specific feature of mediolateral episiotomy and not of perineal laceration.

CONCLUSIONS

Because of the important implications for obstetric practice of the possibility that mediolateral episiotomy may cause long-term dyspareunia, confirmation from larger prospective studies is needed. An ideal population for such a study would be that of the West Berkshire perineal management trial ([4]), if the follow-up concerning genital prolapse promised by the authors were to include an assessment of sexual function.

At present the decision to perform prophylactic mediolateral episiotomy should be influenced by the absence of positive evidence for the value of this procedure, by the attitude of the patient to the procedure, and by the awareness that it may impair sexual function.

BIBLIOGRAPHY

1) Hofmeyr G. J., Sonnendecker E. W. W.: "Elective episiotomy in perspective". *S. Afr. Med. J.*, in press, 1986.
2) Kitzinger S. (ed.): "Episiotomy. Physical and emotional aspects". National Childbirth Trust, London, 1981.
3) Thacker S. B., Banta D.: *Obst. Gyn. Survey, 38, 322,* 1983.
4) Sleep J., Grant R., Garcia J., Elbourne D., Spencer J., Chalmers I.: *B. M. J., 289,* 587, 1984.
5) Harrison R. F., Brennan M., North P. M., Reed J. V., Wickham E. A.: *B. M. J., 288,* 1971, 1984.
6) Gordon H., Logue M., *Lancet, 2,* 123, 1985.
7) Coats P. M., Chan K. K., Wilkins M., Beard R. J.: *Br. J. Obst. Gyn., 87,* 408, 1980.
8) Beynon C. L.: *J. of O. & G. of Brit. Commonw., 81,* 126, 1974.
9) Buchan P. C., Nicholls J. A. J.: *J. R. Col. Gen. Pract., 30,* 257, 1980.
10) Willmott J.: *Midwives Chron. Nurs. Notes, 93,* 46, 1980.
11) Diem K., Leutner C. (eds.): "Scientific Tables". J. R. Geigy S.A., Basle, 109, 1970.
12) Reading A. E., Sledmere C. M., Cox D. N., Campbell S.: *Br. Med. J., 284,* 243, 1982.

TORSION OF THE ADNEXA

R. ZARBO - F. PEPE - M. PANELLA (*) - G. PEPE (***) - A.S. GULISANO (**)

Department of Obstetrics and Gynecology - Catania University (Italy)
(Director: (I. Panella)
(*) Department of Obstetrics and Gynecologic Pathology, Ascoli & Tomaselli Hospital, Catania University, Catania (Italy)
(Director: S. Di Leo)
(**) Department of Embryofetal Pathology - Catania University (Italy)
(Director: A. S. Gulisano)
(***) Department of Emergency Surgery - Catania University, Catania (Italy)
(Director: E. Cirino)

Summary: The Authors report two cases of adnexal torsion. The first case occurred in a 30-year old patient, while the latter was in a women after induction of ovulation with FSH-LH and hCG. The patient, who had begun a pregnancy was treated with adnexectomy, and delivered at term a normal baby.

Key words: torsion, adnexa, surgery.

Torsion of the adnexa is a rare pathology described for the first time by Bland Sutton in 1890 ([1]). The incidence is greater on the right adnexa (60%) ([2, 3, 7, 8, 9]) probably because the left side of the pelvic cavity is almost totally filled by the colon and because there is a major tendency for surgical intervention for suspected appendicitis when a patient presents with pain in the right iliac fossa. In 1 out of 10 cases the torsion is bilateral ([3, 4, 5, 6]). We refer 2 cases of torsion of the adnexa, one in a pregnant women, in patients admitted to the First Clinic of Obstetrics and Gynecology, Catania University Medical School, Catania, Italy.

CASE REPORT

Case 1. S. A., gravida 1, Para 1, age 30.

Menarche at 11 years of age with normal menstruations. Patients had a normal pregnancy with spontaneous delivery at term. Last menstruation occurred 4 days before admission. Patient complained of intense pain for six hours in the left iliac fossa with nausea and vomit. On physical exam general condition was noted as good, with normal arterial blood pressure and heart beat. Abdominal palpation demonstrated pain in the left iliac fossa. Gynecological exam showed antiflex uterus of normal volume with a palpable, slightly movable, and very painful mass posterior to the uterus. Routine blood tests were normal and pregnancy test was negative. Echography demonstrated a uterus and right adnexa of normal volume; on the right of the uterus there was a dishomogeneous mass 9 cm in diameter (fig. 1). On laparotomy the uterus and right adnexa were of normal volume while the left adnexa presented a normal tube with a 9 cm ovarian mass; on the vascular peduncle there were 2 torsions; there was a hemorrhagic infarction on the whole ovary as well as distal to the tube. Left adnexectomy was performed. Histological exam showed massive hemorrhagic infarction of the ovary and tube. Post operative course was afebrile and the patient was discharged cured on the seventh postoperative day.

