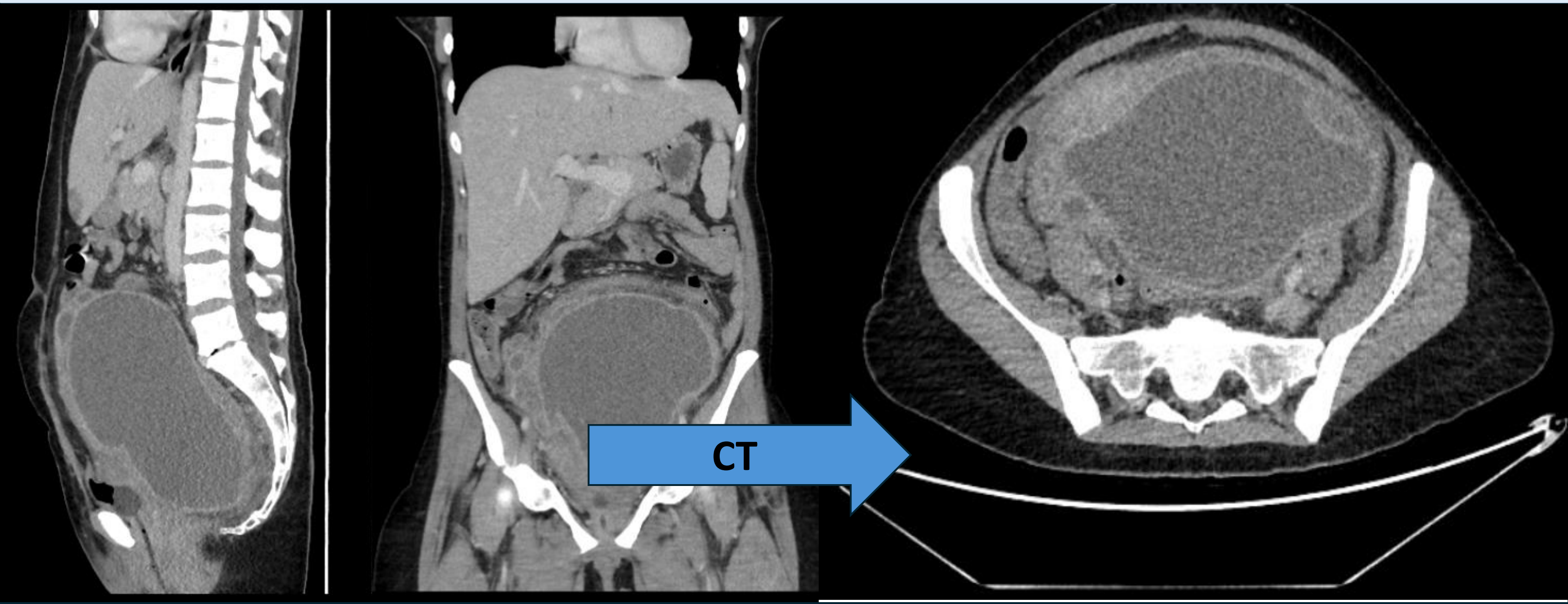
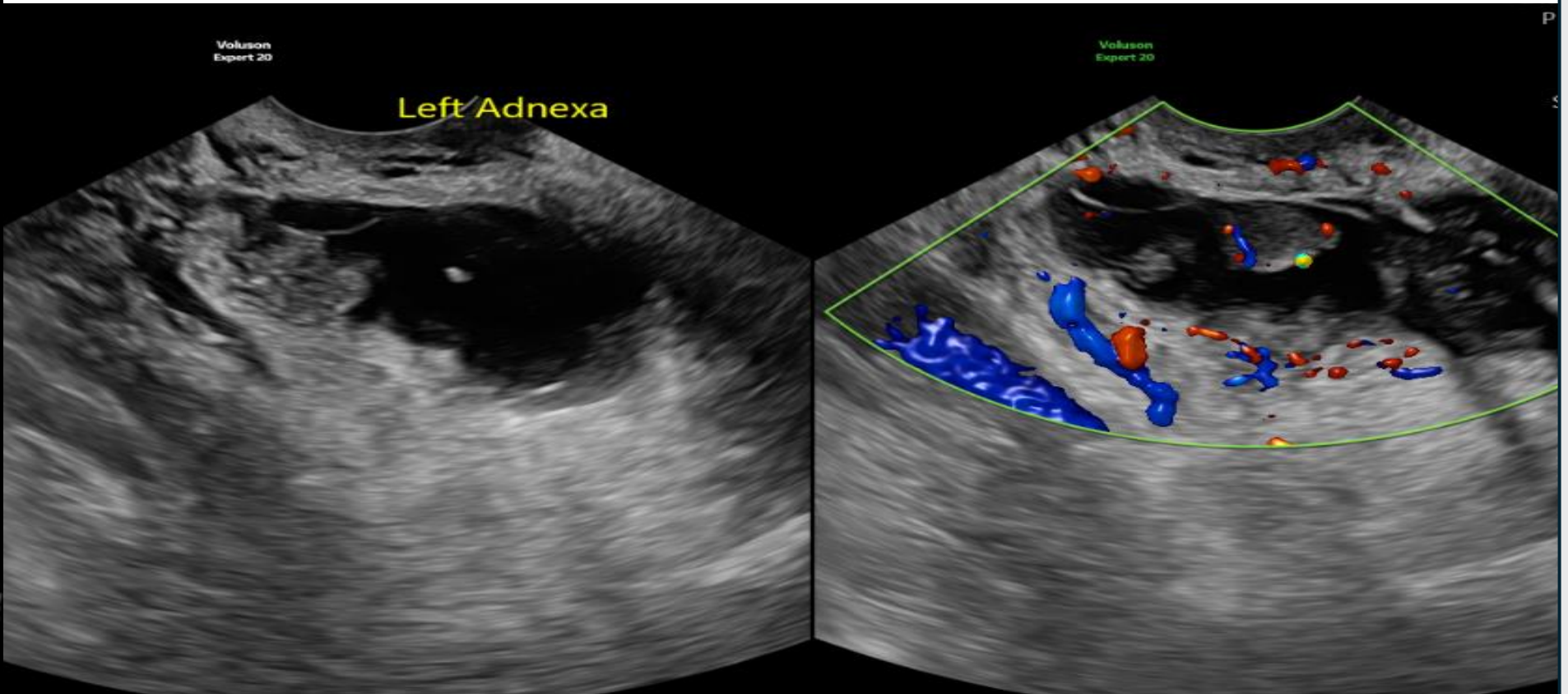
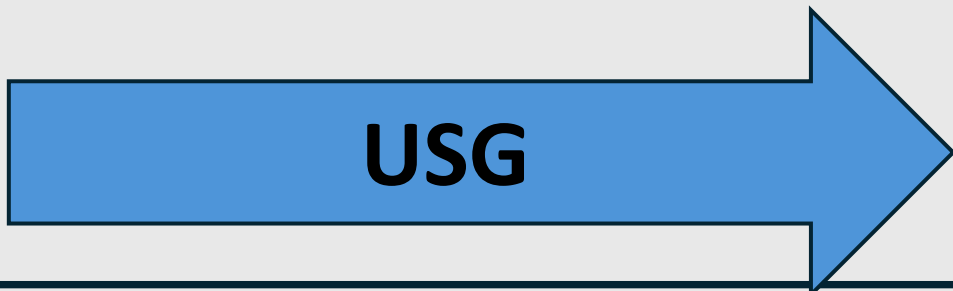
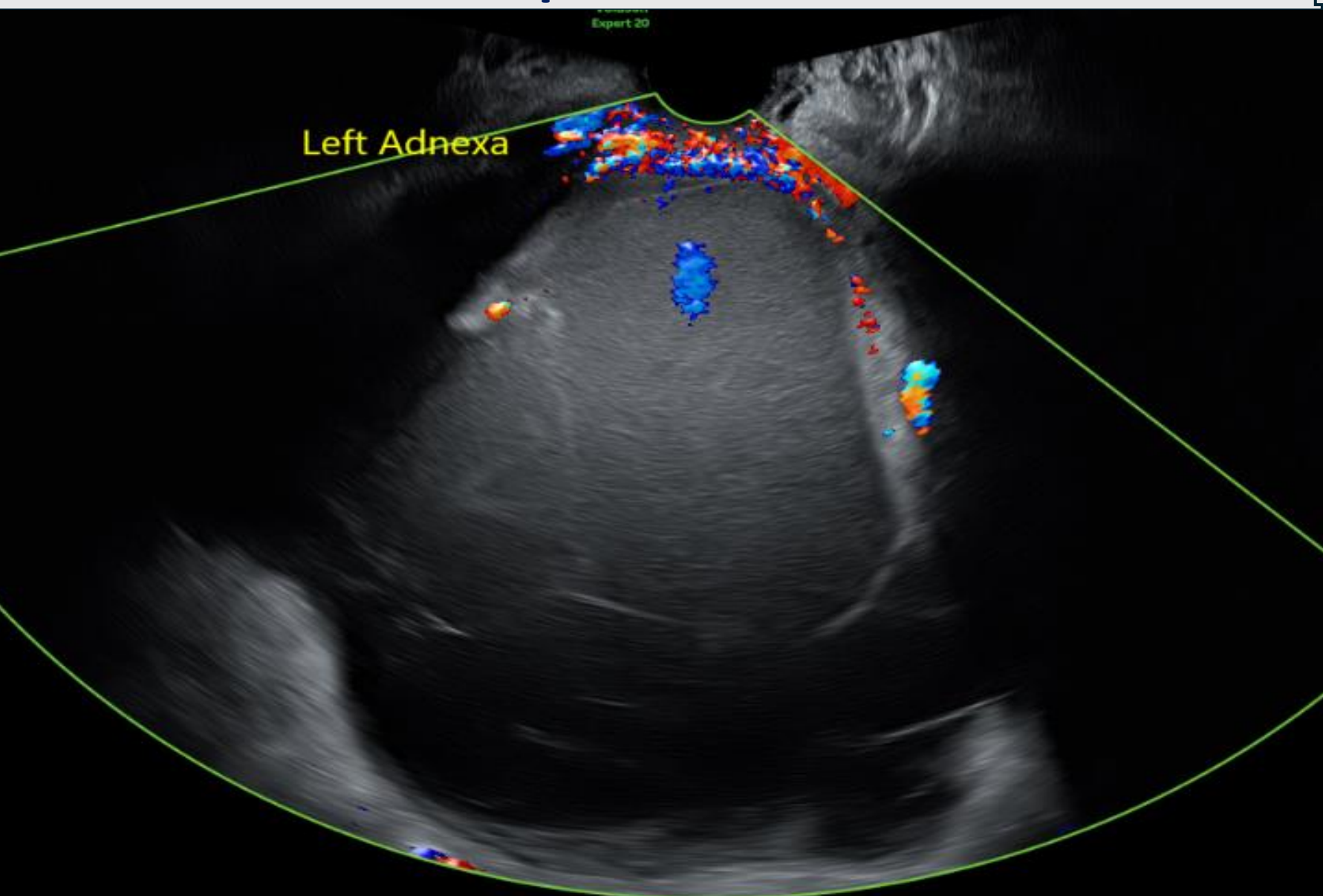


Introduction IVF is a common and effective assisted reproductive technology. Ovum pick-up (OPU), usually done via transvaginal oocyte retrieval (TVOR), is minimally invasive and generally safe. Complications of TVOR can include pelvic infections, bleeding from vessel injury, trauma to pelvic organs (1) Vaginal prep with iodine, saline, or chlorhexidine reduces infections. Ozone-based douching also lowers post-OPU infection risk. (2) This case illustrates a rare but serious complication of IVF, OHSS with a large tubo-ovarian abscess leading to bilateral hydroureteronephrosis. This case underscores the importance of vigilance, prompt diagnosis, and timely management to prevent fertility-compromising complications in IVF patients.		Follow up scan confirming resolution  An anteverted uterus with normal echotexture and a 7 mm endometrium. The right ovary is bulky (20 cc) with adjacent moderate free fluid. The left ovary is poorly visualized. A 100 x 56 x 69 mm avascular, irregular tubular mass with internal echoes is seen in the left adnexa, likely representing post-drainage changes from a tubo-ovarian abscess.
