AICOG 2025
Mumbai
67th All India Congress of Obstetrics & Gynaecology
FOGSI celebrates 75 years – Diamond Jubliee
8-12 January, 2025 | JIO World Convention Centre

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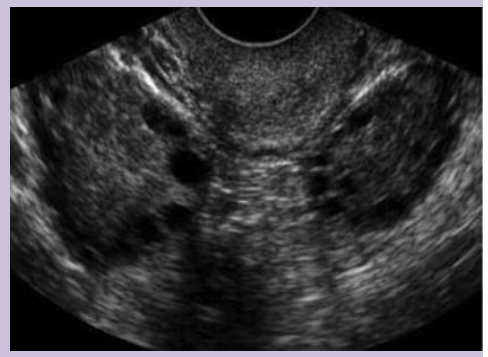
Title: **A rare case of spontaneous ovarian hyperstimulation syndrome in a pregnant female managed conservatively**

INTRODUCTION

Ovarian Hyperstimulation Syndrome (OHSS) is a serious complication of ovarian stimulation therapies, often seen in IVF. It involves an exaggerated response to gonadotropins, leading to enlarged ovaries and fluid shifts, causing significant morbidity. This case report highlights a 24-year-old female presenting with abdominal pain, distension, rapid weight gain, and shortness of breath. Diagnostic evaluation included ultrasonography, lab findings, and clinical assessment. The report aims to detail OHSS pathophysiology, diagnostic challenges, and management, contributing to improved prevention and treatment strategies.



MANAGEMENT

1. **Monitoring:** Monitored abdominal girth, vitals, urine output, blood count, and haematocrit.
2. **Investigations:** Chest X-ray: Normal.
   Blood tests: Normal.
3. **Medical Management:**
   - IV fluids (1.5–2 L/day), antibiotics, and **Tab Cabergoline 0.5 mg for 7 days** with consent.
4. **Therapeutic Paracentesis:**
   - **Day 3:** Ultrasonography-guided paracentesis aspirated 800–1000 mL of ascitic fluid.
   - **Day 5:** Repeat paracentesis yielded similar fluid volume.
5. **Outcome:**
   - By Day 7, symptoms improved with reduced abdominal girth and resolved tachycardia. Discharged on Day 12 with stable vitals and adequate urine output.

CASE REPORT

A 24-year-old G3P2L2 presented with a positive urine pregnancy test and **bilateral cystic adnexal masses** on ultrasonography. She had two prior LSCS deliveries and belonged to a lower socio-economic background. She reported persistent lower abdominal pain and distension for 4-5 days. At a tertiary care centre, she was found to have moderate OHSS with a bilateral ovarian enlargement (right: 200cc, left: 263cc) and a 4-week intrauterine pregnancy. No history of ovulation induction or any bhcg trigger. Management included IV fluids, antibiotics, cabergoline, and close monitoring. Therapeutic paracentesis was performed twice due to worsening symptoms, with around 1L of ascitic fluid aspirated each time. The patient improved and was discharged on Day 12. She expressed a desire for medical termination of pregnancy but was lost to follow-up after being advised to return in six weeks.

IMAGING

Uterus bulky with gestational sac corresponding to 4 weeks with no cardiac activity. Right ovary measured 6.7*7.2*7.8 cm (200cc) & left ovary was 8.8*5.6*7.3 cm (263cc) with multiple enlarged follicles in both ovaries suggestive of OHSS.

CONCLUSION

This case report highlights the importance of awareness and understanding of OHSS among healthcare providers. It outlines the clinical presentation, diagnosis, treatment, and outcomes to offer insights for improving patient safety in assisted reproductive technology. The report underscores the value of a multidisciplinary approach and ongoing research to minimise OHSS risks and enhance patient care.