

ERUM FATIMA

Supervisor: Assistant, PhD Mamatkulova M.J.**OVARIAN APOPLEXY**

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Acute abdominal pain should always be evaluated quickly and accurately due to the possibility of urgent surgical intervention. We report a case of a woman with ovarian apoplexy while taking Clofit Citrate. The patient developed acute abdominal pain after coitus. The patient was diagnosed ovarian apoplexy with ovarian cyst using pelvic ultrasound. The main differential diagnosis of ovarian apoplexy in women of reproductive age is ectopic pregnancy and ovarian cyst torsion. In this article, we describe a rare case of ovarian apoplexy while taking the drug.

Key words: ovarian apoplexy, acute pain, surgical therapy.

Ovarian apoplexy is a sudden rupture of the ovary, which usually occurs at the site of a corpus luteum cyst, followed by hemoperitoneum. The corpus luteum produces progesterone to prepare for and maintain pregnancy. If fertilization does occur, the corpus luteum disappears at about 8–10 weeks of pregnancy, and the placenta continues to produce progesterone for the remainder of the pregnancy. The luteal phase of increased ovarian vascularization may increase the likelihood of cyst rupture, leading to acute abdomen and hemoperitoneum. An extremely rare but potentially fatal manifestation, hemoperitoneum due to cyst rupture, clinical cases in the literature.

Ovarian apoplexy is a sudden rupture of ovarian tissue, usually at the site of a cyst, accompanied by hemorrhage into the abdominal cavity and acute pain. Ovarian apoplexy is rare. Among women who have undergone surgery for internal bleeding, ovarian rupture is found in 0.5–3% of cases [1,2]. Patients may have a wide range of clinical signs, from no signs to severe peritoneal irritation, which can be confused with other differential diagnoses, such as ruptured ectopic pregnancy and acute appendicitis.

Patients with high pain tolerance may not have clinical signs of acute abdomen [3]. A pregnancy test is required to distinguish a ruptured ectopic pregnancy from a ruptured corpus luteum cyst, which can present similarly.

Symptoms and signs of the disease

Ovarian apoplexy is characterized by a number of vivid and sudden symptoms that require attention and immediate response. The main and most common symptom is acute pain in the lower abdomen, which can occur suddenly and intensify with movement or physical exertion. The pain may spread to the lumbar region and may be unilateral, i.e., localized on the side where the ovarian rupture occurred.

In addition to pain, symptoms of ovarian apoplexy may include:

- General weakness, dizziness, rapid heartbeat, which may be associated with blood loss and the onset of shock.
- Nausea or vomiting, which are not always directly related to the digestive system, but may be the body's response to severe pain and stress.
- Symptoms of peritoneal irritation, including tension in the muscles of the anterior abdominal wall and increased pain on palpation.
- Sometimes, delayed menstruation or bloody discharge from the vagina that does not correspond to the normal menstrual cycle.
- Due to the intensity and suddenness of the symptoms of apoplexy, women may experience severe stress and anxiety. It is important to understand that timely medical attention and accurate diagnosis can quickly alleviate the condition and prevent possible complications.

Causes of ovarian apoplexy

Ovarian apoplexy can be the result of a number of factors that cause increased pressure within the ovary or disrupt the integrity of its blood vessels. It is important to

Clinical case.

Patient S., 18 years old. Admitted with complaints of acute abdominal pain and discomfort in the lower abdomen for several hours. In addition, there was persistent

weakness and dizziness. Medical history: married for 7 months, attempts to conceive. According to her, she received anti-inflammatory treatment for the pelvic organs and pregnancy induction with the drug “Clophit citrate” for 5 days. Menarche at 14 years old, regular. Married since 17 years old. According to her, her menstrual cycle is regular, not heavy. Last menstruation 2 weeks ago. No family history of disease. Clinical and laboratory data: Blood test: Hb-56 g/l, erythrocytes- $2.3 \times 10^{12}/l$, color index-0.6, leukocytes- $7.8 \times 10^9/l$, p/y-4%, s/y-66%, monocytes-5%, lymphocytes-25%, ESR-23 mm/h. Blood biochemistry: total protein-60 g/l, glucose-3.7 mmol/l, creatinine- $77.5 \mu\text{mol}/l$, bilirubin- $15.0 \mu\text{mol}/l$, AST-1.0 U/L, ALT-0.5 U/L. Blood type B (III), Rh (+) positive. Ultrasound data: apoplexy of the right ovary. Cyst of the left ovary. Examined by a therapist and anesthesiologist. Right oophorectomy performed. Postoperative period went smoothly. Sutures removed on the 6th day. Discharged home.

The initial imaging method for diagnosing ovarian apoplexy is pelvic ultrasound. It can reveal a complex cyst with free hypoechoic fluid in the abdominal cavity and an echogenic rim surrounding the cystic component in the adnexal region (hemoperitoneum) [5]. If vital signs are unstable, surgical intervention has been an important part of the treatment of ovarian apoplexy. However, if the goal is to preserve ovarian function as well as eliminate the cause of bleeding, the condition can now be managed with a cautious approach. When the patient's hemodynamics are stable (systolic blood pressure greater than 90 mmHg) and hemoglobin levels remain stable for four to six hours of monitoring, a conservative approach is the first course of action. When vital signs are unstable, the patient receives surgical care [6].

In a study by Ganna Kolesnyk (2024), two groups of clinical forms of ovarian apoplexy were compared: anemic and painful forms. After confirmation of the diagnosis of anemic ovarian apoplexy, all patients underwent surgical treatment. In most of the 28 (80%) patients in the comparison group, after confirmation of the diagnosis of the painful form of ovarian apoplexy and in the absence of a significant

amount of serous fluid in the abdominal cavity, no subsequent surgical procedures were performed [7].

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