 45 degree to 720 degree. Most cases have 180 degree rotation similar to our case. According to Jensen uterine torsion can occur in all age group, parties and gestational age [1,5].

In 20 - 30% of cases the cause of uterine torsion is unknown but some scholar suggest that it can associated with adhesion 8.4% of cases, 31.1% with myoma, 14.9% with uterine anomalies 7% cases had ovarian cyst and 4.6% cases had abnormal presentation and fetal anomalies according to Piot., *et al*. Some scholar associate hypermobility posturing with uterine torsion [1,5,7].

Patient with previous cesarean section can have uterine torsion due to poor isthmic healing, structural weakness and angulation [9].

Uterine torsion can present asymptomatic or nonspecific symptom similar our case. It obscure uterine blood follow lead to lower abdominal pain, vaginal bleeding, abdominal discomfort, urinary and abdominal discomfort, abdominal tenderness and shock. Other presented with twisting of vagina, obstructed labor and failure to dilate cervix.

Uterine torsion can diagnosed by Doppler ultrasound. During examination can have ovarian vessels anterior to the uterus by Doppler ultrasound and placental site change from previous scan according to Gule., *et al* [10].

Nicholson., *et al*. suggested X-shaped configuration of upper vagina on MRI (magnetic resonance imaging) as a sign to diagnose torsion. This is based upon the fact that vagina is normally seen on MRI as an H-shaped structure, but with torsion of the uterus and upper vagina, the vagina appears as an X shaped structure [11].

Management of pathologic uterine torsion is laparotomy. During operation important to identify each anatomic land mark to plan type of uterine incision. Delivery of term pregnancy with uterine torsion is by caesarean section. Detorsion may tried and delivery by anterior lower segment cesarean section is possible but derotation term gravida uterus sometimes difficult, posterior lower segment hysterotomy can be done which is similar to our case [12]. To decrease the feature recurrence bilateral round ligament plication is recommend as prophylaxis. In preterm viable uterus laparotomy derotation and conservative management can be done. Even though the chance of feature uterine rupture unknown feature should be by cesarean section [10]. In cases of 90 degrees rotation difficult to detorsion it is necessary to ligate the uterine vessels to avoid rupture of these vessels and take a vertical incision on uterus thereby avoiding traumatic haemorrhage. Hysterectomy can be done during gangrenous gravid uterus, and uncontrolled haemorrhage of 90 degree torsion.

Conclusion

Even though patient with torsion can present asymptomatic or symptomatic with different differential diagnosis, definitive diagnosis can be made during laparotomy. The management of torsioned uterus is laparotomy, detorsion. Depend upon gestational age and viability of uterus cesarean delivery can be but if the uterus is gangrenous total abdominal hysterectomy can be done. Sometimes detorsion is difficult posterior hysterotomy is possible. Even though the percent is unknown chance of future uterine rupture more than those who have anterior transverse uterus two scar.

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