

RECURRENT OVARIAN TORSION IN ADOLESCENCE WITH KNOWN BULKY OVARY

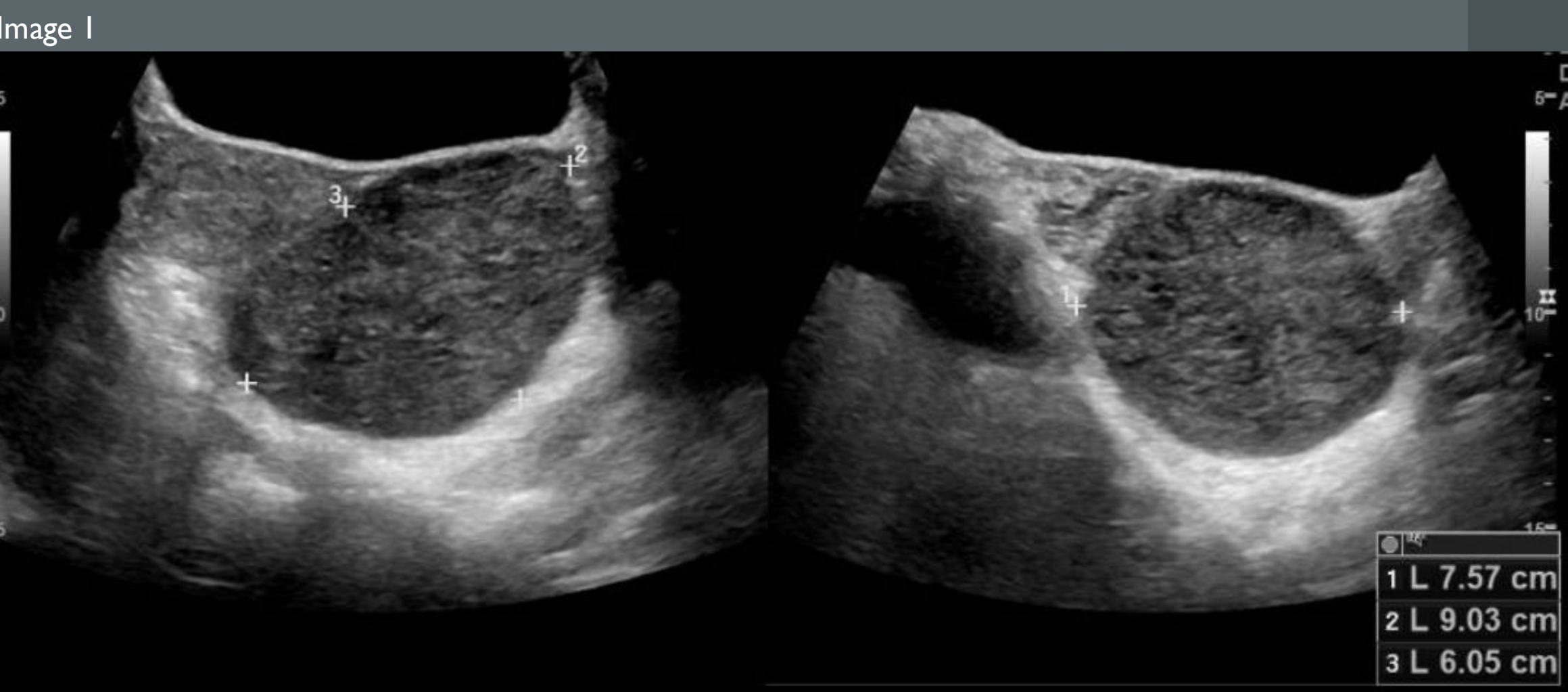
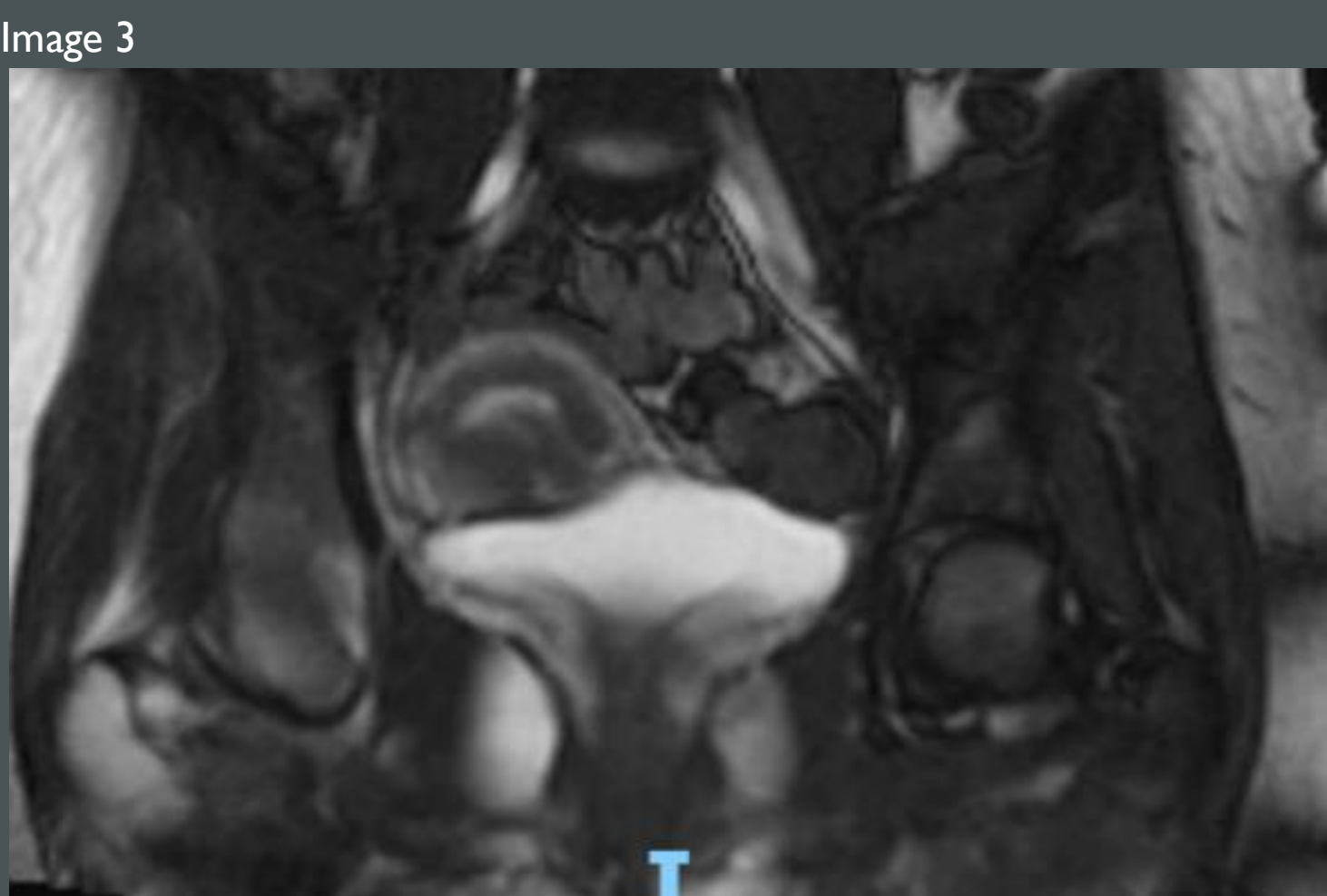
