

Rare case of ovarian oedema masquerading as a pregnancy of unknown location

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Objective

Highlight the conservative management of ovarian edema in women of reproductive age group and the benign nature of the problem.

Methods

This is a case report of a healthy 37 year old lady who presented to us at 7 weeks of pregnancy with a positive pregnancy test for a routine antenatal visit. She was clinically asymptomatic and had history of irregular cycles. On Transvaginal ultrasonography there was no gestational sac located in the intrauterine cavity or extrauterine location. Left ovary was enlarged measuring 9 x 5.9 cm with increased stromal cortex and enlarged multiple anechoic spaces. Colour doppler showed mildly increased peripheral vascularity. The capsule was intact and no papillary projections or posterior acoustic shadowing was noted. Right ovary was normal and no free fluid was noted. On following up with a serum beta human chorionic gonadotropin, it was 555 mIU/L and rest of the tumour markers like alpha-fetoprotein, lactate dehydrogenase, carcinoembryonic antigen and CA-125 done were normal. MRI done showed similar features of enlarged left ovary with heterogeneous T2 hyperintense signal intensity with thick septations and solid components more in line with ovarian neoplasm. There was no evidence of intrauterine, extrauterine pregnancy or presence of free fluid. Her repeat Beta hcg was raised to 648 mIU/L after 48 hours. Following the evaluation, she started having bleeding per vaginum and her repeat serum beta hcg values started falling and a differential diagnosis of a miscarriage, failing pregnancy, ovarian ectopic pregnancy and ovarian neoplasm were considered. Multispecialty team after discussing with the couple had decided for a diagnostic laparoscopy with a frozen section of the ovary and further proceedings, as fertility preservation was of utmost priority to the couple. Interventions: The patient underwent a diagnostic laparoscopic left oophorectomy with peritoneal and omental biopsies along with endometrial curettages.

Results

The final pathology showed massive ovarian edema with no evidence of malignancy. The peritoneal and omental biopsy samples were unremarkable. In addition her endometrial curettages showed proliferative changes of the endometrium. Resolution of Beta hcg values were noted. The procedure was uneventful and the patient was discharged the next day.

Conclusion

Massive ovarian edema due to asymptomatic ovarian torsion should be included in the differential diagnosis of reproductive age patients who present with ovarian mass and elevated Hcg levels. Usually studies have shown a raise in serum androgen levels however in our case we found serum beta Hcg levels to be raised. Although we did not completely follow, conservative measures like detorsion, ovarian biopsy and oophorectomy can be considered as one of the management methods in preserving fertility and preventing recurrence in the patient. (Fertil Steril Rep 2021;2: 468–71. 2021 by American Society for Reproductive Medicine.) Awareness and knowledge of this rare condition can help in managing patients better. There is no pathognomonic or diagnostic feature differentiating it from other solid ovarian masses clinically or by imaging and a specific diagnosis can only be made by histopathological examination. Recognition of this condition is of clinical significance to prevent unnecessary radical procedures and to preserve fertility. Key words: Massive ovarian edema, Beta Hcg-Human chorionic gonadotrophin.



