Case Report

Left Twisted Hydrosalpinx Presenting as Acute Abdomen

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A 30-year-old para 3 not sterilized was admitted on 18.01.2006 with a history of acute pain in the abdomen of one day duration. She was in the 10th day post menstrual cycle.. There was no history of dysmenorrhea. From the rest of her history all other non gynecological causes of acute abdomen were ruled out.

On examination her vitals were stable barring a mild tachycardia; pulse rate=94/min. Per abdomen examination there was tenderness in the left iliac fossa, no guarding or rigidity and bowel sounds were present. Bimanual pelvic examination revealed normal sized uterus with tender cystic mass in left adnexa approximately 4X4 cm and cervical motion tenderness was positive.

An urgent abdominal ultrasound scan was then done which showed a cystic mass in the left adnexa 4X4 cm with fine internal echoes; the left ovary was seen in close relation to this mass. Her urine pregnancy test was negative, hence a diagnosis of either a left ovarian cyst with hemorrhage or a left twisted ovarian cyst was made and the patient was shifted for an emergency laparotomy on 18.01.2006.

At laparotomy, contrary to our preoperative diagnosis there happened to be a left twisted hydrosalpinx with

hemorrhage within i.e. in other words a left twisted hematosalpinx (Fig. 1 & 2 – the red arrow showing the hematosalpinx and the gloved hand holding the uterus).

The left ovary was normal and rest of the pelvic structures did not reveal any pathology. Left salpingectomy was done and as the patient desired ligation, right sided tubal ligation was also carried out. The patient was discharged on 24.01.2006. The postoperative period was uneventful. The patient was given IV ofloxacin and IV-metronidazole for 24 hrs and then switched over to oral ofloxacin for 10 days. She was asked to follow up with the histopathology reports after 15 days. She followed up on 11.02.2006. The report was: gross - tube dilated and tortuous appearing bluish black in color; cut section revealed flattened mucosal folds and filled with blood. Microscopy revealed thin tubal wall, inflammatory infiltrate with areas of interspersed hemorrhage. As the patient was fine and no further treatment was required, she was asked to follow up as and when necessary.

Discussion

This case is being presented because of its rarity. Hematosalpinx has been observed as an unusual complication after medical abortion with oral mifepristone and misoprostal¹. Hematosalpinx has been reported in cases of ectopic pregnancy², even bilateral ones in cases of unilateral ectopics³. Mullerian anomaly with hematosalpinx presenting as amenorrhea and an adnexal mass has also been seen⁴. Serous borderline tumor of the fallopian tube presented as hematosalpinx⁵ imperforate hymen and ruptured hematosalpinx⁶. In cases of gynecologic and obstetric disorders presenting

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Fig 1. Left Twisted Hematosalpinx 1

Fig 2: Left Twisted Hematosalpinx 2

with abdominal pain it is seen that usually the torsion of the adnexa is at the pedicle between the ovary and the uterus in twisted ovarian cysts⁷. Torqued hematosalpinx in a woman in the thirteenth week of pregnancy also has been reported⁸. In our case it was the tube that twisted by itself most probably converting the existing hydrosalpinx into a hematosalpinx as is seen from the figure, that posteriorly the ovary and its pedicle are completely