

## Case Report

# Ovarian Torsion After Laparoscopic Ovarian Transposition in Patients With Gynecologic Cancer: A Report of Two Cases

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**ABSTRACT** Ovarian transposition has proven to be a safe method for preserving ovarian function in young premenopausal women who require pelvic irradiation for treatment of early stage malignancies. We report 2 cases of ovarian torsion after laparoscopic ovarian transposition in 2 young women scheduled for chemotherapy and radiation therapy for treatment of cervical or vaginal cancer. We believe these are the first such cases reported in the literature. In discussions with patients regarding the risks and potential benefits of ovarian transposition, ovarian torsion should be included as a possible, although rare, complication. *Journal of Minimally Invasive Gynecology* (2015) 22, 687–690 © 2015 AAGL. All rights reserved.

**Keywords:** Ovarian oophorectomy; Ovarian torsion; Transposition

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For patients diagnosed with locally advanced cervical cancer, the standard treatment recommendation is concurrent chemotherapy and pelvic radiation therapy [1]. Similarly, patients with vaginal cancer are frequently offered pelvic radiation therapy as definitive treatment. Unfortunately, pelvic radiation therapy is associated with complete obliteration of ovarian function [2]. Loss of ovarian function is associated with menopausal symptoms, loss of fertility, accelerated osteopenia, osteoporosis, and cardiovascular disease. Nearly 8% of all cancers occur in women younger than 40 years of age [3].

Ovarian transposition may be recommended to decrease the likelihood of ovarian dysfunction after treatment in young patients scheduled to undergo chemotherapy and pelvic irradiation. Ovarian transposition is associated with low morbidity rates; however, unfavorable outcomes have been

reported after this procedure, including ovarian failure, ovarian cysts, and metastasis to the transposed ovaries [4].

We report on 2 patients, 1 with locally advanced cervical cancer and the other with vaginal cancer, both of whom underwent robotic ovarian transposition before chemotherapy and radiation therapy and then later developed unilateral ovarian torsion shortly after the surgery.

## Case 1

A 25-year-old woman, gravida 0, presented in September 2014 complaining of dyspareunia and vaginal discharge of 5-month duration. The patient had an unremarkable gynecologic history, and findings from a Papanicolaou (Pap) smear performed in 2013 were normal. The patient's body mass index was 38.3 kg/m<sup>2</sup>. Her medical history was significant only for depression and anxiety. The patient had no pertinent surgical history. Pelvic examination showed a 2- to 3-cm polypoid mass that protruded through the right vaginal wall and was distinctly separate from the cervix. A biopsy of the polyp showed a well-differentiated vaginal adenocarcinoma. A magnetic resonance imaging scan of the pelvis showed a 1.6- × 2.1-cm heterogeneous density in the right

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vaginal wall. Neither this magnetic resonance imaging scan nor a positron emission tomography/computed tomography (PET/CT) scan showed evidence of metastatic disease.

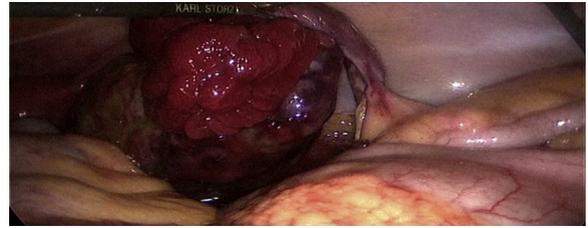
In an attempt to preserve the patient's ovarian function and potential for fertility, she was offered laparoscopic ovarian transposition before the start of concurrent chemotherapy and radiation therapy. A 12-mm trocar was placed in the left upper quadrant under direct visualization, and two 5-mm trocars were placed in the right and left lower quadrants under direct visualization. Another 5-mm trocar was placed in the suprapubic area in the midline. The right retroperitoneum was opened immediately posterior to the right round ligament. The right ureter was identified, and the right utero-ovarian ligament was coagulated and cut. To achieve high placement of the ovary along the paracolic gutter, particularly on the right side, an attempt was made to develop a long ovarian vascular pedicle. Subsequently, the right ovary was mobilized to the superior aspect of the right paracolic gutter and sutured to the peritoneal lining with a V-Loc suture (Covidien, Mansfield, MA). A similar procedure was performed on the contralateral side. The estimated blood loss was 10 mL. The total operative time was 89 min. There were no intraoperative complications. The patient was discharged home the day of the surgery.

