

Tubo-ovarian Abscess After IUS insertion

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Case Report

- 51 yr old female, P3+0. referred by her GP to A&E complaining of symptoms of lower abdominal pain associated with nausea & vomiting and followed by watery foul-smelling diarrhea. She was tachycardic & febrile & has tender lower abdomen with guarding over the left iliac fossa.
- Her medical background was significant for a 3-4 months history of recently occurring menorrhagia which did not improve with medical management with tranexamic acid & mefenamic acid, as a result she had an IUS coil (Mirena) inserted 2 weeks prior to her presentation.
- Her investigations revealed a significantly elevated WBCs & CRP at 23 & 347 consequentially. She was started on Tazobactam IV antibiotic, analgesics & antispasmodics on a working diagnosis of diverticulitis or Colitis & surgical consultation was obtained.
- An Abdomen-pelvic CT showed dilated fallopian tubes with surrounding inflammatory changes suggestive of tubo-ovarian abscess(TOA) and the coil was seen within the endometrial cavity, on this bases she was referred to gynecology for appropriate management.
- A further pelvic US has detailed out a large echogenic solid mass within the left fallopian tube suggestive of TOA & right hemorrhagic cyst.

Case Report

- She was commenced on the PID(Pelvic Inflammatory Disease) regimen; consistent of IV Ceftriaxone & Metronidazole, and PO Doxycycline. The Mirena coil was removed on her 3rd day of starting the PID treatment & she made significant recover. She was subsequently seen 6 weeks after discharge where she was reviewed for her menorrhagia.



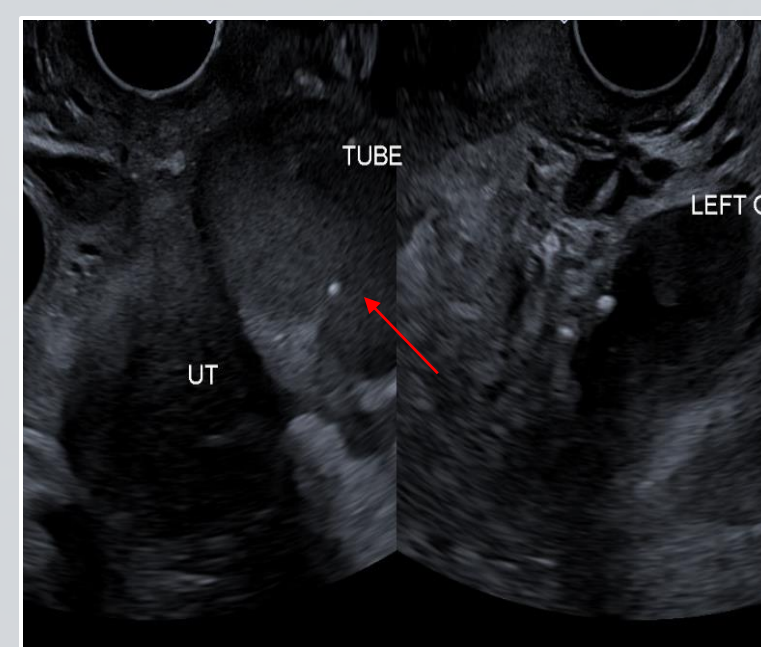
Picture 1: Lt Tubo-ovarian masas on CT pelvis



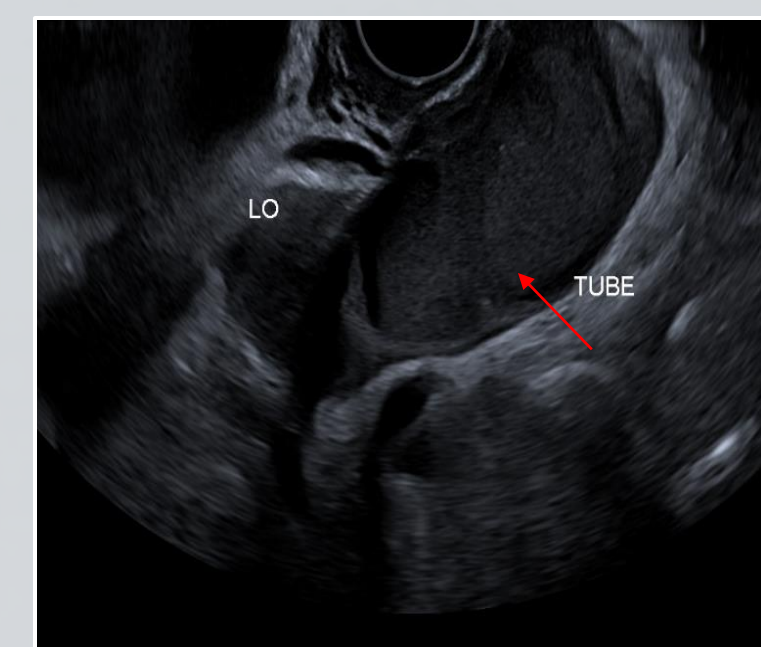
Picture 2: IUS in the uterine cavity.



Picture 3: Lt Tubo-ovarian mass



Picture 4A: Pelvic US showing dilated Lt tube with cog-wheel appearance



Picture 4B: Pelvic US showing dilated Lt tube with cog-wheel appearance

Discussion & Conclusion

Discussion

- TOA is a serious complication of untreated PID that can be severely morbid. It is prevalent in women of reproductive age, and almost 60% of them are nulliparous. PID & TOA associated with IUS or IUD are mostly caused by Actinomyces. Early recognition & treatment is vital, and although presentation can be confused with other disorder such as colitis, diverticulitis or appendicitis. Medical treatment is effective in 70% of cases, but there is still a small proportion that require surgical treatment. Management of TOS associated with IUS should involve weighing the risks of unplanned pregnancy or return of the primary condition for which an IUS was inserted & the risk of sever sequelae of the TOA such as sever sepsis or rupture.

Conclusion

- Management of TOA occurring with IUS starts with early recognition & medical management, removing the coil can improve the clinical condition, but consideration should be made to treat the primary indication of the IUS with proper counselling for the patient.

References

- Munro, KGharaibeh, ANagabushanam, SMartin, CDiagnosis and management of tubo-ovarian abscesses*The Obstetrician & Gynaecologist*201820119[10.1111/tog.12447](https://doi.org/10.1111/tog.12447)