Case 2. S. M., gravida 2, Para 0, age 29.

Menarchy was provoked with estroprogestin and successfully oligomenorrhoic or amenorrhoic cycles of maximum duration of six months. She had 2 spontaneous abortions in second month of pregnancy.

Fig. 1. — Clinical case 1: Echography showed a dishomogenous mass of 9 cm in diameter on the right of the uterus.

After provoked menstruation the patient was treated for two cycles with ovulation inducing medications. In the first cycle of treatment 24 ampules of Pergonal and one ampule of Profasi 5000 on 14th day of the cycle were administered. In the second cycle of treatment 32 ampules of Pergonal from the 5th day to the 13th day and Profasi 5000 on 14th day were administered. 10 days after administration of HCG notable abdominal pain and dispnea appeared. Blood pressure on admission was 115/90 mmHg and cardiac rate 80 bpm. On examination abdomen was distended, and painful on palpation. On percussion ascites was evident. On gynecological exam it was not possible to evaluate the characteristic of pelvic organs due to pain. Echography showed normal uterus and polycystic ovaries with maximum diameter of 10 cm on the right and 8.8 cm on the left. In the peritoneal cavity there was abundant free fluid. On

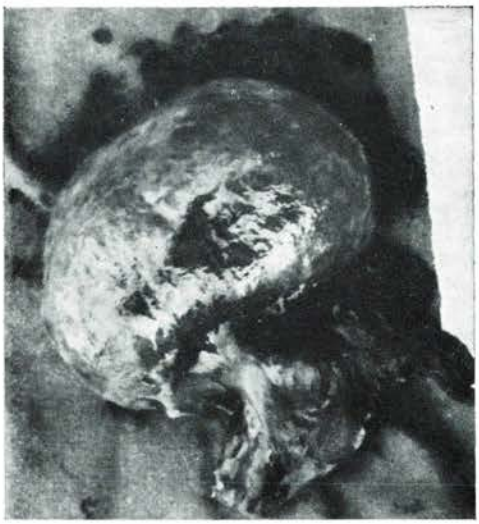

Fig. 2. — Clinical case 2: Massive hemorrhagic infarction of the ovary and tube after torsion of the adnexa.

auscultation and percussion of the thorax no pleural effusion was present.

There was hemoconcentration and leukocytosis, and pregnancy test was positive.

On the next day abdominal pain increased in intensity and hypotension, hyposodemia, and hypokalemia developed. During a sudden pain crisis laparotomy was performed in the suspicion of adnexal torsion.

On laparotomy 5 litres of free fluid of yellow citrinus color was aspirated. The ovaries were transformed into polycystic tumors with yellow walls and in some cases with sierohemorrhagic content. The maximum diameter of the right ovary was 18 cm and of the left 11 cm. There was torsion of the right adnexa and the walls of numerous cysts of both ovaries were lacerated. The uterus was normal and intensely congested. Right adnexectomy, puncture and aspiration of the greater cysts of the left ovary with suture of laceration were performed. On the eighth postoperative day echography showed unchanged volume of the ovary and notable ascites. At the tenth week of pregnancy ascites had disappeared, left adnexa was of normal volume, and the pregnancy was in normal evolution. On the fifteenth week of pregnancy the patient was admitted for threatened abortion and recovered after bed rest and treatment with betamimetics. Delivery occured at term of pregnancy with the spontaneous delivery of a newborn weighing 3450 grams with a normal Apgar index.

DISCUSSION

Torsion of the adnexa has been described in premenarche, menarche, and pregnancy. It is favored by the normal mobility of the ovary which can rotate 90 degrees on the mesovary.

More frequently the excessive length or the spiral course of the tubes, incomplete distal mesosalpinx, hydrosalpinx, hematosalpinx, cysts and tumor of mesosalpinx, mesovary, and of the ovary, ovarian micropolyvstosis, Morgagni's hydatid, increase of volume of the uterus or uterine hypoplasia, sterilization according to Pomeroy, traumas, sudden changes of position of the body, and all factors that impede venous flux of the adnexi are the most common predisposing factors for torsion of the adnexa ([1, 2, 3, 4, 5, 6]).

