Uterine inversion

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Airway: maintain as level of consciousness requires

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Breathing: 100% oxygen by face mask and/or bag-valve-mask as required

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Circulation: shock is usually severe 2 IV lines (14-18G)

If IV not possible, then try external jugular or central vein or long saphenous vein. Take blood for FBC, clotting and cross match 4-6 units

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If shocked: Give 1 litre 0.9% **saline** as rapidly as possible whilst awaiting **blood**

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Give **atropine** 600 mcg IV if heart rate < 60/minute

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Establish monitoring of pulse, BP, respiratory rate, SaO_2, urine output

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Establish adequate **analgesia** and call for senior help (if available)

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Attempt manual replacement as soon as possible
Gently push the fundus back through the cervix before attempting to separate off the placenta

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Successful?

- YES → Once reduced, maintain hand in uterine cavity until a firm contraction occurs, and IV oxytocin is being given (40 iu in 500mls 0.9% saline over 4 hours). Then remove the placenta and explore the cavity gently for trauma
- NO → **Hydrostatic replacement**
  2 litres warmed 0.9% saline run in under gravity from a height of 2 metres into the posterior fornix using 2 wide bore tubes using clenched fist to maintain a seal at the introitus. A silastic ventouse cup can be used to deliver the fluid and provide a seal. The reduction is usually achieved in 5-10 minutes

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  Successful?

  - YES → Once reduced, maintain hand in uterine cavity… (as above)
  - NO → Fails in less then 3% of cases – then requires a **general anaesthetic**