A CASE REPORT: RIGHT OVARIAN TORSION

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Abstract

Torsion of ovary is the total or partial rotation of the adnexa around its vascular axis or pedicle. Ovarian torsion accounts for about 3% of gynaecologic emergencies. A 27 years old female patient was admitted in gynaecology department in a tertiary care hospital with chief complaints of pain in right side of the abdomen which was continuous, severe in intensity and squeezing type associated with vomiting 5-6 episodes since morning of the day of admission. Ultra sound scan of abdomen revealed Right Ovarian Torsion 6x6cm necrotic and twisted. Based on clinical symptoms and Ultra sound scan of abdomen the diagnosis was confirmed as Right Ovarian Torsion. Until two decades ago, the standard approach to twisted adnexa was salpingo-oopherectomy. In recent years minimally invasive laparoscopic surgery has changed the therapeutic management of adnexal masses to such an extent that it can be considered the standard therapeutic option.

Keywords: Right ovarian torsion, Salpingo-oopherectomy, Adnexal masses.

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INTRODUCTION

Torsion of ovary is the total or partial rotation of the adnexa around its vascular axis or pedicle. Ovarian torsion accounts for about 3% of gynecologic emergencies [1]. Torsion is an important complication in ages under aged 30 years and more prevalent in dermoid cysts may cause ovarian necrosis, inflammation, infection and even death in case of delayed treatment [2]. Tumors are responsible for approximately 50-90% of cases of ovarian torsion [3].

The mobility of the left ovary tends to be limited by the sigmoid colon, hence about two thirds of torsions are right sided. Certain anatomical variations and factors have been identified as indicative of risk for ovarian torsion. These include: 1. Developmental abnormalities: an excessively long fallopian tube or absent mesosalpinx may predispose to torsion 2. Ovarian masses 3. Pregnancy 4. Assisted conception 5. Previous pelvic surgery. Typical clinical symptoms in ovarian torsion is of the sudden onset of severe, unilateral, lower abdominal pain that worsens intermittently. About a quarter of patients report bilateral lower quadrant pain. Nausea and vomiting are seen in about 70 per cent of cases [4,5]. A positive whirlpool sign in the twisted vascular pedicle of the ovary can be detected using color Doppler sonography. This is considered the most definitive sign of ovarian torsion [6].

Imaging diagnosis is mostly performed by two dimensional ultrasonography in gray scale or associated color Doppler. Until two decades ago, the standard approach to twisted adnexa was salpingo-oophorectomy. In recent years minimally invasive laparoscopic surgery has changed the therapeutic management of adnexal masses to such an extent that it can be considered the standard therapeutic option [7].

CASE PRESENTATION

A 27 years old female patient was admitted in Gynecology Department in a tertiary care hospital with chief complaints of pain in right side of the abdomen which was continuous, severe in intensity and squeezing type associated with vomiting 5-6 episodes since morning of the day of admission.

Patient menstrual history was normal with 3-5/30 days of normal blood flow with no clots. Obstetrics history of patient 1st pregnancy at age 23 years delivered female child, 2nd pregnancy at age 24 years delivered female child and 3rd pregnancy at age of 26 delivered male child.
General examination, patient was conscious and coherent with mild pallor. P/V- uterus-normal, forniceal tenderness+.

**Laboratory Investigation:** Laboratory investigations revealed decrease in hemoglobin i.e. 9.5gm% (13 – 16gm %), Serum electrolytes, Renal and Liver function tests were found to be normal.

**Differential diagnosis:** Ultra sound scan of abdomen revealed Right Ovarian Torsion 6×6cm necrotic and twisted. Based on clinical symptoms and Ultra sound scan of abdomen the diagnosis was confirmed as RIGHT OVARIAN TORSION.

**Treatment:** The patient therapy was started with the following drugs-IVF fluids 1 pint RL and 1pint DNS, Inj. Cefotaxim 1g IV BD, Inj. Metronidazole 100ml IV TID, Inj. Ranitidine 100mg IV BD, Inj. Diclofenac150mg IM BD. After the diagnosis was confirmed based on ultra sound scan of abdomen on day 3 the patient underwent surgery i.e. laparoscopic ovarian cystectomy. 1 unit of blood transfusion was done before surgery as the levels of hemoglobin was low. Same therapy was continued after surgery till day 10 then the patient was discharged with Tab. Multivitamin /OD, Tab. Iron folic acid OD for 1 month.

**DISCUSSION**
Ovarian Torsion is a rare gynecological emergency with a prevalence of 2.5-7.4% in patients undergoing emergency surgery for acute pelvic pain. Ovarian torsion is often diagnosed based on the clinical presentation, including severe, sharp, sudden onset of unilateral lower abdominal pain and tenderness with a palpable later uterine pelvic mass and nausea/vomiting [8]. The advantages of laparoscopy in the diagnosis and treatment of pelvic masses in gynecology are well established. Rousseau et al reported an inverse relationship between the time interval from admission to diagnosis and to performing conservative surgery [9]. Definitive diagnosis of ovarian torsion is usually made during surgical intervention. The management of torsion includes salpingoophorectomy and conservative surgery, including detorsion and cyst aspiration [10]. In this present case report, the patient had continuous, severe and squeezing type of pain associated with vomiting which match to the clinical presentation of ovarian torsion. Ultra sound scan of abdomen showed a necrotic and twisted right ovary with a cyst of 6×6cm size thus confirming it as Right Ovarian Torsion. The main therapy for ovarian torsion is laparoscopy which was performed in this patient successfully along with cystectomy.
CONCLUSION

Ovarian torsion is relatively uncommon in the second trimester of pregnancy. Diagnosis can usually be made on the basis of the characteristic clinical presentation in conjunction with ultrasound evidence of a unilaterally enlarged adnexal mass. The observation of a gray scale abnormality in combination with an abnormal color Doppler flow pattern and the presence of cul-de-sac fluid offers the highest predictive value for the presence of ovarian or adnexal torsion in a patient with acute pelvic pain. Treatment options are limited to surgery, either by laparoscopy or laparotomy, but the former becomes more difficult after second trimester.

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REFERENCES