

A Case Report On Ovarian Torsion In 35 Years Female

K.M. Jayasree⁽¹⁾, S. Akshaya⁽²⁾, B. Vishnupriya⁽³⁾ S. Nithya Lakshmi⁽⁴⁾

Pharm-D intern, Seven Hills College of Pharmacy, JNTUA.

Pharm-D intern, Seven Hills College of Pharmacy, JNTUA.

Pharm-D intern, Seven Hills College of Pharmacy, JNTUA.

ABSTRACT:

A gynaecological emergency known as ovarian torsion happens when the ovary is twisted or torn around its ligamentous supports. Ovarian torsion due to adnexal mass causes various signs and symptoms on clinical presentation. The common symptom found to be acute onset of lower abdominal pain, accompanied by nausea and vomiting. In between 2% and 15% of patients who undergo surgical therapy for adnexal masses, ovarian torsion develops. An ovarian mass is the greatest danger in ovarian torsion. If untreated, it causes the fallopian tube and ovary to lose blood supply, which leads to infarction and function loss. It can be challenging to detect ovarian torsion in the emergency setting because to the wide differential diagnosis that the presenting symptoms and indications provide. We present a case of ovarian torsion in 35years female patient came with abdominal pain admitted in gynaecology on going examination it was found that right fallopian tube twisted later on acute abdomen evaluation it was diagnosed as RT. OVARIAN TORSION, planned for open oophorectomy and appendectomy.

KEY WORDS: Ovarian Torsion, Abdominal pain, Adnexal mass, Adnexal torsion, Oophorectomy, Appendectomy, Fallopian tube.

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I. INTRODUCTION:

ovarian torsion is a true gynaecological emergency that need quick assessment and treatment. Although ovarian torsion is a rare cause of severe stomach discomfort in women, delaying diagnosis can have fatal consequences. Adnexal torsion occurs when the ovary and frequently the fallopian tube twist around their vascular pedicle⁽¹⁾.

This twisting may be brought on by the adnexa of the ovary can rotate completely or partially along its vascular axis or pedicle. Common risk factors include a moderately sized cyst, free mobility, and a lengthy pedicle, albeit the specific cause is unknown⁽²⁾.

There are fewer instances of an individual torsion involving either the ovary or fallopian tube (one in 1.5 million women), and torsions more frequently affect both. early detection, and to safeguard ovarian and tubal function and prevent severe morbidity, early diagnosis and treatment are crucial. Complete or partial rotation of the adnexal supporting organ with ischemia is referred to be ovarian torsion.⁽³⁾

The cyst becomes tense and may rupture, leading to acute onset abdominal pain, a common presenting symptom in patients. There is a 5-fold increased risk of ovarian torsion during pregnancy, with an incidence of 5 per 10,000 pregnancies⁽⁴⁾.

Age is no barrier to ovarian torsion. Venous return is obstructed by the first twisting. Vascular congestion results from this, and engorgement and edema are the results. Ischemia and infarction are caused by arterial flow becoming compromised as the congestion worsens. Ovarian torsion if untreated can lead to ovarian necrosis, infection, and total ovarian loss. While torsion mostly affects women in their reproductive years, it can also affect children and women who have gone through menopause. Due to the longer utero-ovarian ligament on the right and the existence of the sigmoid colon on the left, it is more frequently observed in the right ovary.⁽¹⁾

Moreover, because of an enlarged corpus luteum during pregnancy, there is an increased risk of torsion. Normal ovaries do experience ovarian torsion. An extended utero-ovarian ligament is assumed to be the cause of the greater risk in paediatric patients with torsion, who are more likely to have a normal ovary.⁽¹⁾