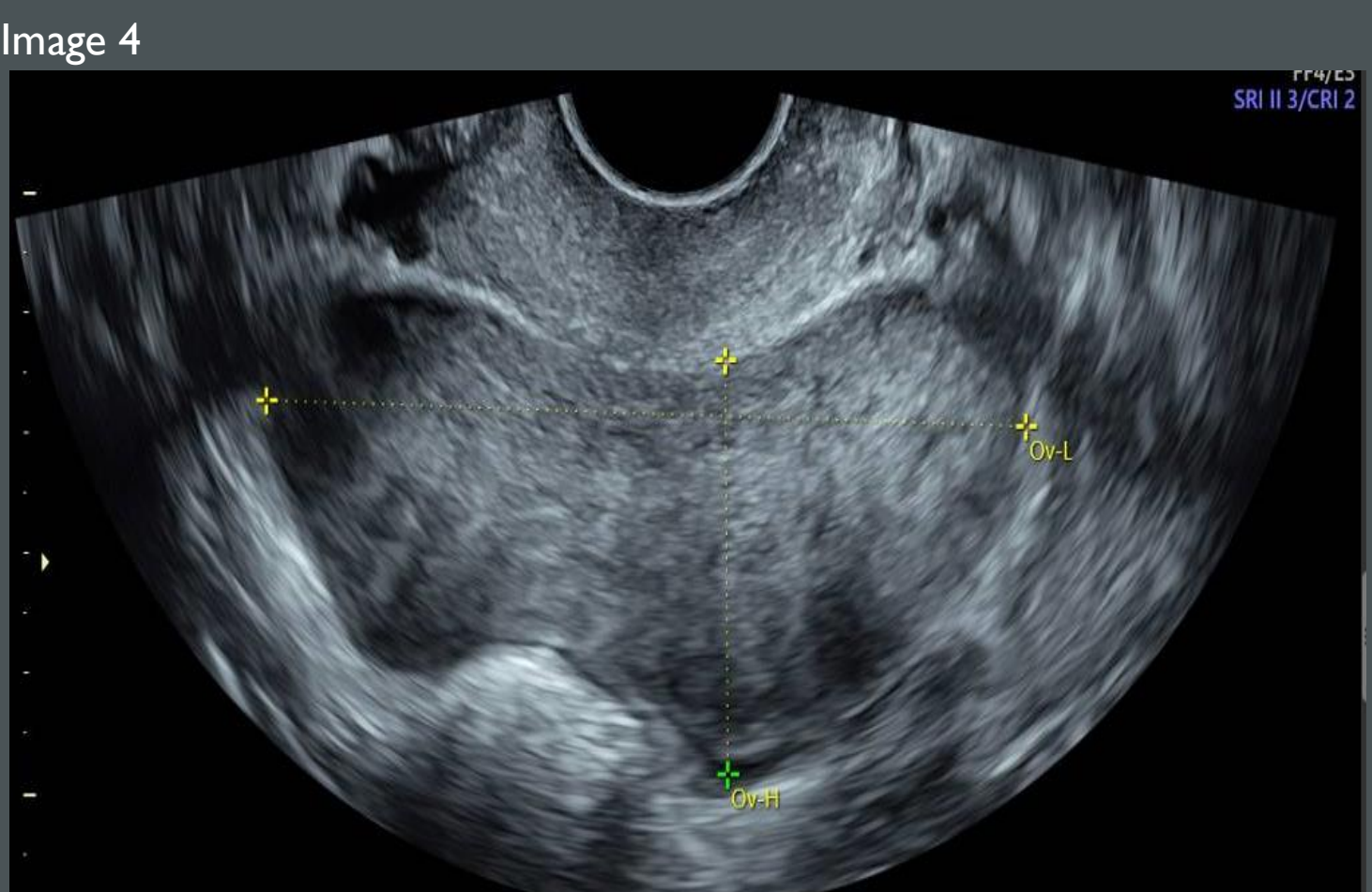
ANSER R, ZAINUDDIN P, AGGARWAL D
WEXHAM PARK HOSPITAL, FRIMLEY HEALTH NHSFT, BERKSHIRE, ENGLAND

