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Ovarian Remnant Syndrome

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Introduction

Ovarian remnant syndrome (ORS) is defined as the presence of symptomatic, histologically affirmed residual ovarian tissue, usually following a complete hysterectomy and bilateral salpingo-oophorectomy. ORS was first described by Shemwell and Weed in 1970, is identified as a pelvic mass with residual ovarian tissue post-oophorectomy. Ovarian remnant syndrome results from an unintentionally incomplete oophorectomy. Typically caused by surgical components that constrain surgical presentation or compromise surgical procedure. This happens due to the nearness of pelvic attachment auxiliary to past surgery, intraoperative dying, pelvic incendiary malady or endometriosis. Dropping of some ovarian tissue into the abdomen during the surgery was suggested as a second cause of ORS. The third explanation is the presence of ectopic ovarian tissue [1-6].

Histological Types

Histological examination of ovarian remnants has revealed a wide range of results, including follicular cysts with or without hemorrhage, endometriosis and the presence of a corpus luteum. Neoplasia is a rare finding in ORS. In the literature, 12 cases of adenocarcinoma and border malignancy developing in an ovarian emnant have been described to date; 1 case of clear cell adenocarcinoma, 2 of mucinous tumor types, 5 of endometrioid types, 3 of adenocarcinomas and 1 of border serous neoplasia [7].

Clinical Manifestations

Symptoms most often occur within the first 5 years of a previous surgery. The foremost critical side effects are pelvic pain, either cyclic or constant. Other side effects incorporate dyspareunia, dysuria and other urinary side effect, and bowel indications. Ovarian remnants may be palpated by vaginal examination as growing cystic structure. The diagnosis of ORS isn't a straightforward errand; it is based on clinical history and upheld with imaging and research facility assessment. Patients with ORS tend to have a history of cement illness and/or extreme endometriosis. The most vital research facility discoveries are serum FSH < 30 mIU/mL and estradiol > 35 pg/mL. In any case, the nonattendance of such values ought to no run the show out the plausibility of ovarian remnant. Preoperative imaging with ultrasonography, abdominal computed tomography, and MRI is important in the diagnosis. MR imaging findings and a significantly elevated CA125 level indicate malignant changes, although a normal CA125 level does not preclude the diagnosis. In contrast to the classic presentation of ovarian cancer, ascites does not appear to be an associated feature, as the tumor tends to have a retroperitoneal location [8-10]. Surgical exploration and biopsy of possible ovarian tissue is required for the definitive diagnosis of ORS. Surgical extraction remains the treatment of choice in ORS as threat can be related with the leftover tissue. Leftover ovarian tissue is evacuated by either laparoscopy or laparotomy and may require different strategies. A wide extraction at slightest 2 cm from all ovarian tissue in arrange to avoid repeat. Surgeons should send frozen sections of suspected ovarian tissue pathology. If malignant tissues are found, the case should be treated as malignant ovary. Donnez, et al. detailed eight cases of essential ovarian adenocarcinoma creating in an ovarian remainder but, to our information, the primary case to happen after laparoscopic hysterectomy and reciprocal salpingo-oophorectomy. We discuss the management of pelvic masses suspected of malignancy after bilateral salpingo-oophorectomy and the possible role of endometriosis in the development of malignancy in ovarian remnant syndrome [11,12]. Romagnoli (2004) suggested that,

for patients who do not want more surgery pharmacologic therapy with gonadotropin releasing hormone analogs (GnRH agonist) or high doses of progestogens is an option for ORS.

Disclosure

The author has nothing to disclose.

References

1. Rosanne MK, Magrina JF, Magtibay PM (2007) Pathologic findings and oucomes of a minimally invasive approach to ovarian remnant syndrome. Feril Steril 87(5): 1005-1009.

2. Shemwell RE, Weed JC (1970) Ovarian Remnant Syndrome. Obstet Gynecol 44(24): 687-692.

3. FU SC, SU HY (2018) Residual ovarian syndrome: A case report with classic symptoms, imaging and pathology findings and treatment. Taiwanese J Obstetrics & Gynecology 57(5): 753-754.

4. Nezhat CS, Kearney S, Malik C, Nezhat F, Nezhat C (2005) laparoscopic management of ovarian remnant. Fertil Steril 83(4): 973-978.

5. Wallace MS (1991) The ovarian remnant syndrome in the bitch and queen. Vet Clin North Am 21(3): 501-507.

6. Feldman EC, Nelson RW (2003) Canine and Feline Endocrinology and Reproduction. 3rd (Edn.), Saunders company, Missouri, USA pp: 1104.

7. Imai A, Matsunami K, Takagi H, Ichigo S (2014) Malignant neoplasia arising from ovarian remnants following bilateral salpingo-oophorectomy (Review). Oncology Letters 8(1): 3-6.

8. Kho RM, Abrao MS (2012) Ovarian remnant syndrome: etiology, diagnosis, treatment and impact of endometriosis. Curr Opin Obstet Gynecol 24(4): 210-214.

9. Petit PD, Lee RA (1988) Ovarian remnant syndrome: diagnostic dilemma and surgical challenge. Obstet Gynecol 71(4): 580-583.

10. Mahdavi A, Kumtepe Y, Nezhat F (2007) Laparoscopic management of benign serous neoplasia arising from persistent ovarian remnant. J Minim Invasive Gynecol 14(5): 654-656.

11. Romagnoli S (2004) Ovarain Remnant Syndrome. Proceedings of Fourth EVSSAR Congress. Barcelona, Spain. pp: 239-241.

12. Donnez O, Squifflet J, Marbaix E, Jadoul P, Donnez J (2007) Primary ovarian adenocarcinoma developing in ovarian remnant tissue ten years after laparoscopic hysterectomy and bilateral salpingo-oophorectomy for endometriosis. J Minim Invasive Gynecol 14(6): 752-757.