Torsion of the adnexa which has variable grades, causes stasis with edema and subsequent hemorrhagic infarction and necrosis of the organ. Diagnosis is rarely made preoperatively due to the lack of specificity of the symptoms which are: nausea, vomit and pain at iliac fossa or in the inferior abdominal quadrants. Shock is rare. Symptomatology is sometimes recurrent. Gynecological exam generally shows tenderness and pain. Palpation of a mass is not always the rule. Differential diagnosis is made by ruling out acute appendicitis when the right adnexa rotates, extrauterine pregnancy, renal colic, and pelvic inflammatory disease. Important tests include leukocytosis which is common in many pathologies. Pregnancy test is usually negative but some cases of torsion in pregnant women, such as our case, have been described. Direct X-ray of the abdomen, which is done exceptionally in pregnancy, rules out intestinal pathologies such as occlusion or presence of radioopaque calculi. Pelvic echography and laparoscopy are more useful.

Conservative treatment is indicated in cases in which hematic flux of the organ

recovers normally after detorsion of the organ. In these cases, if predisposing factors for torsion are present, suture of the adnexa to the posterior broad ligament of to the pelvic cavity is recommended. A possible danger after detorsion of the adnexa is embolic phenomenon due to detachment of thrombi formed in utero-tubaric circulation. When the organ is necrotic, adnexectomy is necessary. Spontaneous amputation of the rotated tube has been described on laparotomy. Finally, controlateral adnexa must always be accurately inspected to diagnose and eventually correct predisposing factors to torsion such as adherence, cysts, etc.

BIBLIOGRAPHY

1) Bland-Sutton T.: *Lancet, 2*, 1146, 1880.
2) Evans J. P.: *J. Pediatr. Surg., 13*, 195, 1978.
3) James D. F., Barber H. R. H., Graber E. R.: *Obst. Gyn., 35*, 226, 1970.
4) Dowmer I. G., Brines O. A.: *Am. J. Obst. Gyn., 21*, 665, 1931.
5) Sarason E. L.: *Surg. Obst. Gyn., 107*, 771, 1958.
6) Robins A. I., Washington D. C.: *Am. J. Obst. Gyn , 68*, 932, 1954.
7) Kohl G. C.: *Obst. Gyn., 7*, 396, 1956.
8) Armentano G., Mauro M., Moretti A. M., Manini G., Stea F., Bracco P. L.: *Clin. Exp. Obst. Gyn.*, XII, 36, 1985.
9) Bompiani A.: "Patologia dell'ovaio". In: *Trattato Italiano di Ginecologia*, vol. III, Istituto Geografico De Agostini, Novara, Edizioni PEM, Roma, 1968.

INTRAVENOUS 16-PHENOXY PGE2 METHYLSULFONYLAMIDE FOR INDUCTION OF LABOR IN CASES OF FETAL DEATH

A. S. GULISANO (*) - F. PEPE - M. PANELLA (**)
C. D. PRIVITERA - G. PEPE - G. PICCIONE ([1])
Department of Obstetrics and Gynecology, Vittorio Emanuele Hospital,
Catania University - Catania (Italy)
(Director: I. Panella)
(*) Department of Embryo-fetal Pathology, Vittorio Emanuele Hospital,
Catania University - Catania (Italy)
(Director: A. S. Gulisano)
(**) Department of Obstetrical and Gynecological Pathology, Tomaselli and Ascoli Hospital,
Catania University - Catania (Italy)
(Director: S. Di Leo)

Summary: Labor was induced via intravenous infusion of 16-phenoxy-prostaglandin-E2-methylsulphonylamide in 13 cases of missed abortion and 19 cases of intrauterine fetal death. In all cases Bishop score was less than 4. Delivery occurred within 24 hours in all cases, with a minimal frequency of side effects (six cases of erythema above the incannulated vein and 1 case of diarrhea). The interval between the beginning of the infusion and delivery was 9.42 minutes. Uterine curettage was performed in 9 cases.

The induction of labor in patients with a posterior, closed and unripe cervix is possible, effectively utilizing prostaglandins (PGs). The Authors study the effectiveness of 16-phenoxy-prostaglandin-E2 methylsulfonylamide (PGE2) in cases of missed abortion or fetal death in patients admitted from 1982 to 1985 in the First Cli-

([1]) Scherin E. Italy.