up HRCT scans showed evidence of residual fibrosis with significant reduction in nodularity.

The presence of bilateral large effusions in sarcoidosis is unusual. The reported prevalence of pleural involvement in sarcoidosis varies from 0 to 5% \(^1\) with unilateral, small effusions usually. Clinically significant bilateral effusions in sarcoidosis are rare. There are few other reports of sarcoidosis presenting with bilateral pleural effusions but the quantity of fluid was small and clinically insignificant.\(^2\) The growth of one colony of Mycobacterium tuberculosis on culture from the lesion in our patient reiterate the possibility that mycobacteria or some of its components may be capable of inducing the immune response and the pathological changes of sarcoidosis.\(^3\)

Hence, sarcoidosis is an important treatable differential diagnosis to be considered in a patient with bilateral pleural effusions especially in the setting of associated pulmonary involvement, non-caseating granulomas\(^4\) and non-response to antituberculous therapy.

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Massive Edema of the Ovary Diagnosed with Laparoscopic Biopsy and Frozen Section

Sir,

Massive ovarian edema (MOE) is a rare condition that is seldom recognized at ultrasonography laparotomy. The first description of MOE was made by Kalstone in 1969.\(^5\) Although, there is still uncertainty about its pathogenesis, intermittent torsion of the ovary resulting in interference with venous and lymphatic drainage is a likely explanation. We report a case of MOE diagnosed with laparoscopic biopsy and frozen section.

A 32-year-old woman, para one was admitted with sudden onset of left lower quadrant pain. She had a missing period for ten days. Her past medical history revealed appendectomy in childhood. Her vital signs were stable. On physical examination, she had left abdominal tenderness with minimal rebound and guarding. Transvaginal sonography showed an enlarged left ovary of 82 x 64 mm and ovarian stroma had dense internal echo. There was free fluid in Douglas pouch. Routine laboratory analysis only showed iron deficiency anemia. Culdocentesis drew clear serous fluid. Changing physical examination findings, with rebound and tenderness led to surgical exploration.

Diagnostic laparoscopy was performed. All pelvic structures were normal except left ovary which was about 8 cm in diameter and edematous in appearance. The only pathology detected was MOE without torsion and ischemia and a small wedge biopsy is taken. Frozen section confirmed MOE. The patient was discharged the next day and one month later, control ultrasonography showed a normal left ovary.

MOE is a rare clinicopathologic entity. World Health Organization defines it as an accumulation of edema fluid within the ovarian stroma, separating normal follicular structures. The clinical presentation of MOE varies from acute abdomen to an incidental finding at laparotomy. Most patients present with abdominal pain and rarely with pelvic mass.

The etiology of this entity is still obscure. It has been suggested that MOE results from interference with the venous and lymphatic flow due to torsion of the mesovarium. Although the right ovary is most commonly affected, bilateral affections have also been reported.\(^2\) Clinicians should also remember that ovarian oedema may occur along with carcinoma.

Prompt diagnosis is possible with recent advances in ultrasonography and magnetic resonance imaging (MRI). Umesaki et al succeeded in making preoperative diagnosis of MOE by MRI and proposed diagnostic imaging criteria.\(^6\)

Management of this entity depends on the condition of the patient and may vary from bilateral salpingo-oophorectomy to simple ovarian biopsy. In the past, Kalstone et al recommended frozen section of a generous biopsy and securing ovaries in a position where they cannot twist.\(^5\) Later on, suspension of the ovary has become the treatment of choice.\(^6\) Today, conservative laparoscopic approach and histologic confirmation is the favourite treatment modality.\(^5\)

MOE must be kept in mind in the differential diagnosis of ovarian enlargement in a female during reproductive years. When the diagnosis of MOE is done, every effort should be made to preserve the ovarian function.

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