TUBOOVARIAN ABCESS SECONDARY TO RIGHT PYONEPHROSIS

A. Stretean

University Hospital of Sibiu, Obstetrics and Gynecology Department

Abstract

Pelvic inflammatory disease is one of the most common forms of gynecologic pathology. Within this pathology acute and chronic adnexal inflamation are most often encountered in young women being a common cause of infertility.

Our case is one in particular because the adnexal inflamatory pathology was consecutive to a similar kidney inflamatory pathology.

Given the rarity of such cases, we considered its presentation necessary due to the ethiopatogenic, diagnostic and therapeutic particularities.

Rezumat: Abces tuboovarian drept secundar unei pionefrite drepte

Boala inflamatorie pelvină reprezintă una dintre cele mai frecvente forme de patologie ginecologică. În cadrul acestei patologii anexitele acute şi cronice sunt cel mai adesea intâlnite, constituind la femeile tinere cauza frecventă de infertilitate.

Cazul prezentat este unul particular prin faptul că patologia inflamatorie anexială supurativă este consecutivă unei patologii similare renale.

Având în vedere raritatea acestor cazuri, am considerat necesară prezentarea acestuia datorită particularităţilor etiopatogenice, diagnostice şi terapeutice.

Cuvinte cheie: abces tuboovarian, pionefrită acută, tratament chirurgical

Introduction

Adnexal inflammatory pathology is common and one of the main reasons for consulting the gynecologist. More frequently the cases are of early catarrhal inflammatory pathology and rarely those coming from suppurative pathology among those mentioned, the latter representing neglected cases or treated inappropriately.

Our case is one in particular because the adnexal inflammatory pathology was consecutive to a similar suppurative kidney pathology which resulted in nephrectomy. Given the rarity of these cases we felt the need to present it due to solving difficulties and surgical particularities.

Material and method

The information on this case report were obtained after a thorough case history, clinical and

CORESPONDENŢĂ: Adrian Stretean, email: adrian.stretean@yahoo.com
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laboratory exams of relevance, and detail observation of the patient charts for both hospitalization - renal and gynocological pathology.

Results

Patient D. F., aged 37, was hospitalized in the OG clinic of SCJU Sibiu on 13/07/2015, chart number 51575.

Historical data highlights irrelevant pathology. Previous recent medical history of relevance to genital pathology is represented by an admission in the Urology clinic with a diagnosis of acute suppurative right pyonephrosis, overinfected thrombosis in the renal hilum, which resulted in right nephrectomy on 04/01/2015.

History of the actual genital pathology shows simptoms encountered after the nephrectomy, with pelvic pain in the right flank, permanent low-grade fever, followed by febrile permanent status before admission in the Gynecology Clinic. Postoperative urological checks revealed a considerable backlog in healing, but it said that it was favorable with no postoperative complications.

The patient presents by own initiative for a gynecological consult which suspects genital suppurative inflammation and recommends hospitalization.

Gynecological examination on admission highlights the vulva, vagina normally conformed without pathologic secretions, without cervix injuries, the uterus hard bounded with reduced mobility, embedded in a tumor mass with right adnexal situation in the pelvis, with increased pain at mobility and touch.

Laboratory investigations were conclusive for the right adnexal suppurative inflammatory pathology.

Laboratory explorations of suggestive meaning mentioned are: WBC 17,800 / mm3, ESR = 100mm / h, PCR = 182, fibrinogen = 462 mg%, PLT = 311,000 / mm3, Hb = 9.4 g ‰.

The MRI exam performed preoperatively revealed obturatory, iliac, paraovarian, paraaortic, infrarenal and paracervical lymph nodes large as 10 mm, mixed structures situated in the right part of the pelvic floor next to the uterus that had thick borders and fluid content, with dimensions of 62 mm.

Ultrasound performed before MRI reveals similar data.

Histopathology after urologic surgery reveals many renal abcesses in the parenchyma of various sizes highlighting the diagnosis of acute pyonephrosis with overinfected thrombosis in the renal hilum.

Histopathology after gynecologic surgery diagnosed a tuboovarian abscess.

Corroborating historical data with clinical and laboratory investigation, the final diagnosis was right tuboovarian abscess, major pelvic postinflamator adherent syndrome, infectious anemia, unique left kidney after surgery. The therapy decided was surgical in association with antibiotics and biological rebalancing and antianemic treatment.

