Case Report

A Case Report of Tubo-Ovarian Abscess in Postmenapausal Woman

Hewawitharana KG[1], Rathnayake E[1], Senthilnathan GP[2], Vasanthraja V[3]

[1]De Soysa Hospital for Women, Colombo, Sri Lanka

[2]Consultant Obstetrician and Gynaecologist, De Soysa Hospital for Women, Colombo, Sri Lanka

[3]Acting Obstetrician and Gynaecologist, Teaching Hospital Anuradapura, Sri Lanka

***Corresponding Author** – Dr. Kavinda Hewawitharana*

E mail - kavi88fmas@gmail.com

Introduction

Tubo-ovarian Abscess (TOA) is a serious complication of Pelvic Inflammatory Disease (PID) with 5%-10% mortality. TOAs are often polymicrobial in origin (30%-40%) & affect women in reproductive age group. TOAs in post-menopausal age group are rare & accounts to 1.7% of all TOAs[1]. TOA carries a high morbidity & can be life threatening with severe sepsis (mortality 5-10%). Approximately 15%-30% of female undergoing treatment for PID will be diagnosed with TOA. Reason for TOA formation may be due to delay in PID treatment or virulence of causative organism/s.

Case History

A 57 years old postmenopausal lady presented with acute onset worsening lower abdominal pain, fever& diarrhea. There was no history of per-vaginal discharges, chronic IUDs left in situ or post-menopausal bleeding.She was having fever, tachycardia and restlessness but was normotensive. Lower abdomen was tender. Pelvic examination revealed tender pelvic walls. Pelvic sonography revealedan atrophic uterus with bilateral complex ovarian cysts & basic investigations showed WBC 23000/µl, ESR 90mm/ 1st hour and CRP 234mg/l. HIV & TB screen were negative along with bacteriological cultures. High vaginal swab was positive for EBSL-Coliforms.Considering signs of Systemic Inflammatory Response Syndrome (SIRS), Sepsis six protocol was commenced together with Broad spectrum antibiotics. Contrast enhanced CT (CECT) was performed to exclude possible other intra-abdominal pathologies. CECT findings were in favor of TOAs as bilateral complex ovarian cysts with peri appendicular inflammation were seen. Condition responded for 14 days of antibiotics andlaparotomy was planned after a 6 weeks interval.

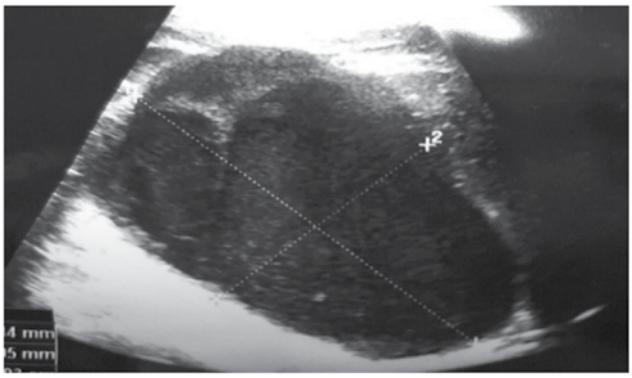

Fig.1-Transvaginal Scan Appearance of TOA of Index Case.

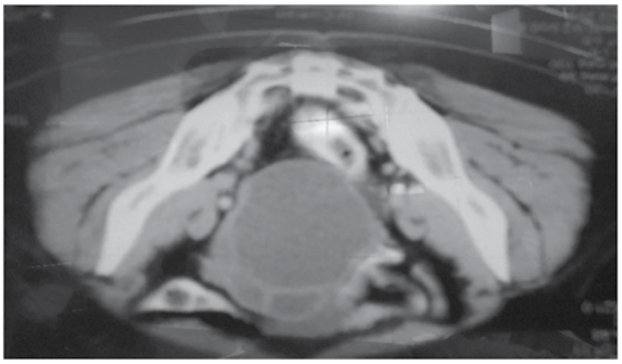

Fig.2-CECT Image of TOA of Index Case

Conclusion

TOA in post-menopausal age is rare.Ultrasound scan assessment is the first line investigation with 81% sensitivity & 78% specificity. But if inconclusive, CECT will assist diagnosis and differentiate from other causes. Presence of Ovarian vein entering the lesion is 94% sensitive & 100% specific for TOA[3].MRI has sensitivity of 95% & specificity of 89%.MRI has advantage over CT since it is non-irradiating imagine modality[4].Role of CA125 in differentiating malignant causes is less valuable in the presence of pelvic inflammation since peritoneal inflammation itself increase CA 125 value.

Medical management address up to 70% TOA cases with high recurrence rate. Interval clearance surgery about 6 weeks after initial event wills allows inflammation to settle. Thus morbidity/mortality due to surgical complications will be lesser. However, there should be a lower threshold for surgery as malignancy risk is about 47% in post-menopausal age group[2].

References

1. Blumenfeld Z, Toledano C, Eitan A, Barzilai A, Brandis JM. Tubo-ovarian abscess in the postmenopausal woman. World Journal of Surgery 1982; **6**(5):634–6

2. Munro K, Gharaibeh A, Nagabushanam S, Martin C. Diagnosis and Management of Tubo-Ovarian Abscesses. TOG 2018; 20:11-9

3. Wilbur AC, Aizenstein RI, Napp PT. CT findings in Tubo-ovarian abscess. American Journal of Roentgenology 1992; 158:575-9

4. Ha HK, Lim GY, Cha ES, Lee HG, Ro HJ, Kim HS, et al. MR imaging of Tubo-ovarian Abscess. Acta Radiologica 1995; 36:510-4