

## Chronic Inversion of Uterus with Submucous Fibroid Polyp Presenting in a Postmenopausal Woman

Ranu Rekha Mirdha\*, Pulak Kumar Roy

**Background:** Chronic uterine inversion is an exceptionally rare gynecological condition, often misdiagnosed due to its nonspecific presentation. Unlike the acute puerperal form, chronic non-puerperal inversion typically results from underlying uterine pathology and poses unique diagnostic and surgical challenges. **Case Presentation:** We report the case of a 64-year-old postmenopausal woman presenting with chronic pelvic discomfort, vaginal bulging, and abnormal bleeding. Physical examination revealed a large vaginal mass with associated polypoid tissue. Ultrasound imaging confirmed uterine inversion, characterized by the typical "bowl-shaped" uterine contour. Surgical management was undertaken via an abdominal approach. Intraoperative findings revealed complete uterine inversion with fundal involvement of both round ligaments and adnexa. A Haultain-like approach was employed to restore anatomy, followed by hysterectomy due to the patient's age and uterine pathology. Histopathology revealed a submucosal fundal fibroid polyp with chronic endometritis. The patient had an uneventful recovery and remained symptom-free at six weeks postoperatively.

**Conclusion:** This case underscores the importance of considering chronic uterine inversion in the differential diagnosis of pelvic organ prolapse, particularly in postmenopausal women with a history of unmonitored vaginal deliveries. Prompt diagnosis via imaging and tailored surgical intervention are critical for optimal outcomes. Hysterectomy remains a definitive treatment in postmenopausal cases with underlying uterine pathology.

### Introduction

Uterine inversion is when the uterine fundus descends to or through the cervix to turn the uterus inside out. It is typically an acute event occurring during delivery, often due to factors such as uterine atony or excessive traction on the umbilical cord. However, chronic uterine inversion, where the uterus remains inverted for an extended period, is very rare, representing about one-sixth of all inversions, and is often overlooked or associated with uterine pathology such as endometrial polyp, leiomyosarcoma, rhabdomyosarcoma and endometrial carcinoma. Chronic uterine inversion can present with symptoms such as abnormal vaginal bleeding, pelvic pain, and a sensation of vaginal bulging, but it is often confused with other causes of pelvic organ prolapse.<sup>1</sup> This case report discusses the diagnostic challenges and surgical management of chronic non-puerperal uterine inversion in a 64-year-old woman.

### Clinical Presentation

A 64-year-old woman presented to the gynecology clinic with complaints of chronic pelvic discomfort, vaginal bulging, and irregular vaginal bleeding over the past year. The patient described a sensation of something protruding from her vaginal opening, particularly after prolonged squatting. She also reported mild urinary frequency and occasional pelvic pressure. Her medical history included hypertension (well-controlled with medication). The patient had delivered four children vaginally, with the most recent delivery occurring 38 years ago. All four were home deliveries. She did not receive postpartum follow-up care, and no further gynecological issues were noted for many years. The patient had been postmenopausal for 14 years and had not used hormone replacement therapy. On general examination, she was pale. Her respiratory and cardiovascular systems were normal. On per abdominal examination, the abdomen was soft and nontender. On local examination, a mass of approx 10 x 9 x 8 cm was

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Department of Obstetrics & Gynecology, R. D. Gardi Medical College, Ujjain, Madhya Pradesh, India

**Correspondence to:** Ranu Rekha Mirdha, Department of Obstetrics & Gynecology, R. D. Gardi Medical College, Ujjain, Madhya Pradesh, India. E-mail: dr.rrmirdha@gmail.com

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seen outside the vaginal introitus with a polyp of size 4 x 3 cm (Fig 1). The mass appeared oedematous, congested, and red. On per vaginal examination, the mass was firm in consistency with a smooth outline. The cervical rim was not able to feel very high up. Bilateral fornices free. Fundal dimple was felt, and tenderness was felt. The provisional diagnosis was a chronic uterine inversion. The ultrasound examination revealed an inverted uterus, displaying a typical "bowl-shaped" appearance. The uterine area appeared slightly distended with minimal fluid collection, which may have been retained blood or tissue. There were no adnexal masses or other notable abnormalities. Routine blood investigation showed mild anemia (hemoglobin 9.4 g/dL), likely due to chronic blood loss. Coagulation tests were within normal limits, and renal and liver function tests were unremarkable. The patient was diagnosed with chronic uterine inversion, likely resulting from incomplete reduction of the uterine inversion after delivery. The condition had remained undiagnosed for decades, but chronic symptoms had developed in her postmenopausal years.

