Objective
Maternal ovarian torsion in pregnancy is a rare complication. Its diagnosis is often missed due to the nonspecific clinical features and uncommon objective findings. Ovarian torsion is seen most commonly at first trimester, but can happen second or third trimester. In late pregnancy, especially in the second and third trimesters, the diagnostic accuracy of ultrasound is limited because the ovaries are displaced from their normal positions.

Methods
A 32-year-old gravida 1, para 0, pregnant woman presented to the hospital with right lower quadrant abdominal pain for 1 day before presentation that was associated with nausea and vomiting. It was not associated with any fevers, change in stool patterns, vaginal bleeding, or abnormal vaginal discharge. The abdominal examination was remarkable for tenderness to palpation, exclusively to the right lower quadrant, with voluntary guarding. She had rebound tenderness. Bowel sounds were within normal limits.

Results
Laboratory results showed a slightly elevated white blood cell count of 13,000/mm3 (normal range: 4,000-11,000 mm3). Hemoglobin, hematocrit, platelet count, CRP and urine analysis were normal. Abdominal USG showed a fetus compatible with 25 weeks. The right ovary appeared significantly enlarged and edematous. No blood flow was detected on color and power Doppler ultrasound of the right ovary. The appendix was visualized in its normal position, and no signs of appendicitis were present. The patient underwent surgery, and a laparotomy was performed because of the pregnancy. Untwisting of the adnexa was not performed, as there was extensive ischemia and removal of the right adnexa was ultimately performed. (Figure 1). Surgery and postoperative follow-up were uneventful.

Conclusion
Ovarian torsion in pregnancy is increasing in frequency due to the growing prevalence of ovarian stimulation treatment. A high clinical suspicion and early laparoscopic management correlate with favorable maternal and fetal outcomes. It necessitates a prompt surgical intervention, because any delay leads to irreversible ovarian necrosis, so that adnexectomy is ultimately required. Despite the technological advances in ultrasonography, the diagnosis of the disease is difficult, especially during pregnancy and occasionally remains a diagnostic dilemma.