

Retrospective Evaluation of the Role of Surgery in Antenatal Ovarian Torsion

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Introduction

Antenatal ovarian torsion (AOT) is uncommon in newborns and must be distinguished from other congenital cystic masses of the abdomen and pelvis. The purpose of this study was to assess the prenatal features and postnatal consequences of AOT. AOTs are easily detectable throughout the prenatal period. Although neoplastic interaction with AOTs is uncommon, it is conceivable. Although AOTs can resemble other cystic diseases, it should be evaluated as one of the initial diagnosis in baby girls who have a palpable intra-abdominal mass and a complicated cystic lesion. It may be treated effectively and safely with minimally invasive procedures. If not treated promptly, ovarian torsion during pregnancy is a relatively rare condition with a significant patient morbidity and fetal death rate. Ovarian torsion is a clinical diagnostic that requires a high level of clinical suspicion on the part of the practitioner to guarantee that it is not overlooked. We cover the appearance as well as the operation and post-operative care of a unique case with intermittent ovarian torsion. Ovarian torsion is a condition that has a significant patient morbidity rate. When the patient is pregnant, this can result in fetal death and the loss of the patient's fertility. The symptoms of ovarian torsion might be similar to those of a variety of other intraabdominal pathologies. To avoid missing this potentially fatal diagnosis, the clinician must have a high degree of clinical suspicion. Imaging and laboratory data can be helpful, but the diagnosis should be based on a thorough history and physical examination. Ischemic pain from an ovarian torsion should be explored when the physical examination does not match the amount of patient discomfort. The most common reason is the development of a corpus luteal cyst, which often resolves spontaneously by the second trimester. The sigmoid colon is supposed to limit the movement of the left ovary, which is why ovarian torsion is thought to be more prevalent on the right rather than the left. To prevent recurrence torsion, it is usual practise to excise or drain the cysts that are thought to have caused the torsion once the IP ligament has been successfully detorsed. Because the most common cyst in the first trimester is a corpus luteal cyst, which helps to nourish the pregnancy until the placenta is fully grown at the end of the first trimester, draining or excision of the cyst may result in the loss of the pregnancy. As a result, some obstetricians choose to use supplementary progesterone to help sustain the pregnancy until the placenta develops more, generally in the second trimester. A clinical diagnosis of ovarian torsion is required. A normal Doppler ultrasonography does not rule out occasional ovarian torsion, as seen in this case. Torsion should be explored

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in any female who has significant lower abdominal discomfort that comes on suddenly. The abdominal examination often does not match to the amount of suffering that the patient presents with, as in this example. When torsion is being explored, an OB/GYN consultation should be sought as soon as possible since both present and future fertility are at risk. To safeguard fertility, successful detorsion must be conducted as soon as possible. A physical examination indicated a temperature of 36.8 degrees Celsius, a pulse of 82 beats per minute (BPM), a respiratory rate of 18 breaths per minute (BPM), and a blood pressure of 125/67 millimetres of mercury (mmHg). At the time of the initial assessment, the patient looked to be in good health and did not appear to be in any immediate danger. Her abdomen was soft, and she had regular bowel noises, according to her assessment. There were no masses, distention, or tenderness found. A pelvic exam was performed, and the practitioner observed that there was no vaginal discharge or bleeding, as well as no pelvic tumours. However, it was recognised that the exam was limited by body habit. The matter was addressed with the on-call obstetrician, who concluded that the pain was most likely caused by a corpus luteal cyst and that it will go away on its own. The patient was released home once the discomfort had totally subsided, with a follow-up appointment with obstetrics and gynaecology (OB/GYN) scheduled in two days. A temperature of 36.1 degrees Celsius, a pulse rate of 64 beats per minute, a respiratory rate of 18 breaths per minute, and a blood pressure of 133/78 mmHg were discovered after a reexamination. The patient was in obvious suffering at the time of reevaluation, hunched over and groaning in pain. The patient was vomiting what looked to be stomach contents on and off. Her abdominal exam, however, revealed no peritoneal symptoms, focal discomfort, or tumours. The abdominal examination of the patient did not correspond to her degree of discomfort. OB was contacted once again and a formal US was sought. A second ultrasound revealed an enlarged right ovary with several cysts this time. The right ovary measured 8.23 cm 8.41 cm 5 cm at the time of the repeat US, whereas the left ovary was 2.22 cm 2.94 cm 3.22 cm. Blood flow was not seen in the right ovary using colour Doppler, although the left ovary had acceptable blood flow.