Tubo-ovarian Abscesses: An Important Consideration in Midlife Health

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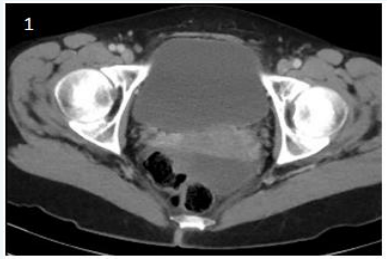
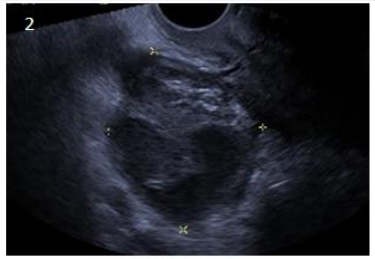
INTRODUCTION

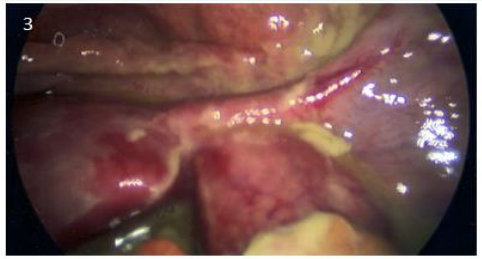
A tubo-ovarian abscess (TOA) is often a late complication of pelvic inflammatory disease (PID) and typically associated with a younger age group. We discuss three cases of middle-aged women presenting to our outer metropolitan hospital with a TOA requiring surgical intervention.

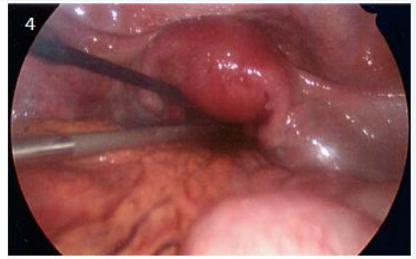
	PATIENT A	PATIENT B	PATIENT C
History	55 years old, post menopausal, 1 day of right iliac fossa (RIF) pain and fevers. Intrauterine contraceptive device (IUCD) in situ 7 years, sexually inactive. Current smoker, otherwise well.	51 years old, perimenopausal, presented septic with 2 days of RIF pain and fevers. Background of BMI 33 and dyslipidaemia, otherwise well, sexually inactive.	46 years old, premenopausal, presented septic with 3 days lower abdominal pain, fevers and abnormal vaginal discharge. IUCD in situ for 3 years, single sexual partner. Otherwise well.
Imaging	Computed tomography (CT): complex free fluid in the pouch of Douglas *[Image 1]*.	Pelvic US: large complex ovarian mass, free fluid in the right adnexa and upper abdominal quadrants *[Image 2]*.	Pelvic US: tubular structure in right adnexa suggestive of TOA with free fluid in adnexa and Pouch of Douglas.

Inflammatory markers were significantly raised in all patients. Despite commencement of broad-spectrum IV antibiotics, all three patients worsened clinically & biochemically.









Surgery	Findings: Right TOA with bowel adhesions, left pyosalpinx, pus in pelvis. Procedure: Laparoscopic bilateral salpingectomy with adhesiolysis.	Findings: Right TOA, left hydrosalpinx, dense bowel adhesions, four quadrant pus, Fitz-Hugh-Curtis adhesions *[Image 3]*. Procedure: Midline laparotomy , adhesiolysis, right salpingo-oopherectomy, left salpingectomy.	Findings: Right TOA, abnormal appearance left tube *[Image 4]*. Procedure: Laparoscopic right salpingo-oopherectomy, left salpingectomy.
Outcome	IUCD grew *Actinomyces* species. No other cultures positive. Discharged home well on high dose penicillin after discussion with Infectious Diseases team.	*Escherichia coli* in intra-abdominal purulent fluid. Discharged home well after a post-operative ICU admission.	Microbiology all negative, including IUCD, vaginal swab, urine, blood culture, intra-operative specimens. No malignancy on histopathology. Discharged home well on oral antibiotics.

DISCUSSION

A TOA is variable in clinical presentation and with rupture, can be life threatening. These patients did not have classic risk factors for PID and it is important that clinicians consider the diagnosis of a TOA early in this less 'typical' population to allow for prompt evaluation and intervention.

REFERENCES

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