INTRODUCTION

Inversion of uterus is a rare clinical diagnosis and non puerperal inversion is still uncommon, accounting for one-sixth of all cases of uterine inversion.\(^1,2\) The fact that many gynaecologists may not encounter in their clinical practice indicates its rarity and remains a diagnostic challenge to gynaecologist.\(^3\) Case presentation: A 43 year old lady presented to our emergency centre with complaints of excessive vaginal bleeding of 10 days duration.

She gave history of menorrhagia of one year duration along with white discharge per vagina. She is P1L1 with history of caesarean section 4 years back. She had no significant past social history and no known drug allergies and was not on any medication.

On admission, her vitals were within normal limits except for severe pallor. Abdomen and local examination was normal. Per speculum examination revealed a circumscribed mass of 8-10 cm, beefy red colour bleeding on touch and extending upto mid vagina. Cervix could not be visualised. On pelvic examination uterus could not be made out and cervix not palpated. Differential diagnosis of uterine fibroid, sarcoma, endometrial polyp, uterine inversion was made. Ultrasound revealed fibroid in lower uterine segment.

Patient was started on broad spectrum antibiotics. Three units of cross matched PRBC transfused in view of 4gm % haemoglobin. Patient was counselled and abdominal hysterectomy planned as patient had completed family. Per operative view of uterine inversion shown in Fig 1. Bilateral ovarian ligaments, ovary, fallopian tubes and round ligament were drawn into the fundus to approximately 4cm depth. Constriction ring was too tight. We tried Huntngtons method but failed so we proceeded to haultains procedure followed by abdominal hysterectomy. Both ureters identified. Patient had uneventful post
operative recovery and discharged on postoperative day 7. The histopathology report revealed leiomyoma.

**Fig 1: inverted fundus along with round ligaments and fallopian tubes seen.**

**DISCUSSION**

Non puerperal uterine inversion is usually caused by traction force of tumour situated at site of fundus though such association may not be present always.\(^3\) Contributing factors proposed for uterine inversion include 1. Sudden emptying of uterus which was previously distended by a tumour.2. thinning of the uterine walls due to an intrauterine tumour. 3. Dilatation of cervix.\(^4\)

Chronic inversion is generally due to benign myomas but rarely can be associated with malignancy such as leiomyosarcoma, endometrial carcinoma, rhabdomyosarcoma, malignant mixed mullerian tumour or endometrial stromal sarcoma.\(^1\) The prominent symptoms are chronic vaginal discharge which is foul smelling, irregular uterine bleeding, pelvic pain and discomfort and anemia.\(^2\) The reposition of non puerperal inversion can be achieved through vaginal route by incising the constriction ring either anteriorly (Spinelli procedure) or posteriorly (Kustner procedure). Same achieved in abdominal route by Hautains procedure.\(^1,3,5\) We preferred abdominal route as it was complete inversion so visualisation of adjacent structures like ureter would be better and haemorrhage efficiently controlled. Generally complete inversion will more likely to lead to hysterectomy.\(^2\)

Informed consent taken.

**Conflict of interest:** nil.

**ACKNOWLEDGEMENTS**
we acknowledge the support of Professor and HOD Dr. K R Bhat in preparation of this report.

REFERENCES