A case of uterine inversion due to submucous leiomyoma in a postpartum patient
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Objective
Uterine leiomyomas are found in approximately 2% of pregnant women; 1 in 10 causes complications during pregnancy. Some of the submucous myomas may be pedunculated and eventually can protrude through the cervical canal and into the vagina and later becomes necrotic and sometimes infected. Uterine inversion is a rare complication of the postpartum period and an extremely rare event in non-pregnant women.

Methods
We describe a case of puerperal uterine inversion due to submucous leiomyoma that was originating from fundus.

Results
A 38-year-old multiparous woman, who delivered by vaginal delivery two weeks earlier, arrived at our outpatient clinic with a complaint of bleeding and profuse malodorous discharge. The patient had a history of asymptomatic uterine fibroid, but no systematic follow-up had been performed. On speculum examination, a prolapsed, infected globular mass, measuring 8 x 6 cm, in the vaginal fornix was detected. The cervix could not be visualized. On ultrasound scan, the uterus was found to measure 86×72 mm, and a 62-mm mass; both ovaries appeared normal. Based on these findings, we suspected a myoma protruding into the vagina. Frozen biopsy was performed to exclude malignancy and antibiotics were started due to infected appearance of the mass. We tried to excise the myoma from the vagina. The uterine fundus could not be palpated; consequently, pelvic ultrasonography showed that a depressed fundic area that made us strongly consider the possibility of uterine inversion and further confirmed at surgery. We attempted to pull up the round ligaments, as classically described by Huntington with pressure exerted from the vagina, but were unable to do so, as the constricting ring was too tight. Subsequently total abdominal hysterectomy was performed. The pathology report confirmed uterine inversion resulting from a 65-mm leiomyoma attached to the uterine fundi.

Conclusion
The main clinical symptoms of uterine inversion are abnormal vaginal bleeding, lower abdominal pain and vaginal pressure. The pathophysiology of uterine inversion appears to be multifactorial, seemingly involving 3 main etiologic factors; sudden emptying of the tumor, thinning of the uterine walls by the intrauterine tumor, and dilatation of the cervix. Vaginal myomectomy is recommended as the initial treatment of choice for a prolapsed, pedunculated submucous myoma except when other indications necessitate an abdominal approach. In our case a prolapsed, infected, pedunculated fundal myoma was detected at postpartum period.