

Occult tubo-ovarian abscess at term may present without fever or leukocytosis and mimic placental abruption, leading to diagnosis only at cesarean delivery.

Background

Tubo-ovarian abscess (TOA) is an uncommon complication of pelvic inflammatory disease (PID)¹, with cases in pregnancy described primarily in isolated case reports and small case series².

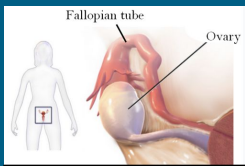


Figure 1: Tubo-ovarian abscess.

HIGH MATERNAL AND FETAL MORBIDITY²⁻⁶

- Abscess rupture
- Preterm delivery
- Pregnancy loss
- Sepsis

Case Presentation

Day 0: OB Triage

Patient discharged with negative abruption workup after fall

Day 7: Admission to Labor and Delivery

A 28-year-old G1P0 at 38 weeks and 2 days gestation presented with severe abdominal pain.

Pregnancy Complications:

- Class II obesity
- Pregestational diabetes mellitus requiring insulin therapy
- Known abdominal trauma one week prior

Maternal and Fetal Evaluation:

- Afebrile
- Neutrophilia without leukocytosis
- Late deceleration with nadir into the 80s
 - Induction initially recommended

Persistent Category II tracing with recurrent decelerations and minimal variability prompted expedited cesarean delivery.

Treatment & Outcome

Unexpected Intraoperative Findings

- Markedly foul odor on abdominal entry
- No evidence of placental abruption
- Large right-sided TOA involving the right adnexa and adjacent bowel

Operative Management

- Right salpingo-oophorectomy
- Adhesiolysis
- Abscess drainage
- Intraoperative cultures

Postoperative Findings and Outcome

- Culture results:
 - (+) *Escherichia coli*, pansensitive
 - (+) *Pseudomonas aeruginosa*, pansensitive
 - (+) *Streptococcus constellatus*
- Afebrile, tachycardic
- Antibiotic therapy, multidisciplinary management
- Discharge on postoperative day 4

Discussion

TOA in pregnancy is **exceedingly rare** and may be difficult to recognize due to **nonspecific clinical findings**⁶. This case highlights three features that complicated recognition at term.

ATYPICAL PRESENTATION	38+2 weeks Term gestation	G1P0 Nulliparous	No history of PID or known adnexal pathology
	Pregestational diabetes may have increased susceptibility to infection despite the absence of traditional PID risk factors .		
OCCULT INFECTION	Afebrile	No leukocytosis	No preoperative evidence of TOA
	Advanced gestation may limit adnexal visualization , allowing significant pelvic pathology to remain occult.		
OBSTETRIC MIMIC	Severe abdominal pain + recurrent FHR decelerations	Concern for placental abruption prompting expedited cesarean	Right TOA discovered No abruption identified
	★ Intraoperative clue: Markedly foul odor upon abdominal entry		

Conclusion

Occult TOA may present at term without classic signs of infection and can mimic obstetric emergencies such as placental abruption. Awareness of this rare presentation may facilitate earlier recognition and management in pregnant patients with unexplained abdominal pain and nonreassuring fetal status.

This case stresses 3 key points:

1. TOA can occur during pregnancy without traditional risk factors, including a history of PID or known adnexal pathology. Absence of fever or leukocytosis does not exclude significant pelvic infection.
2. **Persistent abdominal pain warrants continued reassessment**, particularly after repeated triage presentations. Consider infectious and nongynecologic etiologies, and when technically feasible, evaluation of the maternal adnexa.
3. **Unexpected maternal pathology may contribute to nonreassuring fetal status.** Thorough inspection of accessible pelvic and abdominal anatomy and multidisciplinary intraoperative management can facilitate recognition and definitive treatment of unexpected pathology.

References

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