

CASE REPORT

Identified ureter within structures of residual ovarian syndrome

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Abstract

The most common symptom of residual ovarian syndrome (ROS) is chronic pelvic pain. Extensive pelvic adhesions are the typical operative findings, while follicular cysts and corpus luteum hematoma were the common pathological findings of the residual ovaries. However, malignant changes are also recorded. In this case report the ROS was associated with cystic changes in size with extensive adhesion with peritoneum, omentum and right ureter drawn and impacted within the cyst wall. Opinion of ovarian preservation during hysterectomy for benign indications and the sequelae should be discussed with patient. Our case was carefully managed with adhesiolysis and cystectomy.

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Introduction

The development of pathology in conserved ovaries is defined as residual ovary syndrome. It is estimated that at least 2.85% of patients will develop ROS and require surgery following hysterectomy. Our case was carefully managed with adhesiolysis and cystectomy. Hysterectomy is one of the common operations for the diseases of female genital organs. Ovary is usually conserved in the reproductive age group having no pathology. The postoperative complications residual ovarian syndrome is one of the causes of morbidity seeking for operative management. The incidence varies from 2.85% to 5%.^{1,2} Pathophysiology associated with infection, adhesion, cystic change and involvement of the surrounding structures. Clinical features is variable mostly associated with size of the cyst and other changes. Conservative treatment at first tried after failure of surgical correction with adhesiolysis and cystectomy.^{2,3} The operative procedures are extensive and need experienced surgeon to reduce any further morbidity.

Case report

A 45 year multiparous woman was admitted in our emergency department with severe lower abdominal pain for two weeks which was intermittent and colicky. Patient was very ill looking with below average BMI with history of total abdominal hysterectomy for benign

conditions 12yrs back in a rural clinic. On admission vital sign was normal, Routine investigation reports was also within normal range. USG revealed a deep seated cystic mass present in the lower pelvis. Decision was taken for laparotomy. Under General Anaesthesia per vaginal and per rectal examination done. A mass size about 12 weeks size of pregnancy irregular, soft cystic and free from rectum.

Per operative finding: a smooth surfaced dusky coloured cystic mass impacted at the vault of vagina firmly attached with pelvic peritoneum, omentum and intestine. The tumor origin was diagnosed only with attached scanty fimbria. Mobilization of mass done from the surroundings by cutting with scissors and finger dissection and cauterization. In posterior wall there was observed a tubular peristaltic structure within the cyst wall.

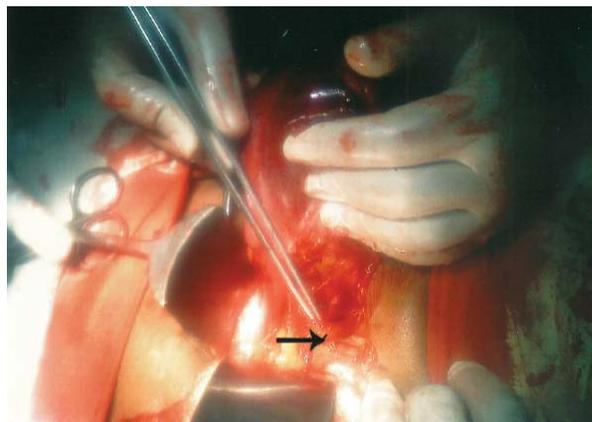


Fig I View obtained at laparotomy-ureter above the tip of forcep

It was carefully separated and identified as right ureter. Possibly pathological site was in the right ureteric tunnel on the base of broad ligament and the anatomical change was associated with extensive adhesion with omentum pelvic wall and posterior peritoneum with cystic changes and impacted in vaginal vault. Carefully separated from adhesion by cutting with scissors finger dissection and electrocauterization. The cyst size was 10 cm by 8 cm. The right ureter, found within the posterior cyst wall was vulnerable to injury. So question of IVU arises before ROS. For every complex and post ovarian mass proper scanning is essential.

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Discussion

The common presentation is the development of a pelvic mass, pelvic pain, and occasionally dyspareunia following hysterectomy without removal of both ovaries. The incidence of ROS was 2.85%. While chronic pelvic pain was the principle indication for subsequent reexploration in 52 patients (71.3%), an asymptomatic pelvic mass noted during routine follow-up examination accounted for 24.6% of operations for ROS.¹ Majority (75.4%) of patients underwent surgery during the first 10 years, while the highest incidence occurred within the first 5 years (46.6%). Furthermore, histological examination revealed functional cysts, benign neoplasm and ovarian carcinoma in 50.7%, 42.6% and 12.3% of the cases, respectively (in nine patients more than one pathology was observed). Ovarian remnant syndrome (ORS) refers to a condition occurring in women who have had a bilateral salpingo-oophorectomy (BSO), with or without a hysterectomy that leaves behind ovarian tissue.²

This residual ovarian tissue then results in pelvic pain or a pelvic mass. Risk factors associated with incomplete removal of an ovary and subsequent development of ORS includes a history of endometriosis, pelvic inflammatory disease, multiple previous surgeries, and pelvic adhesive diseases.³ Patients most frequently present with chronic pelvic pain, pelvic pain associated with a pelvic mass, or an asymptomatic pelvic mass.^{4,5} Definitive criteria for

diagnosis of ORS include a history of BSO with histologic documentation of ovarian tissue obtained during subsequent surgical excision. The recommended treatment for ORS is surgical excision by laparotomy or more recently laparoscopically.^{6,7}

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