II. CASE REPORT:

A female patient of 35 years was admitted in OBG ward with c/o: Rt side abdominal pain from 10 days with intermittent pain for 7 days and continuous pain for 3 days, h/o fever and vomiting 4 days back. Menstrual H/O: menarche at 15 years of age regular cycles not associated with clots and pain. OBG H/O: marriage at 14 years of age, 2 live children, she had her first female baby when she was at the age of 22 years and second male boy was born at age of 24 years. Surgical h/o: Tubectomised at 24 years of age. Her vitals: B.P:98/70 mm hg, RR-14 cycles/min, Temp: afebrile .CECT SCAN: Right ovary is bulky measuring 5.8*5.7 cm with multiple peripherally arranged follicles and a large central corpus luteal cyst there is extensive adjacent fat stranding and hemoperitoneum in the pouch of Douglas. Minimal residual vascularity is seen in the periphery of the ovary. Right Fallopian tube appears twisted.



Fig:1, showing ovarian torsion through CECT scan

By the above examinations it was diagnosed as acute abdomen evaluation RT. OVARIAN TORSION, planned for open oophorectomy and appendectomy as pre op orders patient was given with IVF-1 RL @75ml/hr, inj. ceftriaxone – stat, inj. Pantoprazole-40mg, inj. Perinorm -10mg, inj. Xylocaine s/c test dose, inj. T.T ½ cc- I.M had given to the patient.



Fig:2, Image of Current patient after surgery

After surgery patient was given with NBM-IVF-2 BIG RL, DNS,5 DEXTROSE, Inj.piptaz-4.5g-1-0-1, Inj. Metrogyl-100ml-1-1-1, Inj.Paracip-1g-sos, Inj.Pantop-40mg,1-0-0 for 5 days, Zonac suppositories -PR-2-2-2(for 2 days), after 5 days started oral antibiotics-Tab.Cefixime-500mg-1-0-1, Tab. metrogyl-100mg -1-1-1, Tab. pantop-40mg-1-0-0.

III. CASE DISCUSSION:

Adnexal torsion is characterised by the abrupt onset of unilateral lower abdomen pain that is frequently described as stabbing in nature and that is frequently accompanied by nausea and vomiting. The groin may also experience pain. It is crucial to keep in mind that 40% of patients will experience progressive pain rather than the sudden onset pain that is commonly related to torsion, and some patients may experience back or flank pain. If the ovary has been torsioning intermittently, some patients will describe numerous episodes of discomfort over the period of hours, days, or even weeks. Your suspicion for torsion should rise if you have a history of ovarian torsion, ovarian cysts, or masses, or if you are currently pregnant. When it does occur, fever is often low-grade ⁽¹⁾.

Any age can experience ovarian torsion, although women between the ages of 20 and 30 have the highest incidence rates. The longer utero-ovarian ligament on the right side is thought to be the reason why about 70% of ovarian torsion develops on this side. Moreover, it is believed that the sigmoid colon's location on the left side limits available space, which also contributes to the occurrence of laterality. This is consistent with the case report, where the right side had full torsion and the left side only had moderate torsion. The most frequent differential diagnosis in ovarian torsion patients is acute appendicitis.

Ovarian torsion typically manifests as sudden, severe pelvic pain in a woman who also has nausea and vomiting with adnexal torsion ⁽⁵⁾.

Diagnostic techniques may include diagnostic laparoscopy, computed tomography, magnetic resonance imaging, endorectal ultrasound, and pelvic ultrasound with colour Doppler. Due to the lack of ionising radiation, pelvic ultrasonography is the modality of choice when torsion is suspected, especially in premenopausal women. Overall diagnosis accuracy is reported to be 79% compared to 42% on CT ⁽⁶⁾.

The most common symptoms are typically intermittent, sudden-onset, non-radiating stomach discomfort that is accompanied by nausea and vomiting. When compared to post-menarche individuals, premenarchal patients are more likely to appear with widespread pain rather than localised discomfort, fever, restlessness, a palpable pelvic mass, a bluish or black ovary during surgery, and symptoms that last longer ⁽⁶⁾.

