Clinical Communications: OB/GYN

RIGHT LOWER QUADRANT ABDOMINAL PAIN: DO NOT FORGET ABOUT OVARIAN TORSION ON THE COMPUTED TOMOGRAPHY SCAN

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Abstract—Background: Abdominal pain is one of the most common chief complaints of patients presenting to emergency departments, and emergency physicians (EPs) often evaluate patients with right lower quadrant abdominal pain. Ovarian torsion is a rare cause of abdominal pain, but early diagnosis is essential for salvage of the affected ovary. The diagnostic study of choice for ovarian torsion is a pelvic ultrasound with color Doppler, but it is important for EPs and radiologists to be aware of findings of ovarian torsion that might appear on computed tomography (CT). Case Report: We present a case of a young female with right lower quadrant abdominal pain with CT evidence of ovarian torsion that was initially missed on preliminary report. Why Should an Emergency Physician Be Aware of This?: The presence of radiographic findings associated with ovarian torsion on a CT scan should encourage an EP to order a pelvic ultrasound with color Doppler (if available) and obtain an obstetrics/gynecology consult.

CASE REPORT

A 25-year-old female with history of ulcerative colitis (UC) and systemic lupus erythematosus presented to the ED for RLQ abdominal pain. While on a hike, 5 h before presentation, she had gradual onset of RLQ pain that was crampy and intermittent. She was discharged and then called back when the study was over-read as concerning for ovarian torsion. Why Should an Emergency Physician Be Aware of This?: The presence of radiographic findings associated with ovarian torsion on a CT scan should encourage an EP to order a pelvic ultrasound with color Doppler (if available) and obtain an obstetrics/gynecology consult.

INTRODUCTION

Abdominal pain is one of the most common chief complaints of patients presenting to emergency departments, and emergency physicians (EPs) often evaluate patients with right lower quadrant (RLQ) abdominal pain. Ovarian torsion is a rare cause of abdominal pain, but early diagnosis is essential for salvage of the affected ovary. The diagnostic study of choice for ovarian torsion is a pelvic ultrasound with color Doppler, but it is important for EPs and radiologists to be aware of findings of ovarian torsion that might appear on computed tomography (CT). We present a case of a young female with RLQ abdominal pain with CT evidence of ovarian torsion that was initially missed on preliminary report.

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examination, she had RLQ tenderness to palpation without guarding or rebound. Her pelvic examination exhibited IUD strings from the cervical os, scant blood, no cervical motion tenderness, no adnexal masses or tenderness, and a small, non-tender uterus.

The patient’s complete blood count, basic metabolic panel, and liver function tests were all within normal limits, and a urine pregnancy and urinalysis were normal except for hematuria. A CT abdomen/pelvis with contrast was performed and the overnight preliminary result was: 3.9 cm right ovarian cyst, dedicated pelvic sonogram may be obtained for further evaluation as clinically warranted; small amount of free fluid in the pelvis, likely physiologic; normal appendix (Figures 1 and 2). The EP discussed the CT with the radiologist and the radiologist did not see signs associated with torsion and, given the primary concern was appendicitis, he recommended an outpatient ultrasound as needed. The patient was discharged home with a diagnosis of abdominal pain and a plan for an outpatient pelvic ultrasound.

The following morning, an attending radiologist over-read the CT and addended the results to: asymmetrical enlargement of the right ovary; recommend emergent dedicated pelvic sonogram to exclude ovarian torsion. The patient was called back and received a pelvic ultrasound, which was compatible with right ovarian torsion. The right ovary was markedly enlarged and edematous with peripheralization of the follicles (Figures 3 and 4). She was taken to the operating room by obstetrics and gynecology (OB/GYN) and they found a small amount of hemoperitoneum, a necrotic cyst attached to the right ovary, and the right ovary twisted on itself, appearing necrotic. Upon untwisting of the right ovary, blood supply was noted to return to the right fallopian tube. A partial oophorectomy was performed, and the patient had an uncomplicated postoperative course.

**DISCUSSION**

Ovarian torsion is a challenging diagnosis not only because it is rare, but also because there are controversies about how to diagnose ovarian torsion. The differential for RLQ pain is very broad from infection (appendicitis, cecal diverticulitis, mesenteric adenitis) to mechanical (renal colic, small bowel obstruction, ovarian torsion), but ovarian torsion accounts for < 3% of gynecologic emergencies (1). An additional challenge is that most EDs do not have 24-h ultrasound availability and many pathologies causing RLQ pain present with similar vague symptoms, which leads to many patients receiving a CT scan as the initial diagnostic study.

It is important to realize the value of CT scans in contributing to the diagnosis of ovarian torsion. Specifically, radiographic signs concerning for ovarian torsion on CT scan should encourage the EP to order a pelvic ultrasound with color Doppler and call an OB/GYN.
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