VOLUME - 12, ISSUE - 01, JANUARY - 2023 • PRINT ISSN No. 2277 - 8160 • DOI : 10.36106/gjra

Original Research Paper

Anaesthesiology

AN EMERGENCY CASE OF TORSION OVARIAN CYST IN A ANTI COAGULATED PATIENT WITH ARTIFICIAL MITRAL VALVE

Dr. Kanumetta Rajanikanth Junior Resident,

ABSTRACT The common gynaecological causes of acute pelvic pain are ruptured ectopic pregnancy, hemorrhagic corpus luteal cyst or torsion of an ovarian cyst. Ovarian vascular accidents are reported in women on oral anticoagulation presenting as an acute pelvic pain. Although such vascular accidents with anticoagulation therapy are an unusual , a meticulous history, clinical examination, and laboratory workup to confirm the diagnosis and timely intervention is needed to reduce attending morbidity and mortality. However, a standard algorithm for management is not described in the literature. We hereby report successful management of recurrent hemorrhagic ovarian cyst due to coagulopathy in a woman with mechanical heart valves with timely surgical intervention. This publication will discuss operative versus non operative management approach and may provide value addition to readers encountering such cases in their clinical practice.

KEYWORDS : Haemorrhagic, ovarian cyst, anticoagulants, management, surgery, artificial mitral valve

INTRODUCTION

Long-term anticoagulation is required in patients with arti ficial heart valves to avoid thromboembolic complications. In such cases, a target international normalised ratio (INR) has to be maintained for anticoagulation to prevent thromboembolism which needs to be balanced carefully to avoid haemorrhagic complication[1].

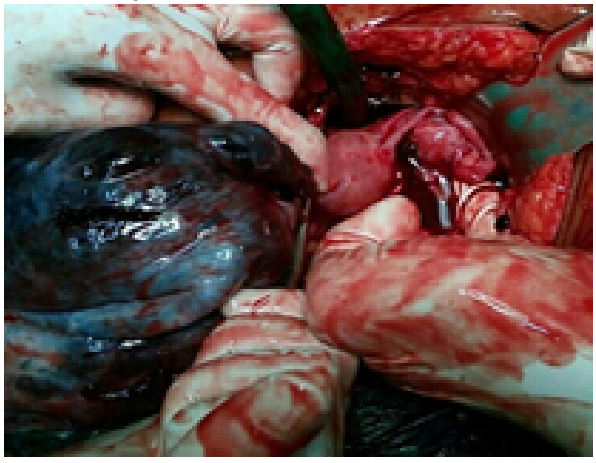
AIMS AND OBJECTIVES

Perioperative challenges in this case are explained.

CASE REPORT

A 25 year old female patient presented with pain abdomen which was twisting type and history of fever since 10days. she underwent mitral valve replacement 2 years back and postopera- tively on anticoagulant medication- Tab.Acenocoumarol 2mg once daily, Tab Aspirin 75mg once daily with a INR of 3(done on the day of admission) .she is being treated for hypertension since two years with Tab.Metoprolol 25mg once daily. She was taken up for emergency left ovarian cystectomy for torsion left ovary.

A complete pre-anaesthetic checkup was done and case accepted under ASA Grade 4 Informed and written high risk anaesthesia consent was taken. Emergency anticoagulation was done by transfusing one unit FFP, one unit platelets, withholding Tab.Acenocoumarol and Tab Aspirin and Inj Vitamin K 1mg i.v



Intra Operative Management

-Patient was shifted to OT
-secured two 18 G iv cannula to right hand and left hand.
-preoxygenated with 8Lit of Oxygen
-Pre medication was given with Inj Ondan 4mg i.v, Inj Rantidine 50mg i.v, Inj Midaz 1mg i.v, Inj Fentanyl 50mcg
-Pt was induced with Inj.Propofol 2mg/kg, Inj Vecuronium 0.1mg/kg and anaesthesia was maintained with Oxygen, Nitrousoxide and Isoflurane MAC 1.5.

Pt was intubated with 7 sized cuffed endotracheal tube and fixed after checking for bilateral air entry and adequate chest rise-connected to mechanical ventilator
-Heart rate, ECG, oxygen saturation and end tidal Co_2 were monitored.
-Intraoperatively patient was managed by controlling heart rate,
ventricular preload, diminished RV and LV contractile function and coexisting pulmonary hypertension. Sinus rhythm was pre- served. Tachycardia is poorly tolerated because of the decreased time for diastolic filling of LV and was avoided.
-All measures to avoid increases in pulmonary arterial (PA) pressures (i.e. avoid hypoxia, hypercarbia, acidosis, lung hyper- expansion and nitrous oxide) were taken.
-Intra operatively two units of FFP(fresh frozen plasma)was given.
- As patient was maintaining hemodynamic stability, she was extubated after surgery
-Postoperatively patient was given Inj Heparin 5000 IU i.v sixth hourly and Tab Acenocoumarol 2mg once day and Tab Aspirin 75 mg once day were restarted after three days while monitoring for PT and INR. On third day PT was 17.6 INR was 1.4.

CONCLUSION:

Spontaneous bleeding is one of the most common adverse ef- fects of anticoagulants, and factors such as old age, dose, dura- tion of therapy, drug interaction and occult diseases further de- termine the risk of bleeding. Strict monitoring of the coagulation profile in patients taking long-term anticoagulants is essential. Women in the reproductive age group can present with bleeding and haemorrhage often related to a ruptured corpus luteum cyst. Haemoperitoneum in such patients on anticoagulants is a rare and sometimes scary scenario to encounter. Such patients present a challenge as abrupt reversal of anticoagulation is required to control any ongoing haemorrhage and further surgical blood loss[2].

REFERENCES:

1. Singh U, Agarwal R, Dhar M, Biswas S. Emergency sur- gery for a ruptured ovarian cyst in an anticoagulated patient with artificial mitral valve and massive haemorrhage: Maintain- ing a delicate balance. *Indian JAnaesth*.2019;63(6):499501.doi:10.4103/ija.IJA_18_19
2. Curtis R, Schweitzer A, van Vlymen J. Reversal of warfarin anticoagulation for urgent surgical procedures. Can J Anesth. 2015;62:634–49.