

A CASE REPORT OF OVARIAN TORSION**¹*Bharati Nilkanth Zunjarrao and ²Dr. Manda Sanjog Ghorpade**¹P.G Scholar, ²H.O.D and GuideDepartment of Strirog Prasutitantra, MAM'S Sumatibhai Shah Ayurvedic Mahavidyalaya,
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Corresponding Author*Bharati Nilkanth
Zunjarrao**P.G Scholar, Department of
Strirog Prasutitantra,
MAM'S Sumatibhai Shah
Ayurvedic Mahavidyalaya,
Hadapsar, M.U.H.S, Pune,
Maharashtra.**ABSTRACT**

Ovarian torsion is rare but emergency condition in women. Early diagnosis is necessary to preserve the function of ovaries, fallopian tubes and to prevent severe morbidity. Ovarian torsion also termed as adnexal torsion, refers to partial or complete rotation of the ovary and portion of fallopian tube along with its supplying vascular pedicle. It can affects female of all ages, but occurs more commonly in reproductive age group; more on the right side I.e. 60% and often present with acute lower abdominal pain lasting for few hours upto 24 hours followed by nausea and vomiting. It is acute gynecological devastating condition, hampering blood supply of ovary, which may leads to total necrosis of ovarian tissue and complications. Pelvic usg can provide information of ovarian cyst, once ovarian torsion suspected; surgery is the mainstay of treatment. hence, we present a

case on twisted right ovarian cyst with symptomatology leading diagnosis and loss of ovary with fallopian tube of right side.

KEYWORDS: Ovarian torsion, Surgical management.**INTRODUCTION**

Ovarian torsion which affects females of all ages is an gynecological emergency. Ovarian torsion termed as adnexal torsion refers to partial or complete rotation of the ovary and portion of fallopian tubes with pedicle vascular supply.

It occurs commonly in reproductive age group occurs in both side of ovary and fallopian tube but more occur in right side 60%. Torsion involving paratubal or paraovarian cyst also been

found early diagnosis and surgery are essential to protect ovarian and tubal function and to prevent severe morbidity.

INCIDENCE

Ovarian torsion occurs for about 3% of gynecological emergency. The incidence of ovarian torsion among women's of all ages is 5.9 per 100,000 women, and the incidence among women of reproductive age 15-45 years is 9.9 per 100,000 women. In 70% cases, it is diagnosed in women between 20 and 39 years of age. The incidence of ovarian torsion is about 2% to 5% in patient who has surgical treatment of adnexal masses. Ovarian tumor larger than 5cm carry risk of ovarian torsion, about 10% to 22% of ovarian torsion occurs in pregnant women.

PATHOPHYSIOLOGY

Predisposing factors for ovarian torsion:

- 1) Trauma.
- 2) Violent physical movement.
- 3) Contraction of pregnant uterus.
- 4) Intestinal peristalsis, these are probably initiate axial rotation.

Torsion of ovary occurs with torsion of fallopian tube as well as there vascular pedicle around broad ligament, although rare case the ovary rotates around meso-ovarian, or fallopian tube around mesosalpinx.80% torsion happens to unilaterally with predominance's on right side. In ovarian torsion ovary rotates around both infundibulopelvic ligament and utero-ovarian ligament.

Precipitating factors are slight rotation of the pedicle—venous occlusion and partial arterial compressions—intermittent forcible arterial pulsations— aggravating axial rotation until it become complete the rotation occurs towards midline, torsion leads to ischemia and tissue necrosis.

Fate: The partial rotation may often untwisted spontaneously but if complete rotation, there is obstruction of both the veins and arteries. As the result, there is intense venous congestion with extravasation of blood inside the cyst, the cyst become tensed and may ruptured, intestine may adhere to gangrenous cyst, which may be infected, organisms derived from gut

or from uterine tube, tumor may be nourished from other abdominal structure to which it is adhered.

RISK FACTORS

- 1) Ovarian enlargement, ovarian masses.
- 2) Ovarian tumors in pregnancy.
- 3) Ovulation induction for infertility treatment.
- 4) Prior tubal ligation.

CLINICAL REPRESENTATION

- 1) Torsion of ovary due to ovarian mass, cyst causes various signs and symptoms.
- 2) Most common symptom is acute onset of lower abdominal pain followed by nausea and vomiting.
- 3) Some patients experience waves of nausea with or without vomiting.
- 4) The abdominal pain usually comes on and off with sudden onset.
- 5) Ovarian torsion without infective disease resulting in low grade fever.
- 6) The lump may be present before or manifested with pain.

DIAGNOSIS

- 1) Medical history and physical examination. The medical history should include any recent adnexal mass, recurrent abdominal pain and low grade fever.