The surgery took place on 16/07/2015. Intraoperative finds: a frozen pelvis through multiple adhesions extended on large surfaces, very tight between ileal loops,sigmoid colon and the genital organs meaning the uterus and right adnex; right adnex magnified by a suppurative inflammatory process that was tuboovarian having the size of 6-7 cm, which was intimately adherent to the pelvic peritoneum, Douglas sack, uterus and the anteriorly mentioned digestive segments, constituting an inflammatory pelvic tumor.

The adhesions were sectioned extremely difficult, freeing the tumor out of the anatomical structures mentioned. Another finding was an ileal loop fallen in the Douglas sack, extremely adherent to the peritoneum, the sigmoid, uterus and adnexal tumor. As the adhesions were extremely tight and organized on extensive fibrous surfaces during the ileal loop release the ileal loop was injured and it required ileo-ileal anastomosis. After the tumor eliberation we performed right adnex extirpation. The left adnex and the uterus were unaffected by the inflammatory process and so they were conserved. We also performed peritoneal lavage, multiple drainage and pelvic hemostatic mesh.

Evolution from the postoperative surgical point of view was favorable with wound healing per

primam and patient discharge in the eighth postoperative day with favorable biological status. Further ambulatory monitoring revealed a favorable postoperative evolution without complications.

Discussion

Although there have been important advances in elucidation of the ethiopatogenic conditions, diagnosis and treatment of genital infections, this chapter remains up to date in gynecologic pathology, especially due to the frequency of this pathology. (1)

Knowledge of these conditions is necessary for the understanding and early correct etiopathogenetic treatment, allowing complete cure of this condition both on the morphological and functional base. (1).

Etiopathogenic factors of female genital infection are represented by favoring causes given by endogenous factors (pregnancy, puerperum, menstruation, endocavitary tumors, endocrine deficiencies, etc.), exogenous factors (sexual transmitted dissease, explorations or surgery investigating the genital tract, IUDs, immunosuppressants, poor hygiene, etc.) and determining causes like bacterial infection (staphylococcus, streptococcus, E. Coli, aerobacter, proteus, gonorrhea, etc., aerobic-anaerobic associations).

In the pathogenetic chain when developing genital infection there are local and general factors involved like general and local defense of the patient, the conditions triggering infection, injury or associated pathology and especially aggressive nature of the bacterias. Aggression can beat local and general antimicrobial defenses leading to pelvic inflammatory disease. (1)

Considering the case report, we insist on how the infection spreads, the ways being multiple: direct microbial inoculation, cervix ascending path, lymphatic path, blood path and infection by contiguity. (1)

In our case we consider that genital infection was consecutive to kidney infection and propagation paths were lymphatic and through blood, taking into account the clinical evolution of the patient after the nephrectomy, the relative short period of time (3 months) between the urologic and gynecologic surgery and the severity of the urological pathology - infectious acute pyonephrosis with vascular thrombosis.

In relation to treatment, most authors recommend antibiotic treatment alone (in mild forms) or associated (in severe forms), anti-inflammatory and biological rebalancing.

In suppurative tubal, ovarian or tubo-ovarian pathology if antibiotic therapy has unfavorable evolution with tendency to generalized peritonitis the recommendation is drainage of the abscess by different methods: ultrasound or MRI guided puncture.

When this is not possible it is recommended to use surgery with removal of septic outbreak (salpingectomy, ovariectomy, as appropriate) and perioperative antibiotics.

Surgical treatment should be as conservative as possible, especially in young women (1, 2).

In our case, after 3 days of investigation and associated antibiotic, the treatment was surgical meaning section af adhesions, right adnexectomy, peritoneal lavage and multiple drainage.

Evacuation of purulent collections by other means (puncture) has not been discussed, taking into account the massive adherent syndrome and risks of injuring other organs that could not be avoided even by classic surgery – injury to an ileal loop during adhesion sectioning that required suture.

Postoperative evolution was favorable, with no immediate or long-term complications.

Conclusions

1. This case report is particularly important and we considered necessary its presentation due to rare ethiopathogenetic conditions of developing this genital infection consecutive to major kidney infection resolved surgically.

2. The case is also particular because of the surgical difficulties with injuring the ileal loop because of a major adhesion syndrome.

3. Remarkable in this case report is also the rare posibility of developing a genital infection after a supurative kidney pathology.

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