

Rare Case of Ovarian Preserving Surgery in Unmarried Woman with a Case of U/L Salpingo-oophorectomy and Its Management: Oophoropexy

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ABSTRACT

Ovarian torsion is one of the common gynecological emergency occurring in women during reproductive age. Here, we are presenting a case of 19-year-old unmarried young girl who came with complaints of pain in abdomen associated with vomiting. She had a history of left-sided ovarian torsion for which she underwent laparoscopic left salpingo-oophorectomy. She underwent right-sided oophoropexy for recurrent torsion.

Keywords: Adnexal torsion, Oophoropexy, Ovarian torsion, Salpingo-oophorectomy.

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INTRODUCTION

Ovarian torsion is rotation/twisting of the ovary along its ligamentous supports causing interrupted blood supply and sometimes, ischemia and necrosis. Traditionally, ovarian torsion was managed with salpingo-oophorectomy, mainly because conserving ischemic adnexa was considered a risk factor for thromboembolic sequel. Later, it is known that the risk of embolic events is low and because ischemic adnexa regain follicular activity, recent studies advocate conservative treatment of ovarian torsion in pre-pubertal and young women.¹ Detorsion and oophoropexy is a conservative surgical approach that should be planned in all young women with ovarian torsion. Oophoropexy for ovarian torsion is easy procedure and can be done either by suturing ovary to, plication of ovarian ligament, lateral pelvic wall, or even fixing to the posterior uterine wall.²

CASE DESCRIPTION

A 19-year-old unmarried young girl came with complaints of the lower abdominal pain in the last 1 day, which was progressive in nature, associated with five episodes of vomiting.

No complaints of dysmenorrhea, white discharge per vagina, burning micturition or increased frequency of micturition, or loose stools. The girl attained menarche at the age of 15 years; LMP = 20 days back. The past cycles were regular, lasting for 3–4 days at interval of 30 days, moderate flow, associated with mild pain and no clots.

The patient gives similar history in the past and was told to have left-sided ovarian torsion for which she underwent laparoscopic left salpingo-oophorectomy 3 years back. On examination, her vitals were stable. There is no pallor, pedal edema. The abdominal examination elicited tenderness in right iliac fossa, no ascites, the previous surgical scar+, healthy, no organomegaly.

Ultrasound was done and showed right adnexal well-defined heteroechoic lesion measuring 7.5 cm × 5.7 cm × 5.8 cm with multiple peripherally arranged follicles and central echogenic stroma, peripheral vascularity noted on color Doppler, right ovary was not visualized separately, adjacent broad ligament showed an increased

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vascularity, minimal ascites noted, left ovary was not visualized (postoperative status). The uterus anteverted, normal size, no free fluid in pouch of Douglas (POD) and was diagnosed with right-sided ovarian cyst with torsion. The patient was taken for laparoscopy which showed normal sized uterus, left-side tube and ovary were not visualized (postop status), right side tube and ovarian torsion noted, congested, necrotic with minimal areas of healthy tissue.

Right ovarian detorsion and ovarian plication was done under spinal anesthesia.

Post-surgery scan done on day 3 showed right adnexal well-defined heteroechoic lesion measuring 6.3 cm × 4.4 cm with multiple peripherally arranged follicles and central echogenic stroma, minimal peripheral vascularity present, and central vascularity in the ovary on color Doppler noted.

The patient resumed her normal menstrual cycle after 2 months of the procedure and was followed up for 1 year. The scan was repeated after 6 months which showed healthy right ovary and tube (Figs 1 to 4).

DISCUSSION

Adnexal torsion is a common condition among gynecological emergencies. The rate of recurrence in postmenarchal women is high mainly due to hyper-mobile or elongated ovarian ligaments,