On postoperative day 5, the patient experienced pain in the right lower quadrant and flank. On examination, vital signs were normal, and the patient was not in acute distress. The abdomen was soft, and the patient had tenderness to palpation throughout it, with guarding and rebound tenderness. Blood tests showed a white blood cell count of  $15.7 \times 10^9/L$ . An ultrasound examination showed bilateral transposed ovaries in the mid-abdomen. The right ovary measured  $7.0 \times 6.5 \times 5.5$  cm. The left ovary measured  $2.6 \times 2.1 \times 2.6$  cm. There was evidence of a diffusely enlarged hypoechoic right ovary, which was highly suggestive of intermittent ovarian torsion. A CT scan of the abdomen and pelvis showed an enlarged right ovary with periovarian fat infiltration and a small amount of fluid inferior to the right ovary.

The patient was taken to the operating room, where a laparoscopic evaluation was performed. Intraoperative findings included several loops of large and small bowel adherent to the right paracolic gutter draped over the enlarged and torsed right ovary. The left ovary was intact and not enlarged or torsed. The adhesions were lysed, and the sutures attaching the right ovary to the peritoneum were cut. The ovary was dark and friable secondary to impending necrosis (Fig. 1). The pedicle of the ovarian vessels was untwisted, and the infundibulopelvic ligament was coagulated and transected. The ovary and tube were placed in a bag and removed. The patient had an uncomplicated postoperative course and was discharged home on postoperative day 1. As of November 2014, the patient has started chemotherapy and radiation therapy and has not had further complications.

**Fig. 1**

Right ovarian torsion with evidence of necrosis.



## Case 2

A 32-year-old woman, gravida 0, underwent Pap and human papillomavirus (HPV) co-testing in January 2013 and was found to have normal findings on the Pap smear, but she had an infection with a high-risk HPV subtype. In June 2013, she had follow-up Pap and HPV co-testing, which showed atypical squamous cells of unknown significance without HPV infection. In January 2014, the patient had another Pap smear, which showed a high-grade squamous intraepithelial lesion. She had a follow-up colposcopy and endocervical curettage, which demonstrated high-grade squamous intraepithelial lesions. The patient was asymptomatic at the time of this diagnosis. Her medical history was significant only for diabetes. Her gynecologic history was significant for endometriosis. The patient had a body mass index of  $26 \text{ kg/m}^2$ . On pelvic examination, the cervix was friable, and previous biopsy sites were noted. On bimanual examination, the cervix and uterus were normal.

In February 2014, the patient underwent an examination under anesthesia and cold knife conization. The final pathology findings were consistent with moderately differentiated squamous carcinoma with a depth invasion of 10 mm. The tumor extended focally to the endocervical, ectocervical, and deep margins of resection. Lymph-vascular space invasion was present. The patient underwent a PET/CT scan that showed hypermetabolism in the uterus consistent with a previous surgical procedure; no metastatic disease was identified outside of the cervix. Because of the patient's interest in future fertility, a robotic-assisted radical trachelectomy was recommended.

In March 2014, the patient underwent attempted robotic-assisted radical trachelectomy. A 12-mm trocar was placed 1 cm above the umbilicus. Subsequently, an 8-mm robotic port was placed 10 cm to the left of the supraumbilical port under direct visualization. A second 8-mm robotic port was placed at a downward angle 10 cm to the left of the first 8-mm robotic port. A third 8-mm robotic port was then placed at a downward angle 10 cm to the right of the supraumbilical port under direct visualization. Finally, a 12-mm assistant port was placed approximately 20 cm to the right of the supraumbilical port. Lymphatic mapping was performed using indocyanine green. The left retroperitoneum was exposed. Three sentinel lymph nodes were identified on

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