

Chronic Ovarian Torsion: An Unusual Cause of Persistent Transverse Fetal Lie

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Introduction

This report discusses a case of chronic left ovarian torsion causing uterine malrotation resulting in persistent fetal transverse lie.

Background

This primiparous patient was in her early forties and conceived with a donor egg and her husband's sperm following a long history of primary infertility. Her BMI was 22 and she was otherwise fit and well with no past medical or surgical history.

The patient had undergone investigations for infertility including transvaginal ultrasound which did not identify uterine structural anomaly or ovarian pathology (left ovary not clearly identified). Attempted egg harvest was unsuccessful, therefore the couple conceived with a donor egg.

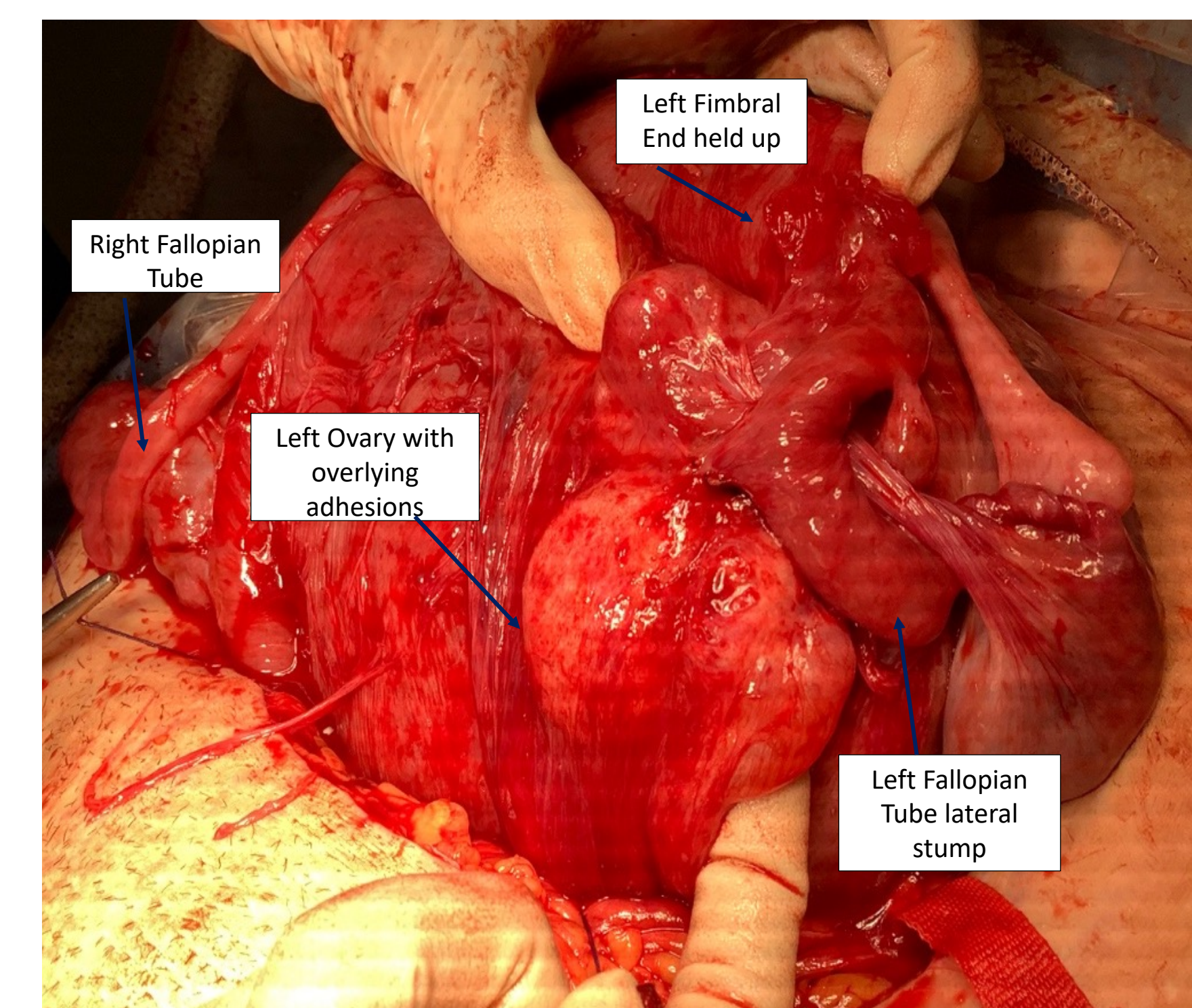
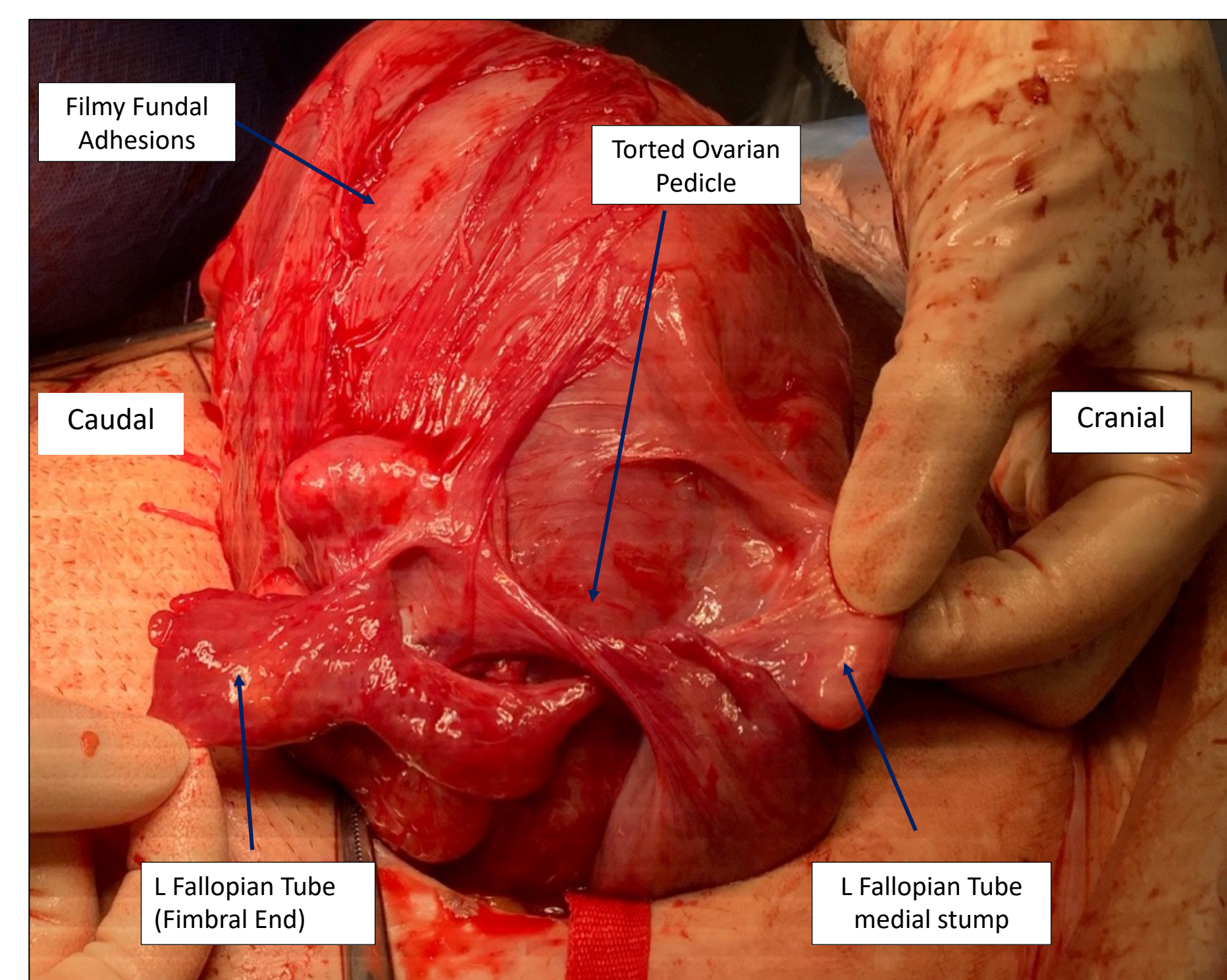
Antenatally, this patient was assigned to the SGA pathway due to her age and underwent serial growth scans throughout her Pregnancy. At 36/40, EFW and AC > 95% and AFI 30cm with transverse fetal lie. She was admitted at 37/40 to await Elective LSCS at 39/40 due to risk of cord prolapse.

