

No. 341-Diagnosis and Management of Adnexal Torsion in Children, Adolescents, and Adults

This Clinical Practice Guideline has been prepared by the Canadian Paediatric and Adolescent Gynaecology and Obstetrics (CANPAGO) Committee; reviewed by the Clinical Practice-Gynaecology, Diagnostic Imaging, and Guideline Management and Oversight committees; and approved by the Board of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To review the evidence and provide recommendations on the diagnosis and management of adnexal torsion in children, adolescents, and women.

Outcomes: Elements evaluated include the risk factors, diagnostic accuracy, management options, and outcomes of adnexal torsion.

Evidence: Published literature was retrieved through searches of MEDLINE, Embase, CINAHL, and the Cochrane Library using appropriate controlled vocabulary and key words ("adnexal torsion," "ovarian torsion"). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. Searches were updated on a regular basis and new material incorporated in the guideline to December 2014. Grey (unpublished) literature was identified through searching the websites of health technology assessment and related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Values: The evidence obtained was reviewed and evaluated by the Canadian Paediatric and Adolescent Gynaecology and Obstetrics Committee of the Society of Obstetricians and Gynaecologists of Canada (SOGC) under the leadership of the principal authors. Recommendations were made according to guidelines developed by the Canadian Task Force on the Periodic Health Examination.

Benefits, Harms and Costs: Guideline implementation should assist the practitioner in developing an optimal approach to the diagnosis and management of adnexal torsion while minimizing harm and improving patient outcomes.

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Women have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice, women should be provided with information and support that is evidence based, culturally appropriate, and tailored to their needs. The values, beliefs, and individual needs of each woman and her family should be sought, and the final decision about the care and treatment options chosen by the woman should be respected.

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in the category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Validation: These guidelines have been reviewed and approved by the Gynaecology Committee of the SOGC and approved by the council of the SOGC.

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Summary Statements

1. Ultrasound with and without colour flow Doppler is the imaging modality of choice for any suspected adnexal torsion (II-2).
2. Laparoscopy is the preferred surgical approach for adnexal torsion (II-2).
3. Ovarian function following detorsion, even in cases of the blue-black ovary, has been consistently documented with colour flow Doppler (II-2).
4. The risk of malignancy at the time of torsion, in both the paediatric and adolescent population and adult population, is very low (II-2).

Recommendations

1. The diagnosis of adnexal torsion should be considered in females presenting with acute abdominal pain (II-2B).

2. Decreased or absent colour Doppler flow, increased total ovarian volume, and abnormal adnexal volume ratios may all be suggestive of adnexal torsion, but the decision to operate should not be based exclusively on sonographic findings (II-2B).
3. The theoretical risk of a thromboembolic event following detorsion is unfounded and should not preclude conservative management (II-2B).
4. A prompt diagnosis and referral to a surgeon minimizes trauma and ischemia to the ovary when torsion is suspected and surgery should be performed as soon as possible (II-2B).
5. Conservative surgical treatment of ovarian torsion, including detorsion with or without cystectomy, should be performed if torsion is confirmed, even in cases of a blue-black ovary (II-2B).
6. Delaying the cystectomy should be considered to avoid further insult to the edematous ovary (II-2B).
7. An oophorectomy rather than a cystectomy should only be considered in the postmenopausal female population with ovarian torsion, due to the increased risk of malignancy (II-2B).
8. Oophoropexy can be considered in situations where the ovarian ligament is congenitally long, patients with repeat torsion, or when no obvious cause for the torsion can be found (III-C).

ABBREVIATIONS

CDU	colour Doppler ultrasonography
CRP	C-reactive protein
CT	computed tomography
IL-6	interleukin-6
MRI	magnetic resonance imaging
PPV	positive predictive value

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