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All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

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Uterine inversion is a rare, but potentially life-threatening, obstetric emergency where the uterus collapses in on itself to varying degrees:\[1\]

- **incomplete** – the fundus reaches the cervix
- **complete** – the fundus passes through the cervix, but does not reach the vaginal opening
- **prolapsed** – the fundus extends through the vaginal opening

There is a further differentiation by timing:

- **acute** – less than 24 hours post delivery
- **subacute** – from 24 hours to 4 weeks
- **chronic** – beyond 4 weeks

Although there are no definitive causes, a common factor is an over-aggressive management of the third stage of labour, which includes excessive fundal massage and cord traction prior to placental separation. The principle pre-hospital management is aimed at supportive care, treatment for shock and rapid transport to an appropriate facility.

### Clinical features

- The most common presentation is postpartum haemorrhage.
- Visual examination may reveal a mass at the vulva, but this is only in a prolapsed uterine inversion.
- Evidence of shock is common.\[2\]
- Severe abdominal/pelvic pain occurs due to excessive traction on the broad ligament and ovarian ligaments.

### Risk assessment

- These patients are at high risk for infection. Therefore, use an aseptic technique and always take appropriate infection control measures.
CPG: Clinician safety
CPG: Standard cares

Is there a postpartum haemorrhage?

Consider:
- IV fluid
- Analgesia

Transport to hospital
Pre-notify as appropriate

Consider:
- Analgesia
- Assist patient to attain position of comfort
- Protect any exposed uterus with moist sterile dressing

Note: Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.