



Right ovarian vein syndrome: Case Report and Review of Literature

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ABSTRACT

The Ovarian Vein Syndrome was first reported in 1964, corresponds to ureteral compression by a dilated ovarian vein. The true pathophysiological entity remains controversial and discussed. It appears to be multifactorial anatomical and hormonal. The diagnosis is essentially radiological (intravenous urography). The Treatment is Urological (drainage by stent) and / or vascular (embolization, resection-ligature by conventional surgery or Coelioscopic). The prognosis of ovarian vein syndrome is generally favorable, without impairment of renal function. Through A new observation, the authors propose to study the pathogenic, therapeutic and evolutionary aspects of the syndrome of the vein Ovarian. Using Embase and Medline, a literature search was undertaken, English and french articles on the ovarian vein syndrome were appraised.

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Introduction

The extrinsic compression of the lumbar-iliac ureter, by dilated ovarian veins is a clinical entity first described by Clark [1] in 1964. Despite the many necropsy and experimental studies that been carried out to support the anatomoclinic bases of syndrome, it has not failed to provoke many controversies [2-3].

Clark postulated that an aberrant ovarian vein, which might arise from persistent embryological posterior subcardinal branches, exerts occlusive pressure on the ipsilateral ureter (4). By crossing the ureter at the level of the pelvic brim, rather than at the usual more cephalad level of L3/L4, Clark felt the aberrant vessel is more likely to cause ureteric compression. He also described aberrant ovarian veins as being much larger than normal, more likely to branch into a number of distal tributaries, and more likely to drain into the right renal vein, all of which he felt could explain the phenomenon of right-sided OVS (5).

Observation:

It is a woman aged 20 single, she have no children, and she suffers from low back pain colic and hematuria evolving for 10 months unrelated to menstruation. It was well regulated. She had no signs of Urinary tract infections. Clinical examination has show sensitivity of the right lumbar fossa, and no fever 37°C.

The biological check-up was normal. The bacteriology of the urine had revealed sterile. The search for Bacille de Koch in the urine was also negative. Ultrasound has showed moderate dilation of the renals cavities without obstruction. A CT urography showed an extrinsic compression

On about 1 cm of the ilio-pelvic ureter with dilatation upstream and retardation of opacification of the downstream ureter (Photo 1). The left uretero-pyelo-calicielles cavities were normal, but we have an aorto mesenteric clamp a retrograde ureteropyelography had concluded an extrinsic ureteral obstruction in the right kidney (Photo 2). We have

mounted a probe jj in the right kidney. The pain had been amended postoperatively.



Photo 1 . A CT urography showed an extrinsic compression

On about 1 cm of the ilio-pelvic ureter with dilatation upstream and retardation of opacification of the downstream ureter.



Photo 2. an aorto mesenteric clamp.

Discussion

The extrinsic compression of the lumbar-iliac ureter by dilated and ectopic ovarian veins a previously controversial clinical entity described for the first time by Clark (1) in 1964. At that time he counted 130 cases. Currently, the number of cases reported in about 280 cases (6). It is therefore an entity

Rare (3,4,7,8). On a five-year study, based on the Intravenous urography for patients. Dykhuizen and Robert (8) were able to show 25 S. Ovarian vein (ovarian vein syndrome) on 10 000 intravenous urographies, or an incidence of 2.5 %. This figure could be more significant if Relative to the general female population. The average age of Occurrence of ovarian vein syndrome is 32 years with extremes ranging from 11 to 49 years (1, 4, 9-10). Since then, discription in pregnant women (1), vein ovarian syndrome may occur outside pregnancy (11) and even in the nulliparous and the children [5, 10].

The ovarian vein syndrome mainly concerns the side right in 95% of cases. In addition, the left ureter can also be touched (1, 9) as well as the two ureters at the same time (12, 13).

Although the designation of ovarian vein goes hand in hand with pathology of the woman, one finds his analogue in men: ureteral obstruction by a gonadal vein dilated (14). From a physiopathological point of view, pregnancy, the ovarian vein sees its triple caliber; the ureter right is compressed by the pregnant uterus against the small basin and is hypotonic by hormonal impregnation. These factors, however, cannot explain the presence of

Ovarien veina syndrome in nulligest. Some observations (2, 5, 12) highlight a factor anatomical: the ovarian vein is aberrant in its origin and its path, it crosses the ureter oppositeL3 and throws itself into the right renal vein or into both veins (Right renal vein and inferior vena cava) sometimes by several abortions in the azygos vein, the vein the external iliac and the inferior vena cava. Crossing is performed where the ureter crosses the iliac artery of S1. The ureter is then caught between an arterial and the venous system.

This syndrome is related to thrombophlebitis suppurative ovarian vein, where, sometimes, the ureter is compressed by the indurated cord of the VO and by the process inflammatory system (15, 16).

The diagnosis is evoked on lumbar pains, often premenstrual, sometimes associated with infections recurring. Oestroprogestogens are also being sought.

It is likely that this entity is only a subunit the classic Taylor syndrome or congestion syndrome pelvic disease related to pelvic varicocele in women Dilation of VO.

The diagnosis is confirmed by radiology. Ultrasound is sometimes of delicate interpretation in women pregnant. CT urography is the key to diagnosis; however, its realization is limited by the gravid state. In postpartum, before establishing such a diagnosis, it is necessary to give a period of 3 months. Classically, there is a sinuous aspect of the lumbar ureter and especially a defect impregnation: a lack or "defect" image between the lumbar segment and the pelvic segment, as is the case of our observation. Retrograde urethrography completes the data intravenous urography and specifies the extrinsic origin of than from the obstacle. US would be a useful examination in the context of S. ovarian vein and would be a good alternative to phlebography, its safety, but it is an operator-dependent examination.

Lesions of the ovarian vein, poorly explored by US may justify the first realization of a phlebo-scanner or a phlebo-MRI (17,18).

Ureterscopy[5] is of capital importance in the confirmation the extrinsic nature of the shrinkage and the possibility to perform biopsies, to treat an associated lithiasis and optionally, a ureteral probe. In short, S. ovarian vein is a diagnosis disposal and only an examination and examination

well conducted and in the slightest doubt, a radiological assessment eliminates any other pathology.

The treatment of this condition has long been exclusively surgical and consists of the ligature section of the ovarian vein by an iliac approach (2, 3, 5, 11) or currently by laparoscopic procedure [18], but this therapy tends to be replaced, some authors have show improvement after probe jj or embolisation (19).

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