Introduction

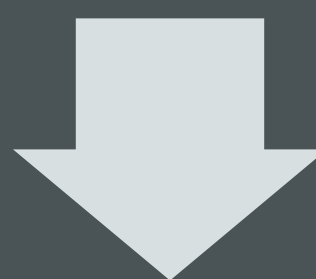
We discuss the case of a 17 year old female who presented multiple times over the course of 7-8 months with recurrent torsion of her left ovary, considering the implications of various management tracks in the District General Hospital, after reviewing the available literature.

Case

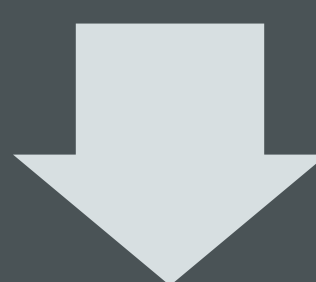
A 17 years old nulliparous, sexually-active, female on Rigevidon, presented to her GP with abdominal pain, dysmenorrhoea, bloating and heavy periods. Her community transabdominal ultrasound scan showed an enlarged echogenic left ovary with no vascularity, which was thought to be an endometrioma (Image 1). Ca125 was performed by the GP which was normal (9).



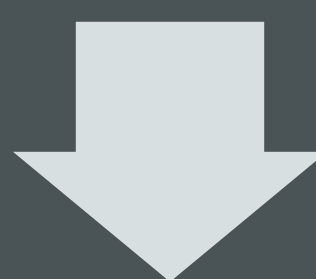
Presentation to Emergency Gynaecology Clinic – seen by a Gynaecologist who diagnosed left ovarian torsion (image 2) – underwent laparoscopy and detorsion (image 5). No cyst noted to drain. Right ovary appeared normal



