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Isolated unilateral symptomatic pleural effusion-an atypical presentation of ovarian hyper stimulation syndrome-a case report

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Abstract: An uncommon presentation of ovarian hyper stimulation syndrome is isolated pleural effusion reporting a case of late onset of ovarian hyper stimulation with unilateral pleural effusion and respiratory distress as a sole manifestation after embryo transfer.

Introduction: OHSS is one of the most grave and iatrogenic complication of controlled ovarian stimulation, clinical manifestation varying from mild to severe, it accounts for 33% of stimulated cycle. Pulmonary manifestation accounts for 7.2% of severe OHSS. But the Isolated finding of pleural effusion without ascites as the main presenting symptom of OHSS is not frequently reported and its pathogenesis is also unknown or remains a mystery. Awareness about the disease can lead to early pickup of such cases and better management. The article reports an unusual case of isolated pleural effusion after controlled ovarian stimulation after IVF and review of literature.

Case History: A 28 years old female married for eight years, no issue bilateral block on laparoscopy there was mild endometriosis no spill. So was taken for IVF. Patient had no past history of COPD, asthma, TB, no family history of chronic illness. Pt was down regulated with oral pills and lupride, D2 FSH-3.77, LH-2.93, E2-29.9. She was stimulated with 150 IU of recombinant for five days and then HMG 150 IU for another five days. At the time of HCG injection E2- 4440, and 8oocyte were retrieved. Pt was comfortable and discharged. D3 transfer was done three grades A embryo was transferred, pt discharged home comfortably. Seven days post ET patient had complain of right side chest tightness, shortness of breath, especially while lying on right side (orthopnea) dry cough. On examination her abdomen was soft no evidence of ascitis, pulse rate was 102/min, blood pressure 100/70 mm of Hg, O2 saturation was 92%, and diminished air entry on right side. Her WBC count was 15,000cells/Ul, her renal function test and liver function test was normal. Chest x-ray showed moderate to severe pleural effusion right side. Ultrasound showed no evidence of ascitis, slightly enlarged ovary. Patient was managed conservatively with a multidisciplinary approach and intensive care monitoring. She was placed in propped-up position along with antibiotic , antacid, nebulisation and chest physiotherapy looking over the amount of fluid and patient distress pleural tapping was done and 600 ml of straw colour fluid was aspirated, send for cytology and culture which was sterile and was exudates. Due to distress retapping was done after two days , patient recovered in another two days, unfortunately her beta HCG did not came to be positive, but she was discharged is good condition.

Discussion: OHSS usually result from stimulation of ovaries by Gonadotropin with the initial onset following the administration of exogenous HCG. In my case patient was young with low BMI presented six days after transfer (late onset) and was managed conservatively.

Conclusion: It demonstrates that pleural effusion may be the only manifestation of OHSS and implies a careful management of patients with pulmonary complaints after treatment with exogenous gonadotropin, so the awareness about this isolated extra-ovarian problem is very important for early and better management.

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