- 2) Physical examination

Abdominal examination reveals tender, tense cystic mass with restricted mobility situated in the hypogastrium and arising from the pelvis. Pelvic examination reveals the mass felt per abdomen is separate from the uterus.

Movement of mass per abdomen fails to move the cervix.

The lower pole of cyst can be felt through fornix.

- 3) Laboratory investigation

Sr ca125

Beta hcg, reveals pregnancy or an ovarian germ cell tumor.

CBC and electrolyte panel.

- 4) Imaging studies: It can identify the uterus and tumor in the same scan. USG can easily distinguish an ovarian mass by its components, location and density, Doppler flow and

size. There can be decreased and absent Doppler flow in the vessels of torsed ovary, Doppler flow has highly sensitive and high specificity in diagnosis of ovarian torsion.

- 5) MRI: It is expensive but helpful in diagnosis of ovarian torsion demonstrated the components of mass in more detail than usg and also helpful to determine whether the cyst is likely to be benign or malignant.
- 6) CT: It is not typically used in ovarian torsion.

MANAGEMENT

The standard treatment for ovarian torsion is surgery only way to confirm the torsion.

2 surgical method : 1) laparotomy

2) laparoscopic

In young patient desirous of fertility:

Ovarian cystectomy- Leaving behind the ovarian tissue is operative of choice.

Salphingoophrectomy-A big tumor that has destroyed almost all the ovarian tissue or for a gangrenous cyst.

If both the ovaries are involved, ovarian cystectomy should be done.

In parous women with age > 40 years :

Total hysterectomy with bilateral salphingoophrectomy is to be done

A laparoscopic approach has become popular procedure if CA ovary. During surgery it is necessary to assess ovarian viability and way to determine is gross visual inspection, dark and enlarged ovaries may have vascular and lymphatic congestion seen non viable. The recurrence can be prevented by oral contraception and oophropexy according to recent research is to be done.

CASE REPORT

A 25 years old female patient with amenorrhea since 2 months having irregular menstrual cycle since 1 year with UPT negative was came at sgak opd 12 with the complaints of severe pain in right iliac region since morning had the mild pain in abdomen since 4-5 days with nausea and also complaining of 3-4 episode vomiting since morning. She was treated at another private hospital for 2 days where she was managed conservatively and adviced USG (abdomen+pelvis) however she didn't have relief, on admission the patient was conscious and well oriented. She was afebrile, her pulse rate was 84 per minute and blood pressure was 110/60 mm of hg, respectively on examination per abdomen there was tenderness in right

iliac region. Per vaginal examination shows cystic mass approximately 4×6cm through right fornix with tenderness, cervical os was closed with the normal uterine size. Usg report suggested normal size uterus with right ovary is significantly bulky in size and shape, thick wall paraovarian cyst of size 58×52mm is seen with minimal free fluid is seen around it mostly right ovarian torsion with right para ovarian cyst. Ovarian tumor marker CA125 was 11.18, beta hcg 9.8g/dl all were within normal range her blood investigations showed Hb% 12.8 gm% wbc 13800/cumm which was slightly raised and platelet count was 3.1 lakh. liver and renal function test were within normal limit. Then decision of emergency operative laparotomy was taken. Intraoperative right sided ovarian torsion of size 5×6cm noted with necrosis of fallopian tube noted, hence right sided cystectomy with salphingoophrectomy was done left sided ovary were checked which were normal. Cyst with ovary and fallopian tube sent for histopathological examination. Upper abdomen and pelvis found normal. Post operative patient was symptomatically relieved. Intravenous antibiotics given for 5 days. Histopathology report was suggested of simple hemorrhagic ovarian cyst.

DISCUSSION

Ovarian torsion occurs because of partial and complete rotation of ovary and tube along its vascular pedicle, hampers blood supply of ovary, occurs mainly in young age women of 15-30 years of age and in post menopausal women. Most common clinical representation is severe lower abdominal pain and pelvic pain along with nausea and vomiting. There symptoms can be intermittent or sustained. The end result of torsion is necrosis of ovarian tissue and hemorrhagic infarction, cyst may rupture leading to peritonitis and sepsis. In most cases of ovarian torsion emergency salphingoophrectomy is done, if not then it may get infected to peritonitis. Mortality is rare. The prognosis of ovarian torsion is good when diagnosed and managed in time. In most of cases delayed in diagnosis leads to necrosis of ovary and fallopian tube and infarction.

CONCLUSION

Although the diagnosis of ovarian torsion is difficult and challenging, careful analysis of presenting symptoms is very critical. Usg (pelvis) can provide information of ovarian cyst, once diagnosis of ovarian torsion has to be done surgery is the mainstay of treatment. Ovarian cystectomy, salphingoophrectomy can be done. The conservative treatment with detorsion can be treated with choice.

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