How Should Ectopic Ovaries Managed?

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Abstract

Background: Ectopic ovaries are an uncommon congenital anomaly. Supernumerary ovaries are sometimes confused with accessory ovaries, mesenteric cysts, and lymph nodes.

Case presentation: We experienced two cases of ectopic ovaries. A 26-year-old woman had a supernumerary ovary of 3x2.5x2 cm mass located on the Cul-de-sac between the rectum and the uterus. A 23-year-old woman had an accessory ovary in right side.

Conclusion: We report a rare case of ectopic ovaries in the retroperitoneum. We should provide careful follow-up of a mass if an accessory or supernumerary ovary is not completely removed from the operative field.

Introduction

Ectopic ovaries including accessory ovaries and supernumerary ovaries are rare gynecologic conditions. Ectopic ovarian tissue is a rare phenomenon, with an incidence estimated between 1 in 29,000 and 1 in 93,000 gynecologic admissions [1]. A more accurate diagnosis is difficult due to a confusing and still disputed classification system, as well as the frequently asymptomatic nature of the condition. We report a case of how should ectopic ovaries managed.

Case Report(s)

Case 1

A 26-year-old woman presented with a 20-day history of vaginal bleeding and discharge. The patient had a benign medical history and no surgical history. She was referred to our department from a local clinic for evaluation and surgical management of a solid pelvic mass. An enhanced computed tomography (CT) scan showed both ovaries in the pelvic cavity. The right ovary had a thick-walled cyst with a surrounding hematoma (a probable hemorrhagic corpus luteal cyst) and there was a thin, egg-shell like calcified cystic mass in the posterior pelvic cavity (Figure 1). An exploratory laparotomy was performed. At the time of surgery, a 10x10x9 cm cyst was noted in the right ovary. The left ovary appeared normal. A 3x2.5x2 cm mass shaped like an ovary was identified on the Cul-de-sac between the rectum and the uterus. The mass was similar to an ovary, but we could not identify another mass in the operative field. We do not routinely perform frozen biopsies, so we removed the mass from the cul-de-sac that was shaped like an ovary. The uterus and bilateral tubes appeared normal. There was no connection between this mass and both ovaries or the omentum, salpingix, or any ligaments. A right oophorectomy was performed, due to necrosis, followed by washing cytology.

The pathologic findings revealed endometriosis in the right ovary and a ghost ovary with infarction within the posterior mass. There were no other urogenital and pelvic organ anomalies.

Discussion

The incidence of supernumerary and accessory

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ovaries is reportedly 1:29,000–1:93,000 [1]. Since Wharton first published two cases of supernumerary ovaries, 50 cases of an additional ovary, including an accessory ovary, have been reported [2]. The supernumerary ovary and accessory ovary terminology are sometimes confused. A supernumerary ovary is referred to as a third ovary; it is independent of both ovaries, and is not connected to any ligaments, such as the broad ligament, utero-ovarian ligament, or round ligament [3]. An accessory ovary is associated with, and close to, an ectopic ovary [3]. During the embryonic development period, a supernumerary ovary develops from a separate primordium and is not supplied by blood vessels from a normal ovary [3]. An accessory ovary develops by the separation of migrating ovarian primordium. It has also been hypothesized that an accessory ovary is an acquired condition, such as one due to inflammation or surgery [4]. Most accessory ovaries are

There are teaching points regarding supernumerary and accessory ovaries. In 36% of cases, associated congenital anomalies are identified, such as accessory fallopian tubes, bifid fallopian tubes, accessory tubal ostia, bicornuate and unicornuate uteri, agenesis of the kidney or ureter, bladder diverticula, accessory adrenal glands, or hepatic lobulations [4]. The present cases had no associated anomalies, but gynecologists should confirm other anomalies. Confusion exists between accessory ovaries and mesenteric cysts or lymph nodes, and distinguishing them is based on pathological findings. We did not perform frozen biopsies, but the final histopathological diagnosis is important to determine the need for a re-operation.

Malignancies in accessory and supernumerary ovaries are rarely reported, but these tumors can be more problematic; thus, we should provide careful follow-up of a mass if an accessory or supernumerary ovary is not completely removed from the operative field.

An ectopic ovary has no increased risk of neoplastic complications, as compared with that of a normally positioned ovary [9]. An ectopic ovary is possible if there are unknown reasons for menstrual irregularities, abdominal pain, or infertility.

An ectopic ovary is a possible cause of infertility and may be used for controlling ovarian stimulation due to an unresponsive normal ovary during infertility treatment [10]. Magnetic resonance imaging (MRI) and laparoscopic surgery is an option for the diagnosis and management of an ectopic ovary [9]. MRI is a primary noninvasive modality for initial diagnosis and follow-up in patients with infertility or recurrent pelvic pain [9]. An ectopic ovary with a Müllerian duct anomaly close to the ureter, which narrowed the ureter, led to inflammation and hydronephrosis [11]. It seems that there was malignant infiltration into the ureter. Laparoscopic surgery is the gold standard to reveal the cause and to manage ovarian problems [11,12]. Gynecologists should carefully consider an ectopic ovary in cases of infertility with a Müllerian anomaly or a urological anomaly [11]. Our case was found incidentally during surgery. However, this case provides hints with which to guide the management of the extremely rare case of an ectopic ovary.
Illustrations

Illustration 1

Figure 1(A). Enhanced computed tomography scan shows both ovaries in the ovarian fossae of the pelvic cavity. The right ovary had a relatively thick-walled cyst with a surrounding pelvic hematoma, indicating a hemorrhagic corpus luteal cyst associated with a pelvic hemoperitoneum. The left ovary was not remarkable in size or contour.

Figure 1(B). A thin-walled cystic mass with egg shell calcification is noted in the posterior pelvic cavity.

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Figure 1(B). A thin-walled cystic mass with egg shell calcification is noted in the posterior pelvic cavity.
Illustration 2

The ovary on the right was located in the utero-ovarian ligament, whereas the other ovary was connected to the infundibulopelvic ligament, and a paratubal cyst was noticed.

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