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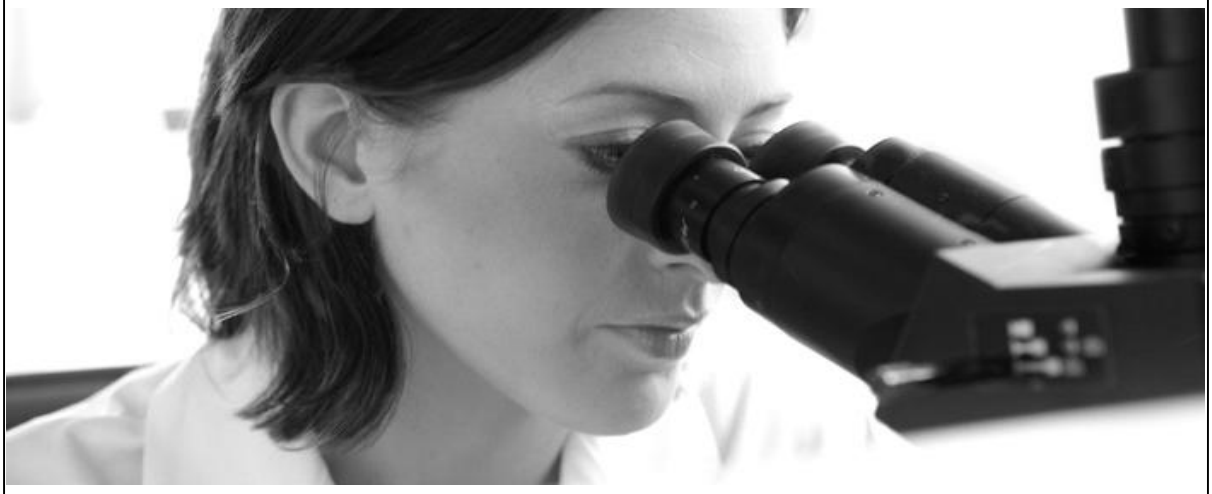

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CASE REPORTS

TUBO OVARIAN PATHOLOGIES –A DIAGNOSTIC DILEMMA FOR A GENERAL SURGEON

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ABSTRACT

Here are case series reporting three cases of intra operative diagnosis of tubo ovarian pathologies. Tuboovarian abscesses are usually complications of sexually transmitted diseases. Clinically it mimics multiple other diagnosis such as acute appendiciti, diverticultis, appendicular perforation, hollow viscus perforation, typhoid perforation etc. In any of these cases we could not come to a conclusion pre operatively neither by clinical means nor by higher investigations (cect abdomen). This article is for suggesting a general surgeon about the inta operative surprises that were faced and the need of awareness of female genital tract surgeries.

INTRODUCTION

Tubo-ovarian abscesses imply an extension of an inflammatory process from the fallopian tubes into the ovarian parenchyma with resultant suppuration. Tuboovarian abscesses are usually complications of sexually transmitted diseases. Clinically it mimics multiple other diagnosis such as acute appendicitis, diverticultis, appendicular perforation, hollow viscus perforation, typhoid perforation etc. Here, this article is for guiding a general surgeon to suspect a diagnosis of tubo ovarian patology on clinical grounds.

Case Reports

I st Case

A 28 year old lady, post partum period, presented with acue onset of abdominal pain, abdominal distention, vomiting – 7 days duration. P/A: abdomen is distended, tympanic note all over with absent bowel sounds. P/R: roomy rectum, without any growth. P/V: no evidence of infection / no forniceal tenderness. A provisional diagnosis of intestinal obstruction was made. Erect X Ray showed multiple dilated bowel loops with air fluid levels. Ultrasonography showed probable GIST lesion of the small bowel. CECT abdomen showed mass arising from the small bowel probably GIST. Laparotomy is performed. Intra operatively small bowel loops are adhered to each other and on careful dissection, there is a ovarian mass, 8*7 cms, cystic in consistency with torsion of its pedicle, leading to ischaemic degeneration of the cyst wall .adhesions released and salpingo oophorectomy done. patient is diacharged home after 7 days with uneventful recovery.

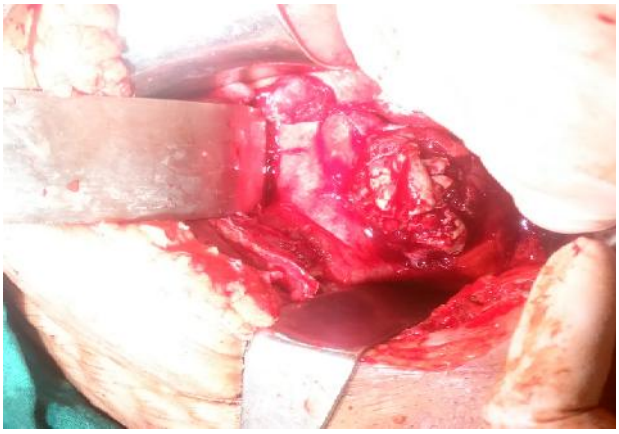

Figure 1 after adhesiolysis, ruptured ovarian cyst wall.

2nd Case

A 32 Year old female presented with acute onset of abdominal pain, vomiting, high grade fever -4 days.O/E: abdomen is distended, diffuse tenderness is present. Bowel sounds absent. X ray erect abdomen is normal other than few dilated bowel

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loops. USG abdomen showed pelvic turbid collection. Emergency explorative laparotomy is peformed showing 1 litre of intra peritoneal purulent collection and an inflammatory mass. Careful dissection /separation of the mass is done showing adherent small bowel loops and appendix. As the appendix is not perforated, a careful search is done to identify the other focus, showing right sided sloughed out ovarian and fallopian tube. Rt sided salpingo oophorectomy is done. Patient is kept on ventilator support for 3 days. Discharged on 30 th day after recovery from intra abdominal sepsis.

