

An Unlikely Twist

SFH & Spontaneous Uterine Torsion

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CASE PRESENTATION

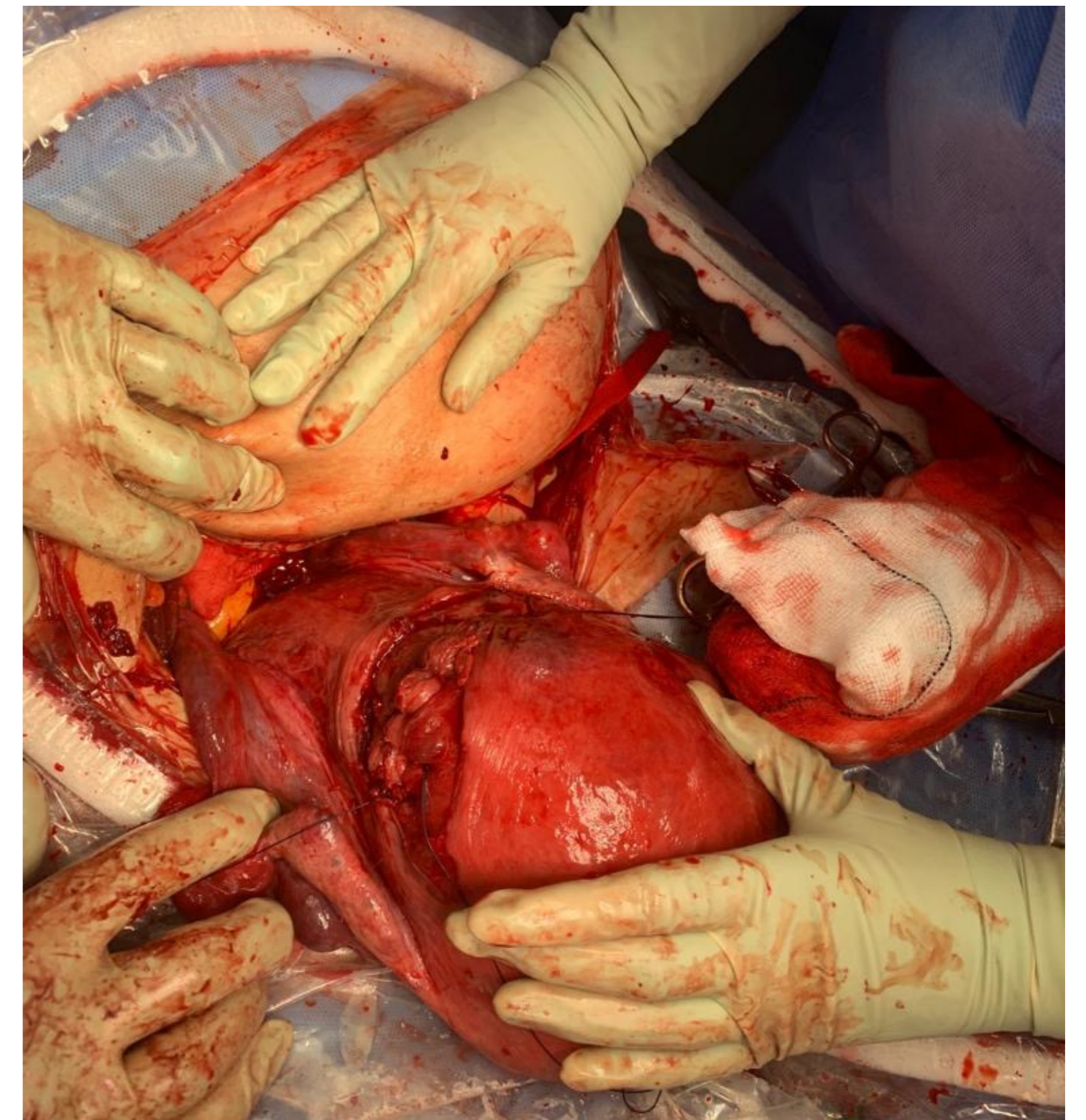
31-year-old G3 P1 (previous EMCS) of 30+2 weeks gestation was brought in by ambulance to labour ward triage in a busy district general hospital (DGH). She complained of:

- Collapse
- Vomiting
- **Severe groin pain**
- Reduced fetal movements

Symphysis-fundal height 42cm despite being 30cm a week prior

Observations: BP 90/60, HR 88, RR 20, T 36.6, Sats 99%.

CTG: bradycardia → emergency caesarean section



Findings at EMCS

- Dusky purple and oedematous uterus
- Difficulty reflecting the visceral peritoneum
- Uterus exteriorised: round ligaments criss-crossed
- The uterus had in fact spontaneously torqued 180° and the baby was delivered through the posterior wall

<https://youtu.be/LVKH9XFBwIM>

Maternal & Fetal Outcomes

- No increased maternal morbidity or mortality; EBL 400ml and the mother made a good recovery
- Baby stabilised in SCBU & shortly discharged.
- Mother debriefed & advised she see an obstetrician in her next pregnancy and deliver by ELCS.

Spontaneous Uterine Torsion Literature Review

- Uterine torsion is defined as rotation $>45^\circ$ around the long axis of the uterus.
- Paucity of information: only a **handful of case reports** siting spontaneous uterine torsion.
- It is not possible to clarify why uterine torsion occurs, but numerous abnormalities have appeared with uterine torsion; most often, abnormal fetal presentation, presence of fibroids and uterine malformations.
- When sited these cases typically carry a **high perinatal mortality** (up to 12% for fetus)¹, high rate of **caesarean hysterectomy**²⁻³ and associated major haemorrhage and increased maternal mortality.

Case Analysis

In uterine torsion venous blood is unable to leave the organ causing engorgement of the uterine muscle and the 'congested' appearance at EMCS.

This also explains the sudden and disproportionate rise in SFH.

The history of collapse, groin pain and RFM could be a sensitive indicator for spontaneous uterine torsion.

A sudden increase in SFH far beyond what's expected for gestation could be a specific sign of this rare occurrence

References

1. Jensen JG, "Uterine torsion in pregnancy", Acta Obstet Gynecol Scand, 1992 May;71(4):260-5.
2. Picone O, Fubini A, Doumerc S, Frydman R., "Caesarean delivery by posterior hysterotomy due to torsion of the pregnant uterus." Obstet Gynecol. 2006 Feb;107(2 Pt 2):533-5.
3. Ahmed FU, Ambreen A, Zubair S, Kiran N, "Torsion of a Term Uterus" J Coll Physicians Surg Pak. 2016 Jun;26(6 Suppl):S50-1.