

TORSION OF OVARIAN CYST DURING PREGNANCY - A CASE REPORT

Babita Vaswani¹, Manisha Laddad²

¹Resident, Department of Obstetrics and Gynaecology, KIMSUDU, Karad.

²Professor, Department of Obstetrics and Gynaecology, KIMSUDU, Karad.

ABSTRACT

BACKGROUND

Ovarian torsion is a rare cause of acute abdominal pain during pregnancy. Torsion usually occurs in ovaries with previously diagnosed cysts and tumours. The risk of ovarian torsion rises by 5 fold during pregnancy. Diagnosis can be difficult. Although diagnostic ultrasound is a frequently used imaging tool in patients with suspected ovarian torsion, it has a poor negative predictive value. A high clinical suspicion and early management correlate with favourable maternal and foetal outcomes. Here, we report successful management of a case of a 31-year-old pregnant lady with 9 weeks of gestation with ovarian torsion. She underwent an emergency laparotomy with left salpingo-oophorectomy without any complications and delivered a healthy baby at term.

KEYWORDS

Ovary, Pregnancy, Torsion.

HOW TO CITE THIS ARTICLE: Vaswani B, Laddad M. Torsion of ovarian cyst during pregnancy - A case report. J. Evolution Med. Dent. Sci. 2016;5(93):6897-6898, DOI: 10.14260/jemds/2016/1559

BACKGROUND

Torsion of ovarian cyst is a rare cause of acute abdominal pain during pregnancy. It is one of the most common gynaecologic surgical emergencies. It results from partial or complete rotation of the ovarian pedicle on its long axis, potentially compromising venous and lymphatic drainage. Torsion usually occurs in ovaries with previously diagnosed cysts and tumours. It is rare for a previously normal ovary to undergo torsion in advanced gestation. Moderate size, free mobility and long axis of pedicle are predisposing factors. The risk of ovarian torsion rises by 5 fold during pregnancy. Incidence is 5 per 10,000 pregnancies.^[1] Patients frequently present with abdominal pain and non-specific symptoms. Diagnosis can be difficult. Missed diagnosis of torsion could lead not only to ovarian necrosis and sepsis, but also detrimental to the pregnancy. We report a case of a 31-year-old gravida 2 with 9 weeks' pregnancy presenting with torsion of ovarian cyst.

CASE

A 31-year-old gravida 2 with 9 weeks of gestational age came to antenatal clinic with pain in abdomen and vomiting since morning. Her LMP: 7/11/14, EDD:14/08/15. Her menstrual cycles were regular. She had a previous LSCS for failure of induction 3 years back. She described the pain as sharp non-radiating type of pain in the left iliac fossa with sudden onset, with no relieving factors. She gave no history of vaginal bleeding or discharge. There was no history of diarrhoea, constipation, fever, urinary complaints or any recent illness. She conceived spontaneously. She had regular antenatal check-ups. No significant past medical and surgical history was noted.

Financial or Other, Competing Interest: None.

Submission 18-10-2016, Peer Review 11-11-2016,

Acceptance 17-11-2016, Published 21-11-2016.

Corresponding Author:

Dr. Babita Vaswani,

Room No. 309, IHR Hostel,

KIMSUDU, Malkapur, Karad-415110,

Satara, Maharashtra.

E-mail: vaswani.babita@gmail.com

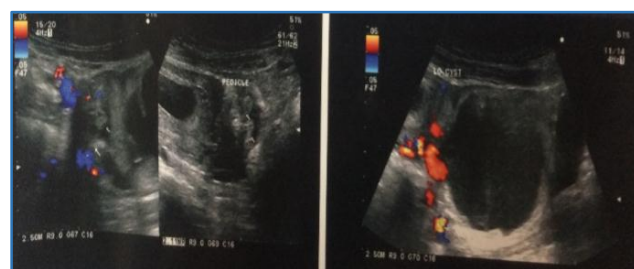
DOI: 10.14260/jemds/2016/1559



On examination, she was moderately built, conscious and oriented. She was vitally stable with no pallor or oedema. Her cardiovascular and respiratory systems were normal. On per abdomen examination, there was minimal tenderness in left iliac fossa, no ascites. On per speculum examination, cervix was healthy and pushed to right side. On per vaginal examination, uterus was 8-10 weeks size, bulky, retroverted, tenderness present. A mass of approximately 8 x 8 cm was felt in anterior and right fornix, soft, cystic in consistency, felt separately from the uterus. Bogginess present in left and posterior fornix.

