Thrombus-like structures seen in the infundibular-pelvic ligament during the laparoscopic management of ovarian torsion

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After obtaining a directed history and performing an appropriate examination, the management of lower abdominal pain in the non-pregnant female usually involves some form of imaging in order to ascertain a possible gynaecological cause.

Ultrasound scanning is the initial gynaecological imaging modality of choice, although it may not necessarily be performed in such cases as the presenting history and examination may vindicate a diagnostic laparoscopy. Alternatively, depending on the background of the initial
assessor, a CT scan may be performed prior to discussion with a gynaecologist.

One of the common, but difficult to diagnose presentations of lower abdominal pain is ovarian torsion. Although the above imaging modalities are not necessarily conclusive, the presence of an associated enlarged ovary is suspicious of ovarian torsion.

Laparoscopic findings usually include an edematous, and sometimes haemorrhagic, ovary that may appear non-viable. Historically, the adnexae were usually removed because there was a suggestion that untwisting the adnexae could increase the risk of thromboembolism. More recently recommendations suggest that the ovary is de-torted and some form of ovarian reduction is contemplated to avoid recurrence in large ovarian masses.

This presentation includes the case of an 18yr old woman in whom a diagnostic laparoscopy was performed based on the possibility of ovarian torsion. An enlarged 8cm bilobed, torted ovarian mass was seen that confirmed this diagnosis. However, during the laparoscopic procedure, structures suggestive of thrombi were identified within the fascia of the infundibular-pelvic ligament.

A brief literature review of the evidence of thrombosis and thromboembolism during ovarian torsion is also included.

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