

TORSIONED UTERO-ADNEXA COMPLEX IN A POSTMENOPAUSAL WOMAN: A CASE REPORT

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ABSTRACT

OBJECTIVE: Uterine and adnexa torsion is a rare occurrence in gynaecological practice . A woman with a non gravid uterus, presenting with abdominal swelling, severe (pelvic) pain and vomiting usually prompts a diagnosis of ovarian torsion. A high index of suspicion of uterine torsion is required in the face of acute pelvic pain in a background of a huge pelvic mass.

CASE REPORT: A postmenopausal woman, presenting with progressive abdominal swelling of 7years and sudden onset severe abdominal pain of 24hours. Clinical and Ultrasound diagnosis were of a suspected bilateral ovarian dermoid cyst. Patient underwent surgery, with findings of a congested/gangrenous uterus with a 540degree rotation at the cervico-uterine junction with congested tortod adnexa. She had a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Histology showed degenerating lipoleiomyoma with extensive uterine gangrene weighing 5500g.

CONCLUSION: This condition, though having non-specific features can be life-threatening because of its risk of ischemia and gangrene, hence early suspicion and prompt surgical intervention can help preserve fertility (in those desirous of future fertility)and offer appropriate treatment to others.

INTRODUCTION

Torsion of a pelvic organ in gynaecological practice is mostly associated with the ovaries, and sometimes pendunculated fibroids. They majorly presents with pain as the main symptoms and this pain is said to be severe, associated with nausea and vomiting and not amenable to analgesics, sometimes this pain can lead to shock.¹ Utero-adnexa torsion though rare presents with similar symptoms and because of these vague symptoms which can been seen with many other acute gynaecological conditions, clinical diagnosis can be challenging.

CASE REPORT

A 51-year old, multi-parous lady, who was 4-years postmenopausal presented to the gynaecology emergency unit with complains of progressive abdominal swelling of 7 years duration and sudden onset acute abdominal pains of 24-hours duration. She had noticed the abdominal swelling but ignored as it was not associated with pain or any other symptoms and attributed it to increasing abdominal fat, however she noticed onset of pain while carrying out her usual daily activities, described as sharp, severe, worsens with movement, associated with nausea and vomiting and radiates to her shoulders.

CLINICAL FINDING

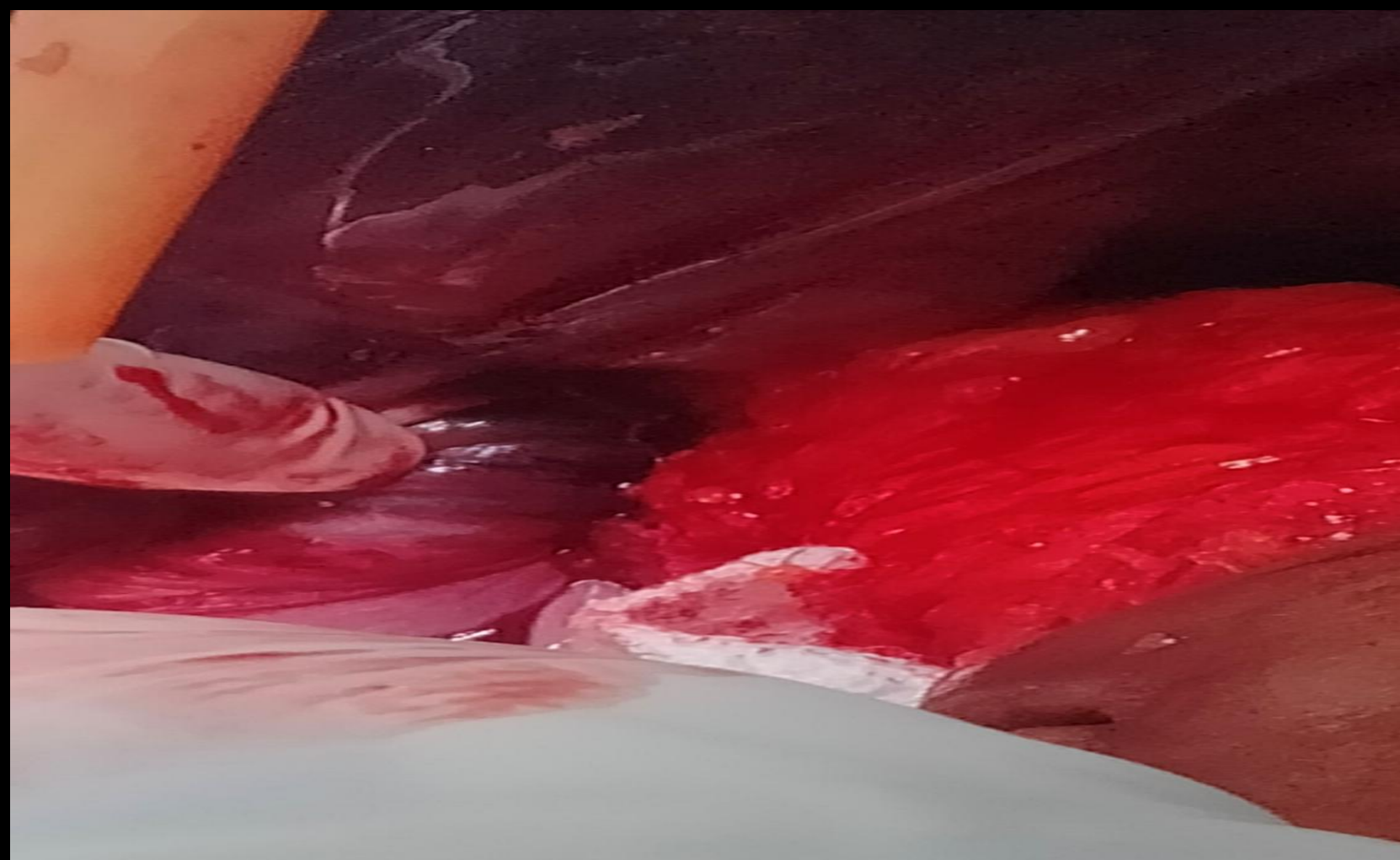
She presented to the facility as pain was not amenable to her over the counter analgesics. She had no known medical condition and no previous surgery. At presentation, she was in painful distress and despite intravenous analgesics she had no relief for her symptoms. She was not pale and her vital signs showed tachycardia and elevated blood pressure of 150/100mmHg. Her abdomen was enlarged, moves with respiration, soft but with deep tenderness and contain an abdomino-pelvic mass about 28weeks size, smooth, firm, with marked tenderness on mobility of the mass. There was no clinically demonstratable ascites. There was adnexa fullness and marked tenderness on bimanual examination.

