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CASE STUDY OF OVARIAN TORSION IN PREGNANCY

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ABSTRACT

Torsion of the ovary during pregnancy is an uncommon complication with a high patient morbidity and fetal mortality if not treated immediately. It is a gynecological emergency which affects females of all ages.[1] A 10 year review of 128 patients with adnexal torsion state that 2.7percent emergency surgical cases involve ovarian torsion.[2] We present a case report of ovarian torsion in pregnancy.

KEYWORDS:- Ovarian torsion, Pregnancy.

INTRODUCTION

Torsion of the ovary is the total or partial rotation of the adnexa around it's vascular axis or pedicle. Although the exact etiology is unknown, common predisposing factors include moderate size cyst, free mobility and long pedicle.

Torsion of ovarian tumours occurred predominantly in the reproductive age group and is less common in pre-menarchal girls and post-menopausal women. Majority of cases presented in pregnancy-22.7percent than in non-pregnant women-6.1percent. Commonly found ovarian cysts are dermoid and serous cystadenomas.[3]

Complete torsion leads to venous congestion, hemorrhage and necrosis. The cyst becomes tense and may rupture leading to acute onset abdominal pain which is a common presenting symptom in patients.

Ovarian cysts less than 6cm and appearing benign on ultrasonography are generally treated conservatively as they may undergo spontaneous resolution. Cysts more than 10cm are usually resected due to increased risk of malignancy, rupture or torsion.[4]

The gold standard to treat ovarian torsion is surgery and this is also the only way to confirm ovarian torsion.
2 Surgical methods can be used – laparoscopy and laparotomy.

CASE REPORT

A 25year old female patient having obstetric history as $G_4P_3L_3D_1$ with 6 months pregnancy and USG report suggestive of SLIUP with GA 25-26wks with large ovarian exophytic cyst of 118×97×89mm with possible torsion presented to OPD of Striroga Prasutitantra department of Sane Guruji Arogya Kendra. She complained of severe abdominal pain since 6-7hrs. She described the pain as sharp and non-radiating. The patient was then admitted at Sane Guruji Hospital for further management.

Patient was afebrile and her vitals were stable.
O/E – P- 86/min
BP- 120/70 mmHg
SPO2- 98%

Per Abdominally, uterus was ≈26weeks and relaxed. Fetal heart sounds were around 132/min and regular. Severe tenderness was noted in left lower quadrant with guarding.

On sterile per speculum examination, cervical os was closed and no discharge was noted.

Patient was given analgesics for relief from pain and discomfort. After obtaining informed consent, patient was posted for laparotomy under spinal anesthesia for ovarian torsion. After delivery of ovarian cyst from midline vertical incision, detorsion was performed and then ovarian cystectomy was performed without any complications. Abdomen was then closed layerwise.

Post-operative period was uneventful.

Patient was treated with antibiotics, analgesics and tocolytics in the post-operative period and was discharged in stable condition after 8 days.

Investigations

	Pre-operative	Post-operative
Hb%	10.4	10.1
Tlc	3.89×10^3	7.96×10^3
Platelet count	196×10^3	284×10^3
P.t.	14.4	-
Inr	1.07	-
Bt-ct	1.35-4.20	-

HIV- Negative

HbSAG- Negative

VDRL- Negative

Blood Group- B positive

USG Report

Single live intrauterine fetus with average gestational age 25-26weeks.

There is large cystic lesion measuring 118×97×89mm seen in the left lower abdomen and left lumbar region anterior to the left kidney and retroperitoneal vessels are likely part of edematous left ovary seen along the infero lateral aspect of the cyst. The right adnexa and right ovary are normal. There is high possibility of this being a large left ovarian exophytic cyst with possible torsion, the torsion sequence as minimal vascularity is seen in the visualized small edematous left ovary. No obvious bowel loop dilatation seen.

Follow-UP

The HPE report revealed the sample to be that of endometrial cyst.

The patients further pregnancy was uneventful and she delivered a full term healthy baby by cesarean section.

DISCUSSION

The incidence of adnexal torsion is unknown. Simple cysts may be managed expectantly with serial ultrasound surveillance. However, they may require emergency laparotomy for rupture, torsion or infarction in as many as 50 % cases. Ovarian cyst during pregnancy may be managed conservatively in first trimester. Optimal time for surgical intervention during pregnancy is between 16 and 28 weeks of gestation. Immediate surgical intervention, irrespective of gestational age may be warranted in case of ovarian torsion, ruptured ovarian cyst or suspicion of malignancy.[5]

CONCLUSION

Ovarian Torsion is an urgent gynecological emergency and can occur during pregnancy. Surgical intervention should be considered in development of adnexal torsion regardless of gestational age.

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