Torsion or twisting can occur in the uterine adnexa, which is made up of the ovaries, fallopian tubes, and supporting ligaments. Particularly in OT, the ovary twists on its axis, obstructing ovarian arteries and potentially inducing ischemia and necrosis that might result in infertility or even death. ⁽⁷⁾

The major goals of treatment for ovarian cyst torsion are to preserve ovarian function and avoid adverse effects such as bleeding, peritonitis, and adhesion development. Only gelatinous or necrotic tissue is treated with an

oophorectomy. Research have shown that torsion releases have a connection to some patients' ovarian function returning, thus this is being done as soon as possible. ⁽⁸⁾

IV. CONCLUSION:

Ovarian torsion is a medical emergency that needs to be treated quickly with surgical examination in order to protect ovarian function and future fertility. When there is no underlying ovarian pathology, conservative care should be seriously considered. This case study demonstrates how early detection of ovarian torsion and prompt surgical treatment can save and sustain ovarian function. Through this surgery the patient got recovered from ovarian torsion.

V. ACKNOWLEDGMENT:

I express my deep sense of gratitude to OBG staff and HOD for encouraging, for guiding about this disease and also helped me to complete this case report successfully. Their contributions are sincerely appreciated and gratefully acknowledged.

VI. FOOT NOTES:

DECLARATION OF FIGURES AUTHENTICITY:

All figures that here submitted have been taken from the current patient which are original with no duplication and have not been previously publishes in whole or part. With the patient acceptance only these pictures were took and uploaded.

REFERENCES:

- [1]. Ovarian torsion- Lauren Evans, SAEM journal, nov-2019-
- [2]. Recognition of Ovarian Torsion: A Case Report, Lindsay K. Wells, M.D, Proceedings of UCLA Healthcare.
- [3]. A review of ovary torsion ,Ci Huang, Mun-Kun Hong, Tzu Chi Med J. 2017 Jul-Sep; 29(3): 143–147,doi: 10.4103/tcmj.tcmj_55_17
- [4]. Ventolini G, Hunter L, Drollinger D, Hurd WW. Ovarian torsion during pregnancy. http://www.residentandstaff.com/issues/articles/2005-09_04.asp
- [5]. Ovarian torsion in a 22-yearold nulliparous woman, Hsiao-En Cindy Chen & Chris Georgiou, Thursday, May 24th, 2012
- [6]. C. Rey-Bellet Gasser, M. Gehri, J. M. Joseph, and J. Y. Pauchard, "Is it ovarian torsion? A systematic literature review and evaluation of prediction signs," *Pediatric Emergency Care*, vol. 32, no. 4, pp. 256–261, 2016. View at: Publisher Site | Google Scholar
- [7]. A Case Report of Pediatric Ovarian Torsion: The Importance of Diagnostic Laparoscopy
- [8]. Alana Corre^o, BA,* Shebani Dandekar^o doi: 10.5811/cpcem.2020.12.50319, 2021 Feb; 5(1): 109–112.
- [9]. Ovarian Torsion after Hysterectomy: Case Report and Concise Review of the Reported Cases | <https://doi.org/10.1155/2018/6267207>
- [10]. Lee CH, Raman S, Sivanesaratnam V. Torsion of ovarian tumors: a clinicopathological study. *Int J Gynaecol Obstet*. 1989;28:21–25. doi: 10.1016/0020-7292(89)90539-0. [PubMed] [CrossRef] [Google Scholar]
- [11]. Yen CF, Lin SL, Murk W, Wang CJ, Lee CL, Soong YK, Arici A. Risk analysis of torsion and malignancy for adnexal mases during pregnancy. *Fertil Steril*. 2009;91(5):1895–902. doi: 10.1016/j.fertnstert.2008.02.014. [PubMed] [CrossRef] [Google Scholar]
- [12]. Huchon C, Fauconnier A. Adnexal torsion: A literature review. *Eur J Obstet Gynecol Reprod Biol*. 2010;150:8–12. [PubMed] [Google Scholar]