DIAGNOSTIC SUSPISCION AND WORK UP:

A clinical suspicion of a benign ovarian mass ?rupture was made and basic haematological and other blood workups were essentially normal. An abdomino-pelvic ultrasound scan was performed and showed bilateral huge cystic adnexa mass with diffused echogenicity obscuring deep structure, no internal vascularity and no ascites; findings suggestive of bilateral ovarian dermoid cyst. Other investigative modalities that would have been employed such as CT-scan and MRI were not available

INTERVENTION:

While blood was sent for ovarian tumour markers, a decision for immediate surgical exploration was made as pains were severe and not abating with analgesics and a possibility of torsioned ovarian mass or ruptured was entertained with persisting pain. At surgery, there was a huge uterus, smooth but ‘darkish’ with bilaterally gangrenous tortod ovaries. The uterus was torsed around itself at the cervico-uterine junction making a 540dregree dextro-rotation. There was no ascites nor haemoperitoneum. She has a total abdominal hysterectomy and bilateral salpingo-oophorectomy haven previously consented for this procedure prior to surgery.



Gloved finger pointed at 540 degree



After complete detorsion of the uterus with gangrenous adnexa

OUTCOME

Histological examination of the tissue showed a uterus weighing 5500g with degenerative lipoleiomyoma and extensive ovarian and uterine gangrene. She has a smooth recovery and was discharged home three days after surgery. Her follow up was essentially normal. A written consent was obtained from patient for publication of this report.

DISCUSSION:

Uterine torsion is rare in gynaecological practice with majority of cases being reported in pregnancy.² It is defined as the rotation of the uterus of at least 45degrees on its long axis. Most rotations are dextro-rotation as the above case reported occurring in about two-third of the cases seen.³ Though the aetio--pathogenesis of uterine torsion is unknown, it has been associated with large leiomyomas, uterine anomalies and large ovarian tumours. However, in the index case with a postmenopausal state, an enlarged uterus with fibroid masses in a background of laxity of the supporting ligaments due to low hormonal state can result in excessive movement of the uterus with deviation of the axis and subsequent rotation. Because of the symptom of pain which can been seen in many abdomino-pelvic conditions, diagnosis can be difficult and like this case, most cases in literatures are diagnosed intra-operatively, or with imaging such as MRI and CT-scan.⁴ However in a rural-centre with low access to CT-scan and MRI as a modality of pre-operative diagnosis,² pelvic ultrasound-scan can be less sensitive and specific, hence a high index of suspicion is required for intervention. Surgery was used to make the diagnosis in this our case as ultrasound scan was ultrasound scan imaging showed a different diagnosis. Most cases of uterine torsion show rotation within 45⁰ to 180⁰,⁵ however this particular case has a 540⁰ rotation along its rotation. Before this case, none of the team as well as the authors have seen a case of utero-adnexa torsion in our practices due to fibroid and this diagnostic dilemma was worsen with poor investigative modality. A quick intervention despite the dilemma improved outcome, and in pre-menopausal women, this can help to salvage the ovaries and uterus

CONCLUSION

This condition, though having non-specific features can be life-threatening because of its risk of ischemia, gangrene, shock and infection. Imaging plays a role in making a diagnosis though in majority of cases, diagnosis are made intra-operatively, hence early suspicion and prompt surgical intervention can help preserve fertility (in those desirous of future fertility)and offer appropriate treatment to others.

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