Clinical Practice Guidelines:
Obstetrics/Uterine inversion

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Clinical.Guidelines@ambulance.qld.gov.au

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<th>Date</th>
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<td>Purpose</td>
<td>To ensure consistent management of Uterine inversion.</td>
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<td>Scope</td>
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<tr>
<td>Author</td>
<td>Clinical Quality &amp; Patient Safety Unit, QAS</td>
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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.
Is there a postpartum haemorrhage?

**Y**

**Consider:**
- IV fluid
- Analgesia

**N**

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

**Note:** Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.

**Transport to hospital**

**Pre-notify as appropriate**

CPG: Paramedic Safety
CPG: Standard Cares