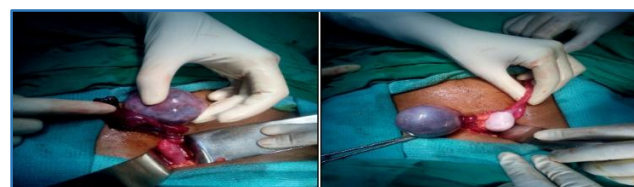
Routine blood and urine reports were within normal limits.

USG report- Uterus shows gestational sac with embryo showing cardiac activity. Left ovary enlarged with large cyst measuring ~8 x 9 cm with echogenic contents within it? haemorrhagic cyst. Twisted ovarian pedicle is seen s/o torsion of ovary.



Patient was Posted for Emergency Laparotomy

Intraoperatively, uterus 8-10 weeks size, anteverted, left-sided ovarian cyst 8 x 8 x 5 cm, left-sided tube and ovary gangrenous, right-sided tube and ovary normal.



Left-sided Salpingo-oophorectomy was done

The patient's post-operative course was uneventful. Progesterone support was given to her. A repeat USG was done which was normal. She was discharged on the 7th post-operative day. Her histopathology report showed haemorrhagic necrosis consistent with torsion of left ovary. Her pregnancy was followed and she delivered a healthy term male child by caesarean section.

DISCUSSION

The incidence of ovarian cyst in pregnancy has increased because of dating ultrasound and an increase in ovulation induction. Most commonly seen are dermoid, corpus luteal cysts and serous cystadenomas.^[2] However, in this case, torsion occurred in a functional ovarian cyst. Ovarian cysts should be differentiated from uterine leiomyoma, non-pregnant horn of bicornuate uterus, appendiceal abscess, diverticular abscess, pelvic kidney retroperitoneal tumour, endometrioma, hydrosalpinx, mesenteric cyst, abdominal pregnancy, metastatic lymphoma and sarcoma. Complications include torsion, rupture, infection, malignancy, impaction of the cyst in the pelvis causing retention of urine, malpresentations and obstructed labour. Cysts less than 6 centimetres in size and appearing benign on ultrasound are generally treated conservatively as they may undergo spontaneous resolution. Cysts more than 10 centimetres in size are usually resected due to increased risk of malignancy, rupture or torsion. Management of cysts between 5 to 10 centimetres is controversial. Ultrasound is the primary investigation used for differentiating benign from malignant lesions based on morphology. If the ovarian cyst is diagnosed in the first trimester, it is better to wait till 16 weeks when the implantation of pregnancy is more secure and also the cyst may disappear spontaneously. Ovarian tumour or cyst can be easily removed till 28 weeks of gestation, thereafter it is not readily accessible.^[3] Presence of complications requires immediate surgery, irrespective of the period of gestation. If the surgery is needed, it is ideal to perform a laparoscopic

ovarian cystectomy at 16-23 weeks of gestation. Laparoscopic ovarian cystectomy has significant advantages over laparotomy.

CONCLUSIONS

The management of ovarian cyst in pregnancy is usually conservative with serial ultrasound monitoring. Although the safety of antepartum surgical intervention has been accepted, abdominal surgery nevertheless carries some risks to a pregnant woman and unborn foetus, and so the choice of management necessitates weighing of risks based on characterisation of the adnexal mass and gestational age. At present, laparoscopy is the most ideal. Laparoscopic adnexal detorsion, not adnexectomy is the procedure of choice unless the tissue is gangrenous. Laparoscopy during pregnancy is associated with a significantly lower prevalence of postoperative complications than laparotomy.^[4] However, in this case, since it was an emergency and laparoscopic facilities were not available in our institute, a laparotomy was performed.

REFERENCES

1. Ramadevi E, Sharada, Padmalatha, et al. Successful management of ovarian cyst torsion during pregnancy: a case report. *Journal of Chalmeda Anandrao Institute of Medical Sciences* 2014;7(1):64-6.
2. Ramadoss R, Abhinaya P, Hameed J, et al. Dilemma in the management of ovarian cyst in pregnancy: a series of three different cases. *IJSS Case Reports and Reviews* 2015;1(8):10-3.
3. Vasavi K, Gurumurthy R, Vellanki V, et al. Torsion of ovarian cyst in pregnancy: a case report. *Cases journal* 2009;2:9405.
4. Ramesh B, Geeta U, Kavitha C. Successful laparoscopic management of adnexal torsion during pregnancy: a case report. *J Obstet Gynecol India* 2010;60(4):337-8.