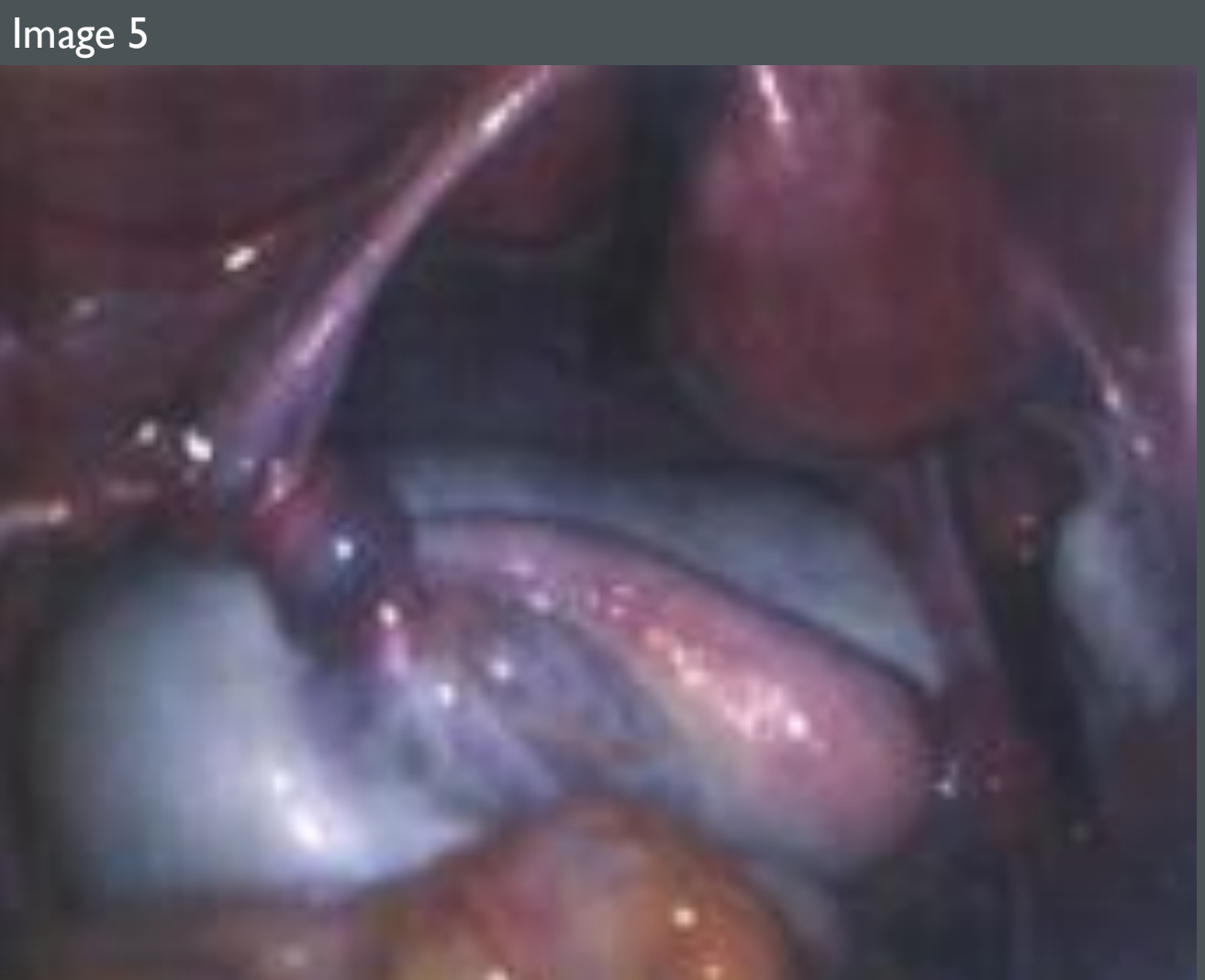
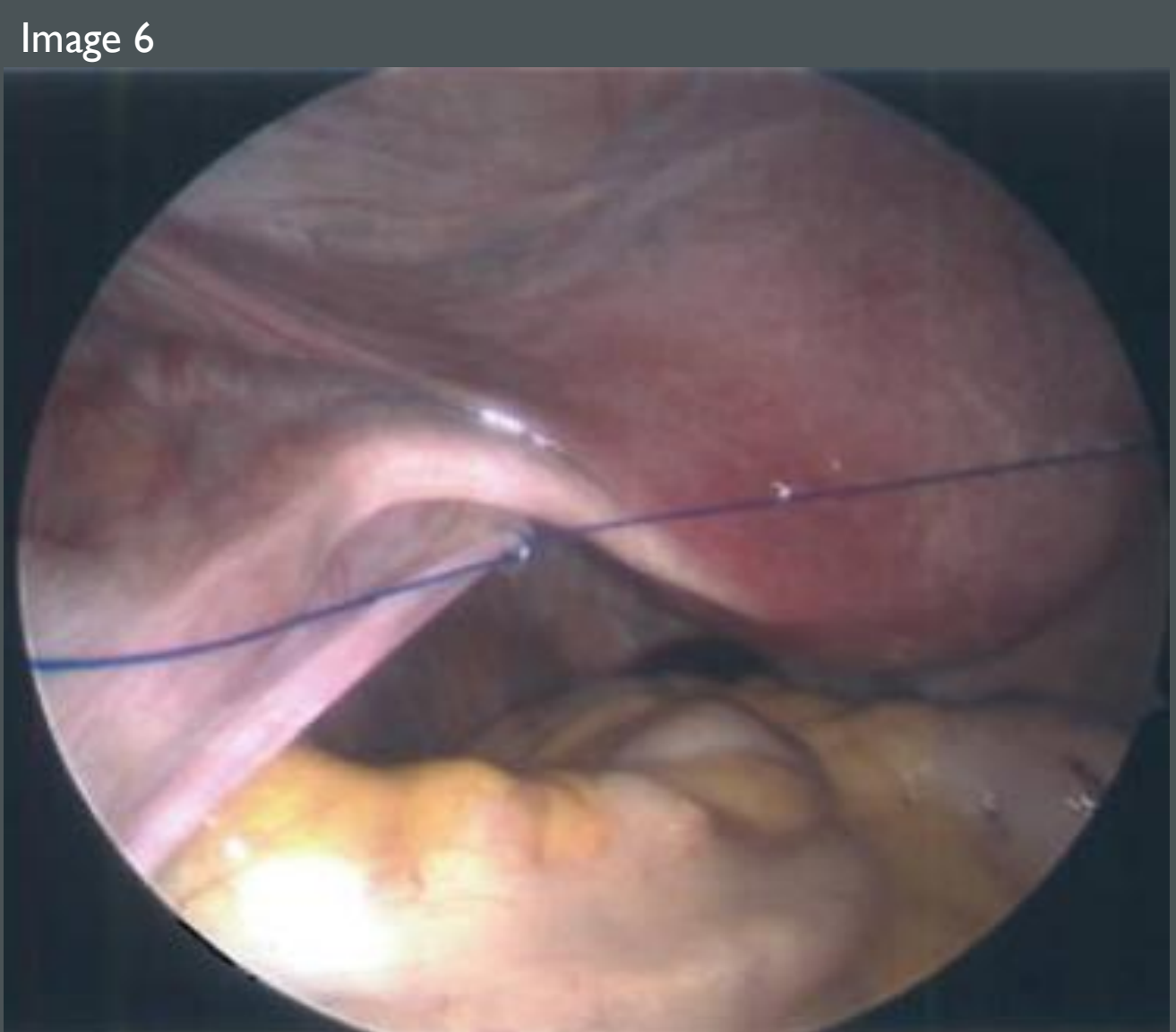
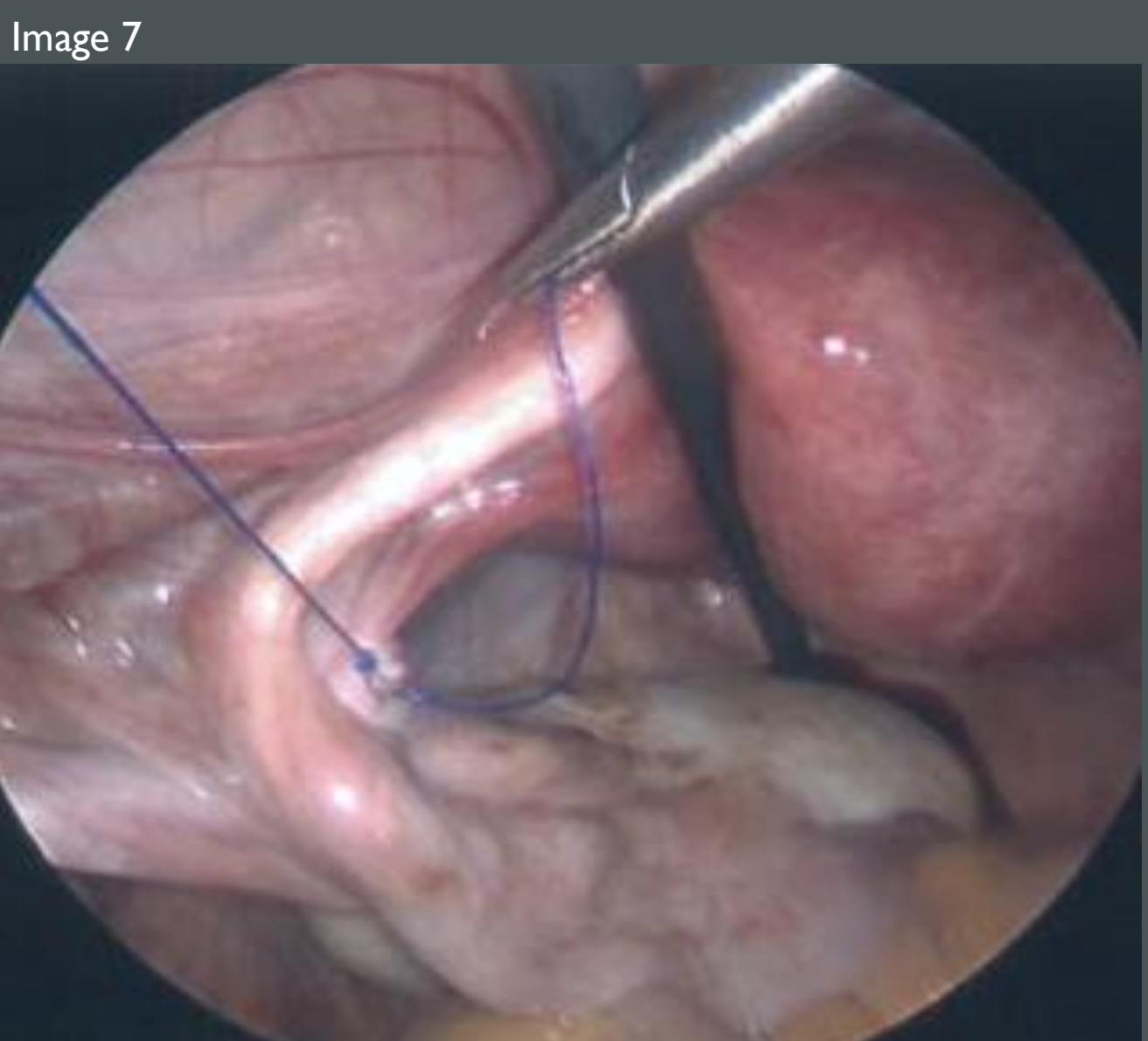
Follow-up MRI scan at 6 weeks post-op showed re-torsion (Image 3). Remaining tumour markers were normal. Taken back to theatre for detorsion and “oophoropexy” in the form of shortening of elongated ovarian ligament (images 6&7).



