

The Diagnostic And Treatment Issues Of Adnexal Torsion In Early Pregnancy

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Abstract

Introduction: In particular during pregnancy, adnexal torsion (AT) is a gynecologic emergency with a vague appearance. Given the significant effects of delaying treatment on ovarian function and maternal morbidity, all pregnant women presenting with acute lower abdomen discomfort should be evaluated for AT. To illustrate the difficulties in managing AT in early pregnancy, we provide a case of AT complicating an early pregnancy and further explore the literature.

Case Report: A 26-year-old pregnant woman with a right-sided low abdomen ache that lasted for two days presented at 8 weeks gestation. As a result of hemorrhagic and necrotic alterations, her following workup revealed AT, needing a laparoscopic assessment and right adnexectomy. After that, she started receiving progesterone therapy.

Inconclusion: A significant gynecologic emergency during pregnancy is adnexal torsion. Along with the other differentials, it should be suspected in all cases of acute abdominal pain during pregnancy. To maintain ovarian function, early surgical intervention should be implemented, preferably by laparoscopy.

Introduction:

Adnexal torsion (AT), which is characterised as the ovary and fallopian tube twisting, is a rare gynecologic emergency that can happen during a healthy pregnancy. It may cause partial or complete blood supply strangulation, with the possibility of progression to ischemia necrosis and loss of ovarian function [1]. With potential negative effects on ovarian function and the foetus, the diagnosis and subsequent care of AT are frequently postponed in pregnancy [2].

It has been shown that detorsion can preserve ovarian function when used promptly. We report a case of an AT-complicated pregnancy and go on to analyse the literature to emphasise the difficulties in addressing such circumstances.

Case presentation:

A 26-year-old woman who was eight weeks along when she last had a period arrived with significant right side low abdomen pain that persisted for two days. She did not have a temperature but did experience nausea and vomiting. Movement made the discomfort worse, and over-the-counter medicines only provided minimal relief. She used clomiphene citrate fertility medication for a year before becoming pregnant, which is significant. She had no previous medical issues or operations in her past.

Initial evaluation revealed a normal general examination with normal vital signs, including the following: 110/60 mmHg blood pressure, 36.5°C axillary temperature, 68 beats per minute pulse, 18 breaths per minute respiratory rate, and 99% oxygen saturation on room air. She reported some discomfort and minor stomach distension. With a white cell count of 7300/l, haemoglobin of 12.1 g/dl, and hematocrit of 36.7%, the laboratory results were generally normal. The results of the liver and renal function tests were mostly normal. The pelvic imaging revealed a polycystic right ovary with free fluid in the peritoneal cavity and an early intrauterine pregnancy at 8 weeks gestation (Crown Rump Length of 17.2 mm). Doppler analysis showed reduced blood flow, which may indicate partial ovarian torsion.

Discussion:

Rarely, pregnancy-related acute pelvic discomfort is caused by AT. It occurs most frequently in the first and early second trimesters of pregnancy and affects about one in every 5000 pregnancies [2]. The currently discussed case initial trimester (8 weeks). By reducing the mobility of the ovarian pedicle, the gravid uterus' compressive effect in the late second and third trimesters helps to protect against AT [3]. However, some cases of AT have been noted in the third trimester, with recurrent ovarian cysts being the main cause [2-4].

Ovarian cysts and tumours are associated with an increased risk of AT [1]. A risk factor for AT in women who are known to have ovarian cysts is pregnancy [1].

Additionally, the risk of AT is raised by the growth of additional ovarian cysts during pregnancy. In fact, situations like ovulation induction, which are known to increase the likelihood of ovarian cysts, are linked to an increased prevalence of AT [1,3]. Right ovarian cyst, which could have raised our patient's chance of developing AT, was present at the time of diagnosis. She had also utilised ovulation induction before becoming pregnant, which is known to increase the chance of ovarian cysts and subsequent AT [5,6].

She had polycystic ovaries, but she didn't have any other clinical symptoms of the ovarian hyper stimulation syndrome (OHSS), which is

known to happen in a few cases after ovulation induction.

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