Figure1 inflammed appendix with tubo ovarian mass filled with slough.

Figure 2 specimen of sloughed ovary with tube

3rd Case

A 40 year old woman presented with abdominal pain, abdominal distention, loss of apetite—1 month. P/A:10* 10 cms abdominal mass, non tender, mobile, with all the borders clearly distinguished. Erect x ray abdomen was normal. USG abdomen showed probable mesenteric cyst. CECT abdomen confirmed mesenteric cyst. Explorative laparotomy is done showing rt sided large ovarian cyst .Rt salpingo oophorectomy was done. Patient was discharged after 2 weeks following uneventful recovery.

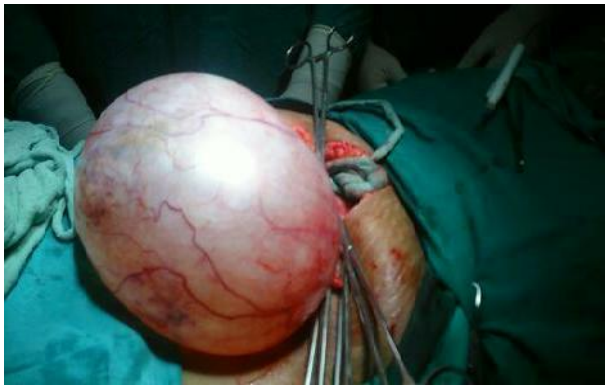

Figure 4 large ovarian cyst.

DISCUSSION

Tubo-ovarian abscesses are usually found in sexually experienced, menstruating women who have been exposed to sexually transmitted diseases and who may have developed salpingitis in the absence of a contraceptive method that prevents ovulation. Tubo-ovarian abscesses reportedly occur in 3 to 16 percent of women with salpingitis. The initial clinical impression may be correct in only 30 percent of cases. The most consistent complaint is pelvic pain and tenderness. Fever and tachycardia are frequently present, and some patients may complain of abnormal vaginal bleeding, vaginal discharge, nausea, anorexia, or diarrhea. In our above study none of the above mentioned symptoms were present .On physical examination, lower abdominal and pelvic tenderness to palpation with or without rebound may be present. An abnormal mass is always present, but its clinical detection depends on location, the patient's weight, and the degree of tenderness to palpation.

In difficult cases, sonography or computerized tomography are valuable adjuncts to the physical examination. Computerized tomography has been reported to be the most accurate of the radiologic techniques evaluated for the localization of intraabdominal abscesses. However in our above study neither of the two (Usg , Cect abd) could come to a conclusion of tubo ovarian pathologies pre operatively .

Tuboovarian abscess (TOA), typically the end result of acute pelvic inflammatory disease (PID), is a condition characterized by a walled-off inflammatory mass in the pelvis. One-third to one-half of patients diagnosed with a TOA acknowledge a history of PID [1, 2]. PID and TOAs are polymicrobial infections of anaerobic and aerobic bacteria. While Neisseria gonorrhoeae and Chlamydia trachomatis are thought to facilitate the infection, they are rarely recovered from an abscess [3, 4]. The most commonly isolated organisms from TOAs are Escherichia coli and Bacteroides species [5]. TOA is a complication of PID in 15% of cases, and 33% of patients with PID requiring admission have a TOA [5]. Mortality associated with TOA has decreased dramatically over the last 50 years. However, the morbidity associated with TOA remains significant with complications including infertility, ectopic pregnancy, chronic pelvic pain, pelvic thrombophlebitis, and ovarian vein thrombosis [6]. While the majority of TOA respond to antibiotic therapy, in approximately 25% of cases surgery or drainage is indicated [7]. There is some evidence that TOA size is associated with need for intervention. Reed et al. in 1991 showed that 35% of abscesses 7 to 9 cm required surgery and nearly 60% of abscesses ≥10 cm required surgery [8].

Aside from intravenous antibiotics (IV), TOA may also be treated by drainage under ultrasound (US) guidance or laparoscopy, as well as laparotomy (i.e., a fertility sparing unilateral oophorectomy or complete bilateral salpingooophorectomy with or without hysterectomy). Approximately 25% of patients with TOA will require surgical management [7]. Larger TOA have been shown to respond better to surgical management. 35% of abscesses measuring 7–9 cm and 60% measuring ≥10 cm ultimately require surgical

management; abscesses >8 cm more often require drainage or surgery and are associated with longer hospitalization [5, 8].

Clinical indicators for a general surgeon to suspect tubo ovarian mass

1. Presence of high grade fever as the initial symptomatology.
2. Presence of only lower abdominal guarding/rigidity with sparing of upper abdomen.
3. With /without per vaginal tenderness
4. Reproductive age female 20—40 years
5. Non tubectomised
6. Normal erect x ray abdomen.
7. Usg showing non specific turbid pelvic collection.
8. Usg and cect reports when there is disparity.
9. Frank pus originating from the pelvic cavity.

There need not be history of p/v discharge, need not have per vaginal / adnexal tenderness to suspect tubo ovarian pathologies as the cause of acute abdomen.

CONCLUSION

We conclude here that the modern era general surgeons also should be aware of the surgeries of female genital tract, so as to handle the emergencies intra operatively.

From the above 3 case senarios we conclude that h/o of per vaginal discharge, presence of per vaginal tenderness are not sastisfactory predictable factors for diagnosis of acute tubo ovarian pathologies. Mentioned above clinical indicators acts as guide lines for earlier suspicion of a tubo ovarian pathology.

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