Nigerian Journal of Clinical Practice
March 2009 Vol 12(1):106-107

CHRONIC UTERINE INVERSION SECONDARY TO SUBMUCOUS FIBROID: A CASE REPORT

***JO Eigbefoh, *SA Okogbenin, *F Omorogbe, **PS Mabayoje**
*Departments of Obstetrics and Gynecology, *Irrua Specialist Teaching Hospital, Irrua, Edo State.*
***I.A.Hospital, Shell Petroleum Development Company, Warri, Delta State, Nigeria.*

ABSTRACT

A rare case of non-puerperal chronic uterine inversion secondary to sub mucous fibroid in a 38-year-old woman is presented. There was complete uterine inversion with the incarcerated inverted uterus protruding through the vagina beyond the vulva. The sub mucous fibroid was attached to the fundus. At laparotomy, a dimple with a constriction ring was found in the position of the uterus. The distal ends of the fallopian tubes and part of the ovary were visible through the constriction ring. Histological examination of the uterus and fibroid following hysterectomy confirmed their benign nature.

Key Words: Uterine, inversion, submucous, fibroid. (Accepted 24 January 2008)

INTRODUCTION

Uterine inversion is commonly encountered in the puerperium when it presents as an acute life-threatening event. Chronic uterine inversion outside the puerperium though rare can occur, where it may be difficult to distinguish from utero vaginal prolapse, sub mucous fibroid and cervical fibroid. We present a case of chronic uterine inversion associated with a sub mucous fibroid.

CASE REPORT

Mrs O.P. was a 38 year old Para 6+0 Christian, who had her last delivery about three years before presentation. She came to the clinic with complaints of increased menstrual blood loss of five months duration and protrusion of "some thing" down the vagina of one-month duration. The duration of blood loss had increased from three days to eight days and the menstrual loss was described as excessive. The vagina protrusion had increased progressively in size over a three-month period, becoming more prominent with micturiction or straining at defecation. The swelling was at first spontaneously reducible but had become irreducible in the ten days before presentation.

She consulted a native doctor one week before presentation. She had topical preparation administered to the mass. It was after this she noticed soreness and later an offensive discharge from the mass.

She attained menarche at the age of 16 years. She menstruated prior to onset of problems for 5 days in a regular cycle of 28-30 days. However the duration of menstrual blood loss had increased in the last five months to 8 days and the menstrual blood loss was excessive with passage of clots during menses. There was no intermenstrual bleeding.

She did not practise any form of contraception. There was no history of chronic cough or straining at micturiction.

She was Para 6+0 with 6 uneventful full term deliveries between 1991 and 2001. The second stage of labour was not unduly prolonged. Her last confinement was three years before presentation. All her children were in good health.

She was the first of three wives in a polygamous family setting. The husband was a building contractor. She was engaged in clothing retail.

On examination, she appeared well. The cardiovascular system was stable. There was no palpable mass on abdominal examination. On pelvic examination, there was a mass protruding from the vagina. The mass was penduculated measuring 25 cm. It had a fleshy pedicle and a semi solid distal end, which was multilobulated. There were necrotic debris and slough on the pedicle and apex.

The vagina was entirely occupied by the mass with the base of the mass not discernable. There was no demonstrable cystocoele or rectocele. The uterus was not palpable.

A working diagnosis of incarcerated sub mucous fibroid polyp was made. She was counselled and prepared for examination under anaesthesia.

A full blood count, electrolyte and urea were done. The haematocrit was 19%. Other parameters were normal. She was transfused with three units of packed cells under frusemide cover. The post transfusion haematocrit was 30%. Vaginal irrigation

Correspondence: Dr J O Eigbefoh
E-Mail:eigbefoh2003@ yahoo.com

with hydrogen peroxide and eusol was done for three days.

Surgery was done four days after presentation. Finding at examination under anaesthesia revealed a complete uterine inversion with an attached sub mucous fibroid attached to the uterine fundus measuring 8cm by 6cm. The 'stalk' of the fibroid was the inverted uterus lined by velvety endometrium with a constituency different from the attached uterine fibroid.

Findings at laparotomy revealed a dimple with a constriction ring in the position of the uterus posterior to the bladder. The distal ends of the tubes and the ovaries protruded through the ring with the rest of the fallopian tubes disappearing through the constriction ring.

The diagnosis intraoperatively was chronic uterine inversion secondary to sub mucous fibroid. A combined abdominal and vaginal surgery was done.

The sub mucous fibroid at the fundus of the inverted uterus was excised per vaginam. The constriction ring was divided per abdomen by a longitudinal incision on the posterior wall of the uterus. The inversion of the uterus was then corrected. A routine three-pedicle hysterectomy was then done.

Histological examination confirmed the benign nature of the excised specimen.

She was discharged from the hospital five days afterwards following an uneventful postoperative period. She was stable at her follow up visit four weeks after discharge. Her surgical wound had healed completely with minimal scar formation. She felt completely well and eager to resume normal activities.

DISCUSSION

This is the first case of non-puerperal chronic uterine incision seen in this hospital. The hospital since inception in 1991 has served as a regional referral centre for 6 states with a combined population of 10 million. The uterine inversion occurred secondary to the attached sub mucous fibroid. The condition though rare has been reported in the literature[1, 2, 3.] Other causes of chronic uterine inversion are rarer still and may occur in association with uterine sarcoma[4] and endometrial carcinoma[5]. Mwinyoglee et al in 1997, in a report on non-puerperal uterine inversion noted that 97.7% were associated with a tumour of which 20% were malignant.

The case presented with a major diagnostic dilemma. The differential diagnoses at presentation included utero- vaginal prolapse, sub mucous fibroid polyp (which was the working preoperative diagnosis) and cervical polyp. The definitive diagnosis was only established intra operatively. The diagnostic difficulty was also compounded by the late presentation. This is the experience of other workers [5], who noted that many cases have to be managed without previous experience.

The ulceration and offensive discharge occurring at presentation was probably because of the topical herbal preparations. This type of health seeking behaviour is not unusual in Nigeria. This is because sociocultural and economic consideration militate against early presentation in an orthodox medical facility.

The operation of choice was excision of the fibroid, correction of the uterine inversion and total abdominal hysterectomy. This was because she had completed her family size.

The case in many respects is instructive. The differential diagnosis of “some thing” coming down the vagina should be constantly revised to avoid diagnostic pitfall. This will save the gynaecologist the professional embarrassment that may arise in wrong diagnosis, treatment and referrals.

REFERENCES

1. **Mayadeo NM, Tank PD.** Non-puerperal incomplete lateral inversion with sub mucous leiomyoma: a case report in J. Obstet Gynaecol Res 2003. Aug. 29(4): 243-5.

2. **Skinner GO, Lowden KA.** Non puerperal uterine inversion associated with an atypical leiomyoma in: Aust. N. Z. J. Obstet Gynecol. 2001. Feb; 41 (1); 100-1.

3. **Mwinyoglee. J, Simela N, Marivale. M.** Non puerperal uterine inversion . A two case report and review of the literature in Cent. Afri. J. Med. 1997. Sept. 43(9) 268-71.

4. **Moodley M, Moodley J.** Non-puerperal uterine inversion in association with uterine sarcoma: Clinical management in Int. J. Gynaecol. Cancer 2003. March-April 13(2); 244-5.

5. **Moulding F, Hawnaur. JM.** MRI of non puerperal uterine Inversion due to endometrial carcinoma in Clin. Radiol. 2004. June 59(6) 534-7.

.