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Case Report / Olgu Sunumu

Uterin torsion in pregnancy

Gebelikte uterus torsiyonu

Fazilet Kübra Boynukalın[1,1], Ayşe İlknur Aral[2], Ömer Tolga Güler[3]

[1]Anatolia Women's Health and Infertility Clinic, Ankara, [2]Department of Obstetrics and Gynecology, Şanlıurfa Women's Diseases Hospital, Şanlıurfa, [3]Department of Obstetrics and Gynecology, Pamukkale University School of Medicine, Denizli

Abstract

We report a case of torsion of the pregnant uterus at 39 weeks mimicking abruption of the placenta. The patient was 43-year-old, gravida 13, parity 10, at 39 weeks with a singleton pregnancy. She was admitted to hospital by regular uterine contractions. During intrapartum care, cesarean delivery was recommended with the indication of fetal distress that suggesting the possiblity of placental abruption and emergency cesarean section was performed. The inadvertent posterolateral incision was stitched in two layers. There was no evidence of abruption and the placenta visualized as normal for the gestation. The postop care was uneventful. Our case demonstrates the difficulties of making a diagnosis of uterine torsion. Symptoms that could have suggested the diagnosis were associated placental abruption. As a result, the diagnosis of torsion was established after opening the peritoneal cavity and the retraction of the uterine venous plexus was the key point of the operation.

Keywords: Uterine torsion, pregnancy, cesarean delivery

Özet

Plasenta dekolmanını taklit eden 39 haftalık gebelikte uterus torsiyonu olgusu sunulmaktadır. Hastanın, 43 yaşında, gravida 13, parite 10, 39-haftalık tekil gebeliği vardı. Hastaneye düzenli uterin kasılmalar ile başvurmuştu. İntrapartum takip esnasında olası plasenta dekolmanı ile oluştuğu düşünülen fetal distress endikasyonu ile sezaryen önerildi ve acil sezaryen yapıldı. Farkedilmeden ve istenmeden yapılan posterolateral insizyon iki tabaka halinde dikildi. Dekolmanı düşündüren durum yoktu ve plasenta normal olarak izlendi. Postoperatif seyir normaldi. Bu olgu uterin torsiyonu tanısının zorluğunu vurgulamaktadır. Belirtiler plasenta dekolmanını düşündürmekle birlikte batına girildikten sonra uterin torsiyonu tanısı konuldu. Uterin venöz pleksusun retraksiyonu ameliyatta dikkati çeken bir bulgu idi.

[1] Dr. Kübra Boynukalın, Anatolia Kadın Hastalıkları ve İnferilite Merkezi, Ankara
kubraboynukalin@yahoo.com

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Anahtar sözcükler: Uterin torsiyon, gebelik, sezaryen doğum

Introduction

Uterine torsion is rotation of the uterus on its long axis of more than 45 degrees [1].It is a rare event in humans. Dextrorotation occurs in two-thirds of the cases and laevorotation is found in the other one-third [2]. Clinical presentation of the uterine torsion is nonspecific. Extreme torsion of 180° at term is a rare and can be more problematic.

Uterine torsion causes venous obstruction that may lead to increased pressure in placental cotyledons and this may cause placental abruption. When it progresses to uterine artery obstruction, placental perfusion reduces which can lead to fetal demise. Leiomyomas, uterine malformations, ovarian cysts, and adhesion are the known factors associated with uterine torsion [3]. We report a case of torsion of the pregnant uterus at 39 weeks mimicking abruption of the placenta.

Case

The patient was 43-year-old, gravida 13, parity 10, at 39 weeks with a singleton pregnancy. She was admitted to hospital by regular uterine contractions. Vaginal examination demonstrated 4 cm cervical dilatation and 50% cervical effacement. The fetus was found to be in a vertex presentation. Fetal cardiotocogram was reassuring. Estimated fetal weight was 4200 g. She was attended to the delivery room. After 1-hour cardiotocography, unprovoked decelerations were seen. Uterus was tendered and maternal hypotension and tachycardia was revealed. Cesarean section (CS) was recommended with the indication of fetal distress due to abruption of the placenta and emergency CS was performed. Under general anesthesia, a Pfannenstiel incision was made. An engorged venous plexus crossing the anterior operating field was noted. After identifying the ovaries and fallopian tubes, it was seen that round ligament was rotated more than 90 degrees. We retracted the venous plexus and made a low segment transverse incision. A 4550-g baby was delivered. Levorotation of the uterus was corrected after delivery. The inadvertent posterolateral incision was stitched in two layers. There was no evidence of abruption and the placenta visualized as normal for the gestation.

Discussion

The mechanism and etiology of uterine torsion is not known exactly. The predisposing factors are thought to be malpresentation of the fetus (especially transverse lie), myomas, uterine anomalies, pelvic adhesions, ovarian cysts, uterine suspension, abnormal pelvis, and placenta previa.

Although the clinical presentation is usually non-specific and asymptomatic, symptomatic torsion occurs when the degree of twisting is sufficient to interfere with arterial or venous circulation. The most common symptom is abdominal pain of varying intensity and main main differential diagnosis is abruption placenta [4].

Our case demonstrates the difficulties of making a diagnosis of uterine torsion. Symptoms that could have suggested the diagnosis of an associated placental abruption. As a result, the diagnosis of torsion was established after opening the peritoneal cavity and the

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retraction of the venous plexus was the key point of the operation. In cases of torsion at term, manual correction followed by delivery with caesarean section is recommended. In cases where correction is not possible, a deliberate posterior hysterotomy can be done for delivery of the fetus [5].

Piot et al. [6] and Jensen et al. [1] have extensively reviewed the reports of torsion of gravid uterus. Jensen et al. [1] reported 212 cases from a variety of countries and it was encountered 12 % fetal mortality rate. It appears that the risk of fetal mortality depends on the gestational age and the degree of the torsion. In addition, emergency CS is the lifesaving procedure.

Finally, uterine torsion should always be considered as part of a differential diagnosis of complications in the third trimester of pregnancy.

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