



KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 26: Ovarian Mass Surgery in a Young Woman – Unexpected Oophorectomy, Loss of Fertility, and Medicolegal Liability

1. REAL LIFE CASE SCENARIO

A 27-year-old nulliparous woman underwent laparoscopy for a presumed benign 9-cm ovarian cyst. Preoperatively, ovarian cystectomy had been planned. During surgery, dense adhesions were encountered and very little normal ovarian tissue could be clearly preserved. Because of bleeding and concern regarding the nature of the mass, the surgeon proceeded with unilateral salpingo-oophorectomy. Postoperatively, the patient and her family were distressed. They stated "We gave consent only for cyst removal. Nobody told us that the ovary might be removed." Histopathology subsequently showed a benign lesion. The patient alleged that an unnecessary oophorectomy had been performed and that her future fertility had been compromised. The key medicolegal question became: "When circumstances change during surgery, how far can the surgeon extend the procedure beyond what was specifically consented?"

2. MEDICOLEGAL RISKS IN SUCH CASES

Ovarian surgery in young women carries particular medicolegal sensitivity because it may affect:

- Fertility.
- Ovarian reserve
- Future reproductive options
- Hormonal function, particularly if bilateral surgery occurs
- Psychological well-being

Common allegations include:

- Unnecessary removal of an ovary.
- Inadequate preoperative counseling.
- Failure to discuss possibility of oophorectomy
- Inadequate evaluation of malignancy risk.
- Failure to document why conservation was impossible

Failure to attempt ovarian conservation
Procedure performed beyond consent

Damage to the contralateral ovary

The younger the patient, the more important fertility-preserving decision-making becomes.

3. WHAT THE LAW EXPECTS

A surgeon is expected to obtain procedure-specific informed consent and discuss reasonably foreseeable extensions of surgery.

Before ovarian mass surgery, counseling should ordinarily include the possibility of:

- Cystectomy.
- Oophorectomy when ovarian conservation is not reasonably possible
- Salpingo-oophorectomy where clinically indicated.
- Conversion from laparoscopy to laparotomy
- Additional procedures if unexpected pathology is encountered

However, a broad statement such as "any procedure deemed necessary" should not be treated as unlimited authority to perform substantially different non-emergency surgery. If an unexpected situation creates an immediate threat to life or serious health and delaying treatment to obtain fresh consent would itself create significant danger, the clinical and legal considerations are different.

The indication, urgency, alternatives, and reasoning must then be meticulously documented.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

Before surgery, document:

- Age and parity.
- Ultrasound/MRI findings.
- Malignancy risk assessment.
- Possibility of ovarian conservation.
- Possibility of laparotomy/conversion.
- Fertility wishes
- Tumor markers where indicated
- Planned procedure
- Possibility of oophorectomy
- Fertility implications discussed

If oophorectomy becomes necessary intraoperatively, the operative note should explain:

- Actual operative findings.
- Amount of salvageable normal ovarian tissue.
- Suspicion of malignancy where relevant.
- Why cystectomy alone was unsafe or impractical
- Status of the opposite ovary
- Condition of the ovary
- Adhesions/torsion/necrosis/bleeding where present
- Attempts at conservation, if appropriate

Never document merely: "Oophorectomy done." Document why it became necessary.



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5. PRACTICAL SAFE PRACTICE – WHAT TO DO

- Ask about future fertility before surgery.
- Assess malignancy risk appropriately.
- In young women with apparently benign disease, prioritize ovarian conservation where clinically reasonable.
- Counsel preoperatively about possible loss of the ovary.
- Photograph or video significant operative findings when routinely permitted by institutional policy and consent framework.
- Send appropriate tissue for histopathology.
- Explain unexpected intraoperative findings honestly after surgery.
- Document the clinical reasoning immediately.
- Review imaging personally.
- Discuss conversion to laparotomy where relevant.

The operative note should allow another gynecologist reading it years later to understand why the ovary could not reasonably be preserved.

6. COMMON MISTAKES TO AVOID

- Treating generic surgical consent as permission for every possible procedure
 - Removing an ovary merely because cystectomy is technically difficult
 - Failure to discuss fertility before surgery
 - Poor preoperative assessment of an adnexal mass
 - No description of remaining normal ovarian tissue
 - No documentation of the contralateral ovary
 - Writing an extremely brief operative note
 - Telling the patient only after surgery that removal was “necessary” without explaining why
 - Performing extensive non-emergency surgery beyond the scope of consent without adequate justification
- Technical difficulty alone should not automatically become an indication for organ removal.

7. CLINICAL–LEGAL PEARL

In a young woman, preserving fertility is part of good surgery—but preserving an organ at any cost is not. When removal becomes genuinely necessary: the indication must be clinically sound, reasonably within the consent framework or justified by a true emergency, and clearly documented.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

A landmark Indian Supreme Court decision relevant to this issue is *Samira Kohli v. Dr. Prabha Manchanda* (2008). The case established important principles regarding informed consent and the extent to which a surgeon may perform additional procedures beyond those for which consent was obtained. The Supreme Court distinguished between procedures that are necessary to address an immediate threat to life or health and additional procedures that could reasonably have been postponed until specific consent was obtained. The practical lesson for gynecologists is important: Consent for one procedure should not automatically be interpreted as unrestricted consent for a substantially different procedure. Therefore, foreseeable possibilities—such as oophorectomy during surgery for a large ovarian mass—should ideally be discussed before entering the operating theatre.

9. TAKE-HOME MESSAGE

Ovarian surgery in reproductive-age women requires more than technical competence.

It requires:

Fertility assessment → Appropriate evaluation → Organ-preserving intent → Procedure-specific consent → Sound intraoperative judgment → Detailed documentation.

The question after an unexpected oophorectomy should never be:

“Why didn't you take consent?”

Ideally, that possibility should already have been discussed..

Next Week's Topic: Sexual Assault Examination – What Every Gynecologist Must and Must Not Do Medicolegally



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