Tubo-ovarian Auto Amputation:
An Unexpected Finding at Diagnostic Laparoscopy

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BACKGROUND

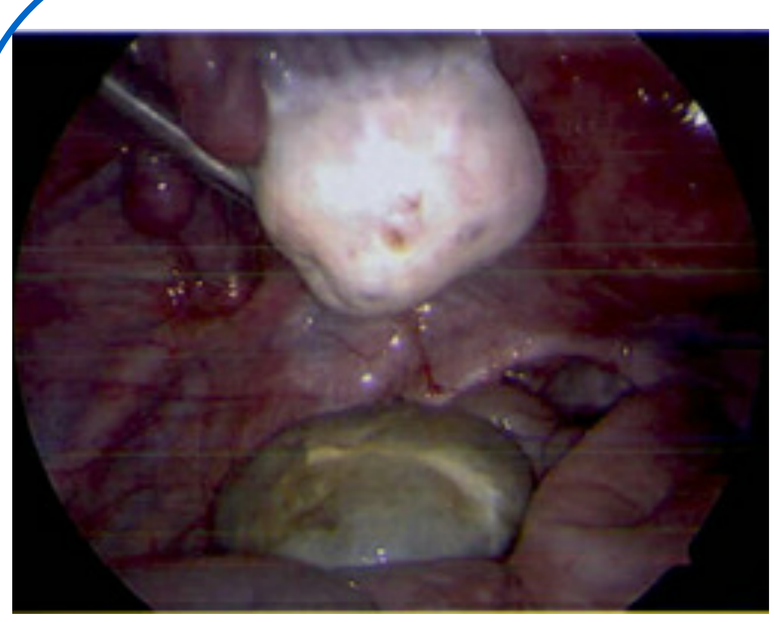
Tubo-ovarian auto amputation is a rarely encountered gynaecological condition (1,2). The incidence has been estimated to be approximately 1 in 11000 cases in the paediatric population (3).

Torsion of the ovary with subsequent infarction and necrosis is widely accepted to be the primary causative event (1,2).

Typically, torsion presents as acute abdomen, but atypically it can be asymptomatic (4). In our case, the presenting complaint was chronic pelvic pain.

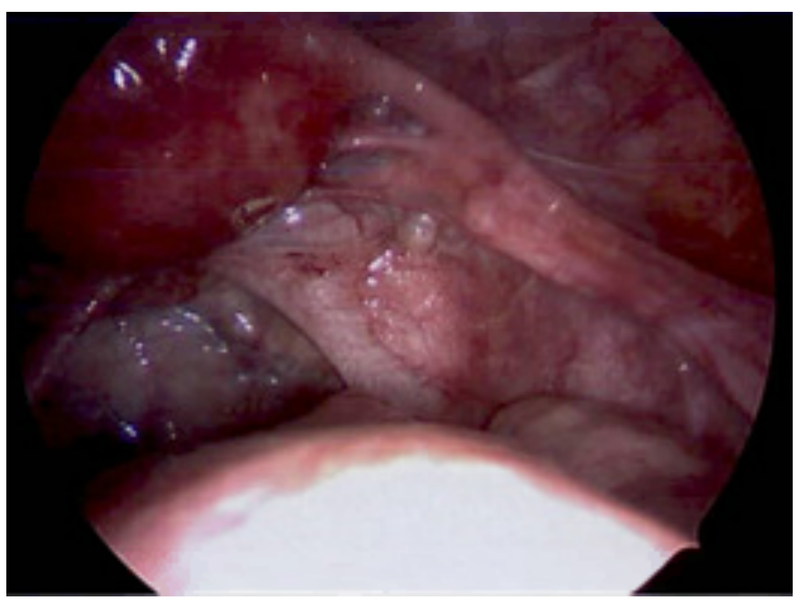
We are reporting a fascinating case of this rare pathology with an atypical presentation.

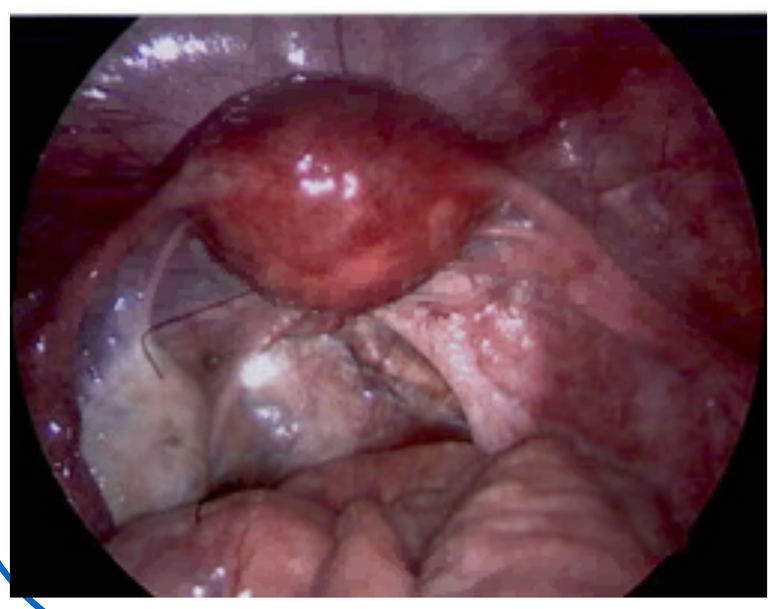
CLINICAL PHOTOS



Picture 1
A free-floating mass is seen adjacent to the LEFT ovary

Picture 2
There is an absence of any distinguishable RIGHT fallopian tube or ovary





Picture 3
Missing RIGHT fallopian tube and ovary

CASE

A 25 years old nulligravida woman was seen in our gynaecology clinic with a history of deep dyspareunia and menses-related pelvic pain for several years. She denied any history of acute abdomen. Her background included chlamydia infection at age 17, iron deficiency anaemia, irritable bowel syndrome and Raynaud's.

A previous pelvic ultrasound demonstrated an unremarkable pelvis with normal left and right ovaries and tubes.

She had a diagnostic laparoscopy to exclude endometriosis. Intraoperatively, no endometriosis was found. However, a 3cm free floating mass was found in the uterovesical pouch. Concurrently, the right fallopian tube and ovary were missing, but the left side was completely normal.

The histopathology revealed calcifications, necrosis and fibrosis, but no definitive ovarian tissue was identified.

A post-operative ultrasound KUB demonstrated no Müllerian abnormalities.

DISCUSSION

The majority of free-floating intraabdominal mass seen is thought to originate from the ovary (4). Most are diagnosed incidentally at time of surgery or ultrasound (1, 2).

Sigmoid colon is thought to protect the left ovary from torting, and thus right sided torsion is seen more often (5).

Histopathology usually demonstrates necrosis and calcifications. Sometimes remaining ovarian tissue can be visualized (1, 6).

When an auto-amputated ovary is found, the recommendation is to remove it, because it may implant into the omentum & peritoneum, and/or possibly turn malignant (1, 2, 6).

References

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