

## CASE REPORT

PROF-1004

**UTERINE TORSION IN TWIN PREGNANCY****DR. MUHAMMAD SAJJAD MASOOD, MBBS**

Registrar/Medical officer  
Department of obstetrics & gynaecology  
Nishtar Hospital Multan

**DR. HUMA QUDDUSI, FCPS**

Associate Professor  
Department of obstetrics & gynaecology  
Nishtar Hospital Multan

**DR. MUHAMMAD SAMEE AKHTAR, FRCOG**

Professor of Obstetrics & Gynaecology  
Nishtar Hospital Multan

**DR. NASEER-UD-DIN, FCPS**

Assistant Professor  
Department of obstetrics & gynaecology  
Nishtar Hospital Multan

**ABSTRACT...** [drsajjad131@yahoo.com](mailto:drsajjad131@yahoo.com) A young married women in her 3<sup>rd</sup> ongoing pregnancy, having no alive issue presented at 37+ weeks with labour pains. Cesarean section was planned because of twin pregnancy and past bad obstetrical history. During operation, the uterus was found to have rotated to 180 degree to the right. A transverse incision was made on posterior wall of uterus to deliver babies. After suturing the incision site, the uterus was repositioned in right place. This paper presents a case of torsion of gravid uterus in which the delivery and repositioning of the uterus was successful.

**Key words:** Uterine torsion, Cesarean section, Posterior uterine incision.

**INTRODUCTION**

Pathological torsion of the human pregnant uterus is a rare complication<sup>1</sup>. Clinical diagnosis is difficult since symptoms are either absent or non specific<sup>2</sup>. The diagnosis is usually established only after opening the abdomen or some times even after closure of the uterine incision<sup>3</sup>. If uterine torsion is noted, the surgeon should search for a pathologic process responsible for the rotation. At delivery, the type of uterine incision performed is individualized. In general, rotation to the normal uterine position before performing a hysterectomy is prudent. Otherwise, a posterior entry is performed. In this report, we describe our experience of one such case.

**CASE REPORT**

A 27 year old lady married for 5 years having no alive issue presented in her 3<sup>rd</sup> pregnancy in labour room at 37+ weeks with palpable uterine contractions. Previously one of her baby died in early neonatal period and other pregnancy ended up in miscarriage at 6 month. The patient's last menstrual period was July 13, 2004 and her expected date of delivery was April 20, 2005. Pregnancy was spontaneous conception and was confirmed by urine pregnancy test. It was booked case of Nishtar Hospital Multan. Her first trimester was uneventful. She felt quickening at 5<sup>th</sup> month. Scan at 20<sup>th</sup> week revealed normal, active, alive twin pregnancy. She continued to

have her regular antenatal checkups. Her 2<sup>nd</sup> & 3<sup>rd</sup> trimesters were uneventful. She was received in labour room on 1<sup>st</sup> of April 05 at 37+ week gestation with palpable uterine contractions. Her history was reviewed and keeping in mind the previous bad obstetrical history, Cesarean section was planned. Physical examination was unremarkable. Relevant investigations were carried out. Her blood group was found to be B+ and Hb 11.9gm/dl. USG revealed twin pregnancy, both cephalic with dividing membrane. There was no fetal anomaly and amniotic fluid volume was normal. Patient was prepared for cesarean section. All prerequisite met for procedure of cesarean section.

The abdomen was opened by pfannensteil incision. Uterus was approached. Grossly dilated blood vessels resembling pampiniform plexes were observed in the lower uterine surface, uterovesical peritoneum was difficult to identify for reflection of bladder. Both ovaries were lying anteriorly. Uterine torsion was diagnosed because of the above mentioned findings. Attempts to rotate the uterus to its correct anatomical position were unsuccessful due its enlarged size.

As the gravid uterus would not yield to anatomical repositioning, delivery through a posterior uterine wall was unavoidable. Both babies were delivered easily. Placenta and membranes were delivered completely. The posterior uterine incision was repaired in two layers. After the completion of stitching, uterus was repositioned in right place. Complete Haemostasis was achieved and blood loss was about 200ml. No maternal abdominopelvic pathology or fetal abnormalities were demonstrated. The patient recovered well from her surgery and was discharged on the 7<sup>th</sup> postoperative day.

## DISCUSSION

Torsion has been defined as a rotation of more than 45 degrees of the uterus around its long axis. The extent of the torsion is most often 180°, but cases involving twists from 60-720° have also been described<sup>4</sup>. Extreme torsion of 180 degree at term is a rare perplexing obstetric event to the physician<sup>5</sup>. It is not possible to clarify why uterine torsion occurs; abnormal presentation of fetus, leiomyoma of the uterus, large ovarian cyst, and pelvic

adhesion are known factors associated with pregnant uterine torsion<sup>2,4</sup>.

Reported clinical associations include sudden movements of the patient, long or rigid cervix, abnormal pelvis, hydramnios, multiple gestations, hyperactive fetus, and interstitial pregnancy. Although uterine torsion was asymptomatic in this case, most patients present with abdominal pain, cervical dystocia, vaginal bleeding, shock and intestinal or urinary complaints<sup>2,4</sup>. The non-specific clinical course and rarity of pathological torsion of the gravid uterus makes the preoperative diagnosis difficult.

Usually it can not be diagnosed before delivery and final diagnosis is only made at the time of laparotomy<sup>2,3</sup>. With magnetic resonance imaging (MRI), however, an accurate diagnosis of uterine torsion may now be made preoperatively. Suspicion of torsion was raised in this case because of grossly dilated blood vessels running horizontally to the uterus in the lower uterine surface, absence of the normal uterovesical peritoneum and anterior position of both ovaries. Torsion of the human pregnant uterus is a very rare complication and raises several critical management considerations. Treatment of torsion depends on when in pregnancy it occurs. The treatment in the earlier months of pregnancy is immediate laparotomy and detorsion of the uterus and, if practicable, adjunct surgery to eliminate the possible etiologic factors.

Whether the pregnancy should be allowed to continue is unclear. Whether any procedures should be performed to fix the uterus in the usual anatomic position is also uncertain. In this unique setting, care must be individualized. In instances in which the fetus is of sufficient maturity to be considered viable, the best treatment is cesarean delivery. The incisional approach is highly variable, chosen based upon the underlying pathology, the degree of rotation, and whether or not the torsion is correctable. Several cases of torsion have been reported in which the degree of rotation was so severe that the hysterotomy incision at the time of cesarean delivery was performed on the posterior uterine wall. Some surgeons have described these posterior incisions

as inadvertent, while others have deliberately performed them.

Some posterior entries are performed because the uterus cannot be rotated into the normal position until it is emptied. Postoperative manual correction is easily performed, as was done in this case. It seems reasonable that an effort at rotation to the normal position should precede the performance of a hysterotomy. If detorsion is impossible, a transverse incision is best, curved upward, mimicking the usual anterior procedure. Maternal prognosis is good after surgical treatment; however, perinatal mortality remains high<sup>2</sup>. The fetal and maternal mortality rates since 1976 are 12% and 0% respectively<sup>4</sup>.

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