Intra-Operative Findings

Routine entry was performed, however on entrance to the peritoneal cavity, the uterus was noted to be rotated nearly 45 degrees to the left with right the round ligament and adnexae anterior. The lower segment of the uterus was poorly formed and twisted facing to the left making access extremely difficult.

Examination of the left adnexa revealed a bisected and fibrosed fallopian tube, likely secondary to chronic ovarian torsion. The ovary was enlarged with a 2x2cm central fibroma and overlying adhesions covering left adnexa and uterus which were responsible for holding the uterine fundus in place causing torsion.

In combination with a large for gestational age fetus and polyhydramnios, this resulted in malrotation of the uterus and a persistent transverse fetal lie.



Discussion

- 1:300 fetuses will be in transverse lie at term ^[1]
- In primiparous and multiparous patients, 66% and 33% will have predisposing factors respectively ^[2]
- In this case, transverse fetal lie was attributed to large for gestational age foetus and polyhydramnios antenatally. This remains a plausible contributing factor.
- No clear cause was identified to explain these intraoperative findings. The patient denied any acute episodes of pelvic pain besides a brief admission to Hospital with conservatively managed appendicitis 8 years previously. She had no history of abdominal or pelvic surgery and had no risk factors and no previous diagnosis of PID.

Conclusion

Although it is unlikely to have changed our management in this case, tubal studies may have resulted in a diagnostic laparoscopy and identification of a predisposition to uterine malrotation preconceptually or have facilitated adhesiolysis. This would have allowed safer surgical planning with presence of a Senior Surgeon if the Caesarean Section had to be performed out of hours.

References:

- [1] Szaboova R, Sankaran S, Harding K, et al. PLD.23 Management of transverse and unstable lie at term. *Archives of Disease in Childhood - Fetal and Neonatal Edition* 2014;99:A112-A113.
- [2] Gerner O, Segal S. Incidence and contribution of predisposing factors to transverse lie presentation. *Int J Gynaecol Obstet.* 1994 Mar;44(3):219-21. doi: 10.1016/0020-7292(94)90169-4. PMID: 7909759.