Background & Medical History 33-year-old female, history of ovarian cyst and idiopathic scoliosis, recently underwent IVF egg collection Initial Presentation Symptoms developed 4 days post-egg collection: Worsening lower abdominal pain, back pain, vaginal bleeding, fever, chills, malaise. Initial Assessment: Febrile (38.6°C), tachycardic Examination: Lower abdominal tenderness, distension ++ Blood tests: Elevated WCC (16.4 × 10⁹/L).Low Hb (9.8 g/dL)Raised CRP, USG was ordered-> reported below. Working diagnosis : OHSS and sepsis-initiated treatment with broad spectrum antibiotics	Therapeutic Intervention: CT guided drainage with MDT input - Due to the size and risk of rupture of the tubo-ovarian abscess, a CT-guided drainage procedure was performed. - Approximately 250 mL of purulent fluid was aspirated and sent for microbiological analysis. - The patient was started on broad-spectrum intravenous antibiotics (piperacillin-tazobactam). - Multidisciplinary team (MDT) involvement ensured coordinated care and decision-making. - The patient’s condition stabilised post-drainage, and surgical intervention was avoided.	Discussion and Suggestions: This case underscores that severe complications following oocyte retrieval such as severe OHSS, pelvic abscess and bilateral hydroureteronephrosis can occur, even in the absence of known risk factors. Timely imaging and targeted, minimally invasive intervention can prevent escalation to surgical management and preserve fertility. There is a clear need for more development of updated clinical guidelines to support prevention, early recognition and consistent management of such complications following oocyte retrieval. 1. Risk Stratification Is Essential: Identifying patients with underlying conditions such as endometriosis, pelvic inflammatory disease, or previous pelvic surgery may help anticipate infectious complications. 2.Judicious Use of Antibiotic Prophylaxis: While not routinely indicated in low-risk patients, prophylactic antibiotics could be considered on a case-by-case basis for those with identifiable risk factors. 3.Thorough Pre-Procedural Assessment: Pre-TVOR speculum examination may help detect signs of infection or anatomical concerns that could increase procedural risk. 4.Cautious Selection of Antiseptic Agents: The choice of vaginal cleansing solution should balance infection control with potential cytotoxic effects on ovum. 5.Value of Early Imaging and Laboratory Workup: Prompt investigation with ultrasound, CT imaging, and blood markers can help identify abscesses or evolving sepsis early. 6.Minimally Invasive Drainage Can Be Effective: In this case, CT-guided drainage avoided surgery, supporting its role as a first-line intervention in suitable cases. 7.Multidisciplinary Team (MDT) Input Enhances Outcomes: Coordinated care between fertility specialists, radiologists, microbiologists, and acute care physicians is key to managing complex post-IVF complications.(1)
Imaging Ultrasound of the abdomen showing a large, well-defined pelvic mass with internal echoes and thin septations, suggestive of a complex adnexal mass, likely a tubo-ovarian abscess. Free fluid is noted in the pouch of Douglas.   Due to unclear findings, a CT scan was requested CT Abdomen and Pelvis (CTAP) (9th October 2024): Imaging revealed a large tubo-ovarian abscess on the right side measuring approximately 10 cm in diameter, with surrounding inflammatory stranding compressing adjacent structures and causing bilateral hydroureteronephrosis with marked dilation of both ureters and mild renal pelvicalyceal dilation. This indicated ureteric obstruction from the mass effect of the abscess, leading to impaired renal drainage.	Follow-up and Outcomes: - After the procedure, the patient’s fever subsided, and her abdominal pain significantly improved. - Renal function returned to baseline, and repeat imaging showed resolution of the hydroureteronephrosis. - The white cell count (WCC) normalized, and she was discharged home after a 10-day hospital stay with oral antibiotics. - A transvaginal ultrasound was performed for follow-up, revealing a well-defined, tubular, irregular mass in the left adnexal region, likely a physiological process of healing post-surgery, with no signs of recurrence of the tubo-ovarian abscess. - At a follow-up visit 6 weeks later, the patient reported a full recovery with no recurrence of symptoms.	
References: - ESHRE Working Group on Ultrasound in ART; D'Angelo A, Panayotidis C, Amso N, Marci R, Matorras R, Onofriescu M, Turp AB, Vandekerckhove F, Veleva Z, Vermeulen N, Vlasisavljevic V. Recommendations for good practice in ultrasound: oocyte pick up†. Hum Reprod Open. 2019 Dec 10;2019(4):hoz025. doi: 10.1093/hropen/hoz025. PMID: 31844683; PMCID: PMC6903452. - Bilateral ovarian abscesses following transvaginal oocyte retrieval for IVF: A case report and review of literature Ehab Kelada · Rauf Ghani Contact information: Dr Pradnya Kamble, Southend University Hospital Pradnya.kamble1@nhs.net		