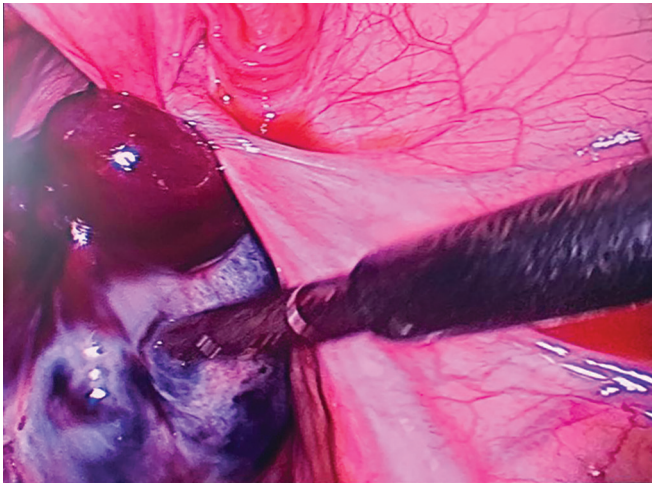


Fig. 1: Detorsion done and reduction in the amount of congestion noted

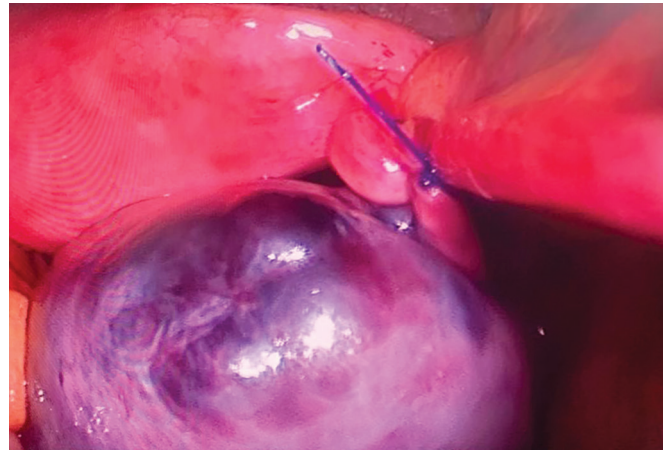


Fig. 4: Post-detorsion, there is reduction in the congestion and regaining of blood supply

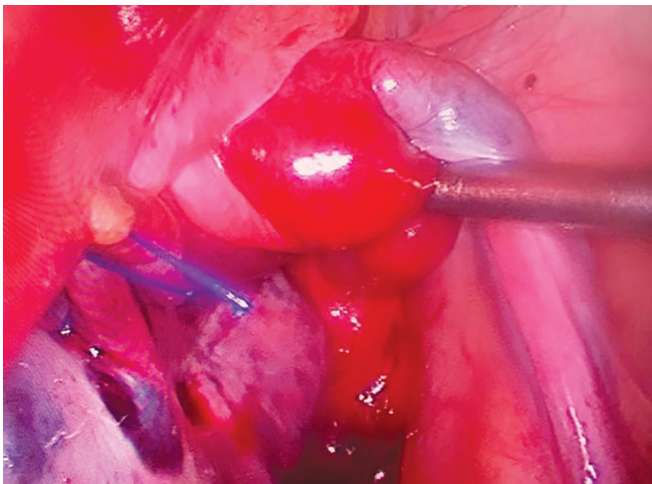


Fig. 2: The ovary was plicated to obliterated umbilical vein using vicryl 1

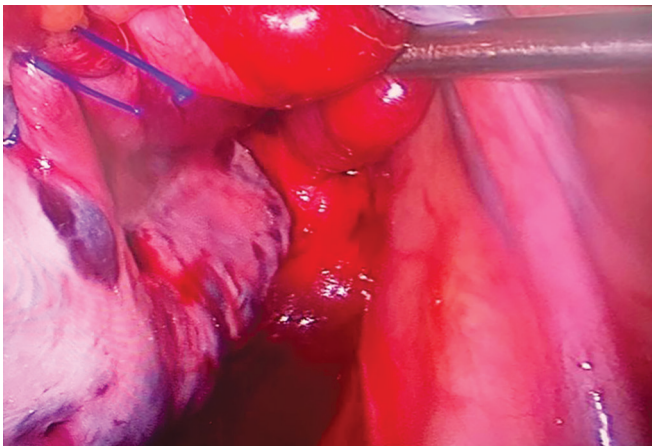


Fig. 3: There is reduced edema and congestion

or loose infundibulopelvic ligament. The ovarian torsion occurs when the ovary rotates around the infundibulopelvic ligament and the ovarian ligament interfering with its blood supply,

partially or completely.² Signs and symptoms of ovarian torsion are often similar to those seen with acute appendicitis; therefore, ovarian torsion is often misdiagnosed.³ The most common clinical symptom being acute abdominal pain that is intermittent, and associated with nausea and vomiting. If the ovarian torsion is suspected, timely intervention with diagnostic laparoscopy is indicated to preserve ovarian function and future fertility.⁴ The signs of torsion are fever, tachycardia, diffuse abdominal tenderness, localized guarding, vaginal examination showing adnexal tenderness, and mass.

The ultrasound feature describes the affected ovary as a solid mass with hypo- and hyperechoic areas with hemorrhage and necrosis. The twisted pedicle may be seen as a “whirlpool” on color Doppler.

The surgical management of adnexal torsion is determined by many factors, including the macroscopic appearance of the adnexa, age, menopausal status, presence of preexisting ovarian pathology and desire to preserve fertility. Oophorectomy should be done only if unavoidable, such as in case of severe necrosis; otherwise, oophoropexy should be considered.⁴

In the case in this report, the left ovary had already been removed previously because of ovarian torsion. Intraoperatively detorsion of the right-sided ovary was done and it was fixed to obliterated umbilical vein. This method was chosen as it is easier to perform and the area is relatively avascular and there are no important structures in this area.

CONCLUSION

Adnexal torsion is the fifth most common gynecologic emergency. A total of 30% among all cases are commonly seen in girls below 20 years of age, with girls above 10 years at high-risk due to the hormonal influences and ovarian growth resulting in an increased incidence of physiological and pathological masses.⁴

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