Case Report

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Auto Amputation of Left Ovary: An Incidental Finding during Cesarean Section

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Abstract

A free floating intraperitoneal mass is extremely rare condition and mostly originates from the ovary. Usually, the torsion of ovary or adnexa presents as a surgical emergency with acute pain abdomen. The asymptomatic autoamputation of ovarian is an extremely rare phenomena that may be due to etiology of torsion/inflammation. This atypical presentation may result in clinical dilemma. We report an interesting case where the intraperitoneal free floating autoamputated ovary was an incidental finding at the time of cesarean section. The calcified, necrotic mass was found free in the abdomen and histopathology showed necrotic tissue debris with calcifications.

Key words: Auto amputation, Cesarean section, Ovarian cyst

INTRODUCTION

An autoamputation of the ovary is a very rare case of intra-abdominal mass. The primary pathological event of an autoamputation of ovary is torsion of a normal ovary or an ovarian cyst and the adnexa, followed by infarction and necrosis.[1-5] While most of the cases of ovarian torsion may present as acute abdomen, very rarely it may be asymptomatic and may be diagnosed incidentally during a surgery or during an ultrasound or while investigating a unrelated disease. This clinical entity is termed as the autoamputation of ovary and is the extremely rare phenomena.[6-8]

CASE REPORT

A 22-year-old, booked primigravida with full term pregnancy presented to outpatient department with labor pains since 12 h and leaking per vagina since 4 h and decreased fetal movements since 1 day. When history of present pregnancy was elicited, she revealed that in the present pregnancy she had on and off pain abdomen for which she had taken analgesics and the pain was relieved. The ultrasound report in 1st and 2nd trimesters showed a left sided ovarian cyst of 4 cm^2 × 4 cm^2, which was managed conservatively. The cyst reduced in size subsequently in the third trimester.

On Examination

The patient was well built and nourished. The cardiovascular, respiratory examination was normal and vitals were stable. On per abdomen examination uterus was term size with mild contractions, cephalic presentation, spine to left, head mobile, FHS 144/min, regular, LOP position. On per speculum examination, thin meconium stained liquor was seen. On per vaginal examination the cervix admitted 1 finger, 30-40% effaced, mid position, vertex high, membrane absent, pelvis average. The diagnosis of primigravida with full term pregnancy with cephalic presentation with unengaged head in early labor with acute fetal distress was made.

Management

Emergency ultrasound was done which showed single live intrauterine gestation, cephalic presentation with 38-39 weeks gestation, placenta Grade 3, AFI-6, BPP, no adnexal/pelvic mass was revealed. The patient was put on left lateral position, oxygen and intravenous fluids were given. The cardiotocogram (CTG) was reactive.

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The patient was advised augmentation of labor with oxytocin infusion. After 4 h of trial of labor the CTG showed persistent late deceleration, hence emergency lower segment caesarean section was done for fetal distress.

Intraoperative Findings

The abdomen was opened by pfannensteil incision. When the parietal peritoneum was opened, greenish flakes similar to meconium were seen in the left lower abdomen. A soft globular, pearly white structure with greenish yellow flakes adherent to its surface, was seen lying freely in the left lower abdomen adjacent to uterus with no ligamentous or direct connection to pelvic organs. The medial 2/3 of the left fallopian tube was seen, while the lateral 1/3 of the fallopian tube including the fimbria was absent. The left sided ovary was not visualized. The right sided fallopian tube and the ovary were in situ and normal. The free lying mass was sent for histopathology. The histopathology reported ovarian tissue with inflammatory and hemorrhagic changes with areas of necrosis. The diagnosis of the autoamputation of left ovary due to torsion or inflammation was made (Figure 1).

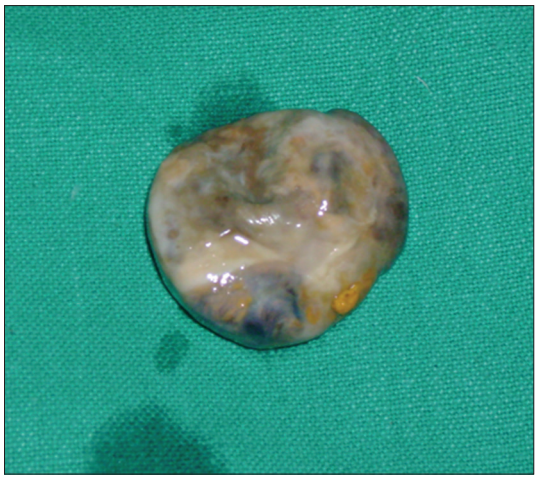

Figure 1: Specimen of Left Ovary

DISCUSSION

An auto amputated ovary is a very rare cause of an intra-abdominal mass.[1,2]

The primary pathological event of an auto amputated ovary is torsion of a normal ovary or an ovarian cyst and adnexa followed by infarction and necrosis. An auto amputate ovary is usually found incidentally during an antenatal ultrasound or at surgery.[1-3]

A free floating intra-peritoneal mass is extremely rare, and almost all originate from an ovary. To date, only two cases in the literature originate from other organs.[9,10] One such mass in a geriatric woman was from gallbladder, due to torsion, and caused acute abdomen, while the other was from appendix, due to torsion. There have been 36 cases of intraperitoneal free floating auto amputated ovary in children ranging from 1 day to 12 years of age.[1] Computed tomography and magnetic resonance imaging may be performed if the mass is complex.[4,5] While ultrasound is a safe and sufficient for diagnosing most ovarian cyst and autoamputation.[1,5,9]

Pathologically necrosis was seen in all cases and calcification was seen in many cases. Small amount of ovarian tissue were seen in several specimens.[1,6]

The review of literature suggests that an auto amputated ovary may re-implant, develop into omentum or peritoneum, and possibly undergo malignant transformation.[1,3,6] Therefore, we suggest that all auto amputated ovary should be excised instead of wait and watch approach.[1,5] The clinicians should make sure about the presence of two ovaries on ultrasound in patients with acute abdomen.[10]

CONCLUSION

An auto amputated ovary is a very rare condition that can result due to torsion. Most of the cases are diagnosed incidentally and can be a challenge to the clinicians. All autoamputation of ovary should be excised instead of wait and watch approach. The ultrasound is a safe and sufficient for diagnosing most ovarian cyst and autoamputation.

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