

A Case of Auto-Amputated Ovary: *too little too late*

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Background: Phenomena of autoamputated ovaries are rare and can be associated with ovarian tumours
Frequently a sequelae of a failure to diagnose ovarian torsion, a common gynaecological emergency, which can lead to ischaemia, necrosis and amputation¹

Case Report:

39-year-old underwent laparoscopic excision of a right-sided dermoid cyst:

- Truncated right infundibulo-pelvic ligament and right fallopian tube with an ovarian remnant
- Right ovary/dermoid cyst complex free floating in the Pouch of Douglas; confirmed on histology

On retrospective review:

- Presented acutely 5 months prior - 3-day history of severe intermittent right-sided loin to groin pain, nausea, bloating and dyspareunia
- Bloods normal, urinalysis – blood +; ? Renal colic
- Pain resolved: planned CTKUB cancelled, discharged with pelvic US
- US 2/12 later:
 - 38x28x45mm hyperechoic lesion in the right adnexa
 - ? dermoid cyst; vascularity was difficult to observe
 - Right ovary not visualised
- Plan made for laparoscopic excision after consultation

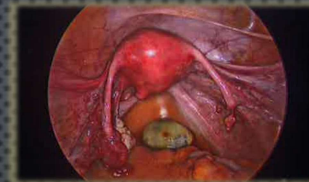


Figure 1: Panoramic view of pelvis with free floating ovarian-dermoid remnant in pouch of Douglas



Figure 2: Truncated right infundibular pelvic ligament and Fallopian tube with right ovarian remnant



Figure 3: Ovarian dermoid cyst complex

Discussion:

- Difficult to diagnose - often patients are asymptomatic
- Can lead to infection and chronic pelvic pain
- USS can lack sensitivity in diagnosis, especially with chronic torsion

Table 1: features that may be seen with each imaging modality

USS - Usually first line examination	MRI - High contrast resolution and larger field of view	CT - Widely availability and low cost, lacks resolution
<ul style="list-style-type: none"> • Unilateral ovary • Mobile pelvic mass with a "rolling effect" • Hypoechoic pelvic mass without functional ovarian parenchyma 	<ul style="list-style-type: none"> • Absence of ovary • Ectopic location of absent ovary • Mass with a lack of connection to lumbo-ovarian vessels 	<ul style="list-style-type: none"> • Identify calcified adnexal remnant • Absence of ovary • Investigate possible dermoid cyst or other differentials of pelvic mass

Management options – patient centred approach

- Symptomatic patients - laparoscopic retrieval with histological examination = gold standard
- Prophylactic contralateral ovariopexy – controversial
- Asymptomatic patients - can consider conservative approach
- Low threshold for diagnostic laparoscopy with future presentations

Conclusions: Cases of autoamputated ovaries are rare and often diagnosed intraoperatively, even in cases with some features suggestive on ultrasound

Preoperative diagnosis allows appropriate patient counselling and expectant management in asymptomatic patients

Autoamputated ovaries may rarely reimplant into peritoneum/omentum and undergo malignant change²

Consider cross sectional imaging with dedicated MRI when abnormality found on US and diagnosis not clear¹