### Management

The management of chronic uterine inversion is typically surgical, and given the patient's postmenopausal status, the decision was made to proceed with an abdominal approach. Dressing of the prolapsed mass was done for 5 days with betadine and glycerine to provide symptom relief. The patient reported some improvement; edema and congestion subsided after the surgical intervention was pursued. Epidural and general anesthesia were used during the surgery. Abdomen opens in layers, finding was a classical mouth of a flower pot appearance. The round ligament had entered the dimple, both ovaries had entered, and the uterine fundus was missing. The inverted uterus could not be made upside down, so surgery became more challenging. An anterior incision was given over the upside-down uterus; through the incision, we could see both the round ligaments, ovarian ligaments and ovaries. Both the round ligament was clamped, cut and ligated. Now the anatomy could be seen. At the same time, the thick posterior cervical rim was divided, and the vaginal portion of the inverted uterus was dragged up from the vagina (Fig 2). Then the hysterectomy of the pulled-up inverted uterus with fundal fibroid was completed. The surgery lasted approximately 80 minutes, and blood loss was minimal. The patient recovered well postoperatively and was discharged on day 10. According to her histology report, she had uterine inversion and a fundal submucosal

fibroid polyp with chronic endometritis. She was prescribed iron supplements to address the mild anemia and was instructed on pelvic floor exercises. At the 6-week follow-up, the patient remained symptom-free and reported a significant improvement in her quality of life.

### Discussion

Uterine inversion refers to the descent of the uterine fundus to or through the cervix, turning the uterus inside out.<sup>2</sup> Chronic uterine inversion is an unusual condition that can present with nonspecific symptoms such as pelvic discomfort, vaginal bulging, and abnormal bleeding. Uterine leiomyoma at the fundus of the uterus, which exerts a traction force to cause the inversion in 78.8 to 85% of cases and was the most common cause.<sup>3</sup> Chronic uterine inversion is often misdiagnosed as pelvic organ prolapse. Early diagnosis is essential to prevent long-term complications such as uterine necrosis, infection, or bleeding. The diagnosis is confirmed through clinical examination, ultrasound, and MRI. Imaging is crucial in assessing the extent of the inversion, bladder, and ureteric involvement and ruling out other pelvic pathologies. In chronic uterine inversions, surgery is imperative. Chronic non-puerperal uterine inversion has been treated using a variety of surgical techniques. While Kustner and Spinelli's procedures are frequently utilized vaginal techniques, Huntington and Haultain are often employed abdominal approaches. Huntington's technique involves identifying the uterine cup that results from inversion, digital widening of the cervical ring, and mild upward pressure of the uterine round ligaments.<sup>4</sup> A vertical incision is created in the posterior cervical rim, and the round ligaments are gently pulled during the Haultain treatment. The Haultain procedure uses a vertical incision in the posterior portion of the cervical rim and gentle traction on the round ligaments. In this case, she was in the post-menopausal period, and uterine endometrial surface laceration and redundant uterine tissue made us select hysterectomy. After repositioning the uterus into the abdomen, an abdominal hysterectomy was performed, avoiding injury to precious organs like the ureter, bladder, and uterine artery, which depicts the skill of the surgical team. She was discharged on the 10th post-operative day after a smooth post-operative period.

### Conclusion

Chronic uterine inversion is an extremely rare and often challenging condition that can cause significant morbidity if not addressed. This case highlights the

importance of considering uterine inversion in the differential diagnosis for postmenopausal women with chronic pelvic symptoms, particularly those with a history of complicated deliveries. Diagnosis is made through clinical examination and imaging, and surgical management provides effective and long-term resolution of symptoms.

### Ethical Approval

The study was approved by Institutional Ethical Committee.

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