Re-presented 4 weeks later with recurrence of abdominal pain. On scan, ovary remained enlarged, and no clear cyst border seen (image 4).



Referred to tertiary centre with fertility preservation and adolescent gynaecology units for long term management.



Discussion:

This case posed a number of clinical challenges -

- 1) Diagnostic uncertainty – atypical presentations, possible chronic torsion?
- 2) Healthy white appearance to ovarian tissue, albeit bulky at 8cm largest diameter
- 3) No clear cyst for cystectomy to reduce recurrence
- 4) Failure of conservative measures i.e. shortening elongated mesosalpinx
- 5) Further investigations (i.e. MRI and tumour markers) needed to assess malignancy risks, although only 0.4% malignant in current literature
- 6) Further measures (debulking, oophorectomy) destructive to an otherwise healthy ovary in a young woman with fertility aspirations.
- 7) Recurrent episodes, appointments and operative procedures disruptive to her life and education, with significant long-term implications.

She was therefore referred to a tertiary unit with fertility preservation and adolescent gynaecology services alongside minimal access specialists.

Conclusions:

The management of ovarian torsion has evolved to preserve the ovary regardless of the appearance during surgery. In case of a known ovarian mass >5cm which predisposes to recurrence, ovarian fixation surgery might be recommended. More research is needed to evaluate the effect of recurrent torsion in the preservation of follicular development in the adolescent.

In this case, further management is ongoing in a Tertiary centre, dependent on ovarian reserve and the above factors. This case did however bring up some interesting clinical discussion regarding the diagnosis and management of ovarian torsion in adolescents for the general gynaecologist in a DGH setting.

References:

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