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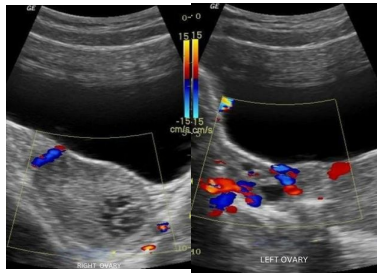
Title: **OVARIAN TORSION IN PREGNANCY : A CASE REPORT**

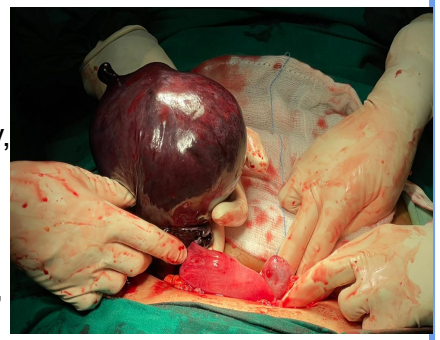
INTRODUCTION

Pregnancy is a risk factor for adnexal torsion as well as corpus luteum cyst aggravated by OHSS and ART . A prompt diagnosis is necessary for conservative, organ-preserving management, as after 36-48 hours of torsion irreversible changes to the ovary occur.

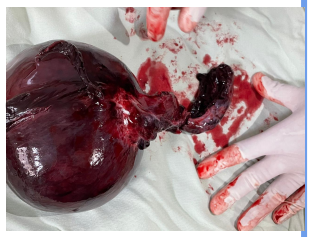
CASE AND INTRAOPERATIVE FINDINGS

A 25 year old, G2P1L1 with a 5 weeks POG came to emergency department % acute severe pain abdomen since 2:30pm of 28/10/22 with no known comorbidities.
On admission: General condition-good, Vitals-stable, Per abdomen-soft, tenderness in right iliac fossa, Local examination-no active bleed ,Investigations-normal limits bHCG levels-725.66mIU/ml .
USG pelvis: right ovarian torsion with large paraovarian cyst with vascularity with intrauterine gestational sac corresponding to 5 weeks with mild to moderate hemoperitoneum.





Under SAB, she underwent laparotomy. Intraoperatively, right hemorrhagic, gangrenous ovary with a cyst of 9 X10cms with one turn of torsion and fallopian tube was fully stretched over the ovarian cyst and could not be salvaged , hemoperitoneum of about 200 ml was noted, left adnexa and right fallopian tube were normal. She underwent right salpingo oophorectomy.
Serial bHCG levels were monitored and was 1295.3 mIU/ml on POD2 and 2033.6 mIU/ml on POD4,Early pregnancy scan was done on POD4 that showed a Single intrauterine gestational sac 5 weeks. Fetal node and yolk sac was visualised and mild fluid in the pouch of douglas and pelvis.Patient was discharged on POD5.She later delivered a live female baby by NVD



DISCUSSION

In the early stages, only venous and lymphatic occlusion occurs, which results in enlargement of the ovary and in any delay in diagnosis or management , will lead to arterial stasis resulting in hemorrhagic infarction and finally necrosis of the ovary.
In early pregnancy, acute pain abdomen is misdiagnosed for conditions such as ectopic pregnancy, spontaneous abortion, appendicitis, renal colic, cholecystitis, intestinal obstruction, pelvic inflammatory disease,, ruptured ovarian cysts, and non-functional ovarian cysts.
For accurate diagnosis of ovarian torsion during pregnancy ultrasonographic confirmation is needed. On color Doppler imaging, absence of intraparenchymal ovarian blood flow suggest the diagnosis of torsion, a decreased blood flow can be due to incomplete torsion.
In the early stages, detorsion of the twisted pedicle can preserve ovarian function. However, in advance cases, when necrosis has already set in, adnexectomy needs to be done. In case oophorectomy is required, the patient should be given progesterone support until 12th weeks of gestation.Ovarian salvage rate is 43.2%. Extensive necrosis was present in 78.2% of oophorectomy specimens.

CONCLUSION

When pregnant women present with Sudden-onset pain, focal tenderness, nausea,and vomiting, we should think of adnexal torsion,especially in lack of fever. Then,using ultrasound, adnexal enlargement or masses should be explored . They should take invasive and urgent therapy to preserve ovaries and prevent complications.This necessitates prompt surgical intervention because any delay leads to irreversible ovarian necrosis

REFERENCES : Sachdeva G, Gainder S. Outcome of pregnancy following IVF/IUI complicated by ovarian torsion. International Journal of Reproduction, Contraception, Obstetrics and Gynecology. 2018 Dec 1;7(12):5170.