Inevitable Cesarean Myomectomy Following Delivery Through Posterior Hysterotomy in a Case of Uterine Torsion

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Background: Torsion of the pregnant uterus at term is a very infrequent obstetric event. It is usually associated with the presence of myoma or congenital deformities. Maternal prognosis is good after surgical treatment; however, prenatal mortality is high. Case report: We report a case of posterior low transverse hysterectomy in a case of uterine torsion at 38 weeks’ gestation, due to a large myoma. At presentation, her cervix was unfavorable and cardiotocography showed spontaneous deceleration demanding delivery by cesarean section. Following delivery, it was realized that the incision had been made on the posterior wall of the uterus and that the uterus was axially rotated by 180 degrees. The mother recovered uneventfully and both mother and the baby were discharged on the fifth postoperative day. Conclusion: Obstetricians must have uterine torsion in mind when performing a cesarean section in patients with myomas. Key words: uterine torsion, pregnancy, cesarean section, myoma.

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1. INTRODUCTION
Uterine torsion is a rotation of more than 45 degrees of the uterus around its longitudinal axis that occurs at the junction between the cervix and the corpus of the uterus. The extent of the torsion is usually 180 degrees, although it has been described torsion from 60 to 720 degrees (1). It is infrequent in humans, and majority of the available papers are case reports diagnosed as incidental findings during surgical exploration (2, 3). Uterine torsion was first described by an Italian veterinary surgeon in 1662 (3). Most reported reviews are from the veterinary literature, particularly in the cattle (4). The most extensive review was published by Jensen, including 212 reported cases (1). The cause of the uterine torsion during pregnancy is unclear. The earliest reported age for uterine torsion during pregnancy is in the sixth gestational week and the latest in forty third weeks (1). It is associated with the presence of uterine myomas or congenital deformities, abnormal fetal presentations, placenta praevia, pelvic tumors or abnormalities, although there are cases in which none of the predisposing factors were present (2, 3). Clinical diagnosis is difficult, since it is rarely considered and symptoms are either absent or nonspecific (abdominal pain, vaginal bleeding, shock, cervical dystocia, painful uterine contractions, dynamic hypertonia, repeated episodes of pathological CTG patterns, urinary and intestinal symptoms) (1, 6).

The diagnosis is often missed, usually made at laparotomy (2, 3). Maternal prognosis is good after surgical treatment; however, prenatal mortality is high (6).

2. CASE REPORT
A 28-year-old nullipara with a diagnosed uterine myoma was referred to our hospital at 38 weeks’ gestation. Her prenatal course was uncomplicated. On vaginal examination the cervix was closed and 2 centimeters long. Cardiotocography showed decelerations demanding delivery by cesarean section. Following delivery, it was realized that the incision had been made on the posterior wall of the uterus and that the uterus was axially rotated by 180 degrees. Detorsioning was carried out by exteriorizing the myoma and the uterus out of the abdominal cavity. The uterus was closed in two layers with a continuous stitch. A 15 cm intramural myoma on the right fundal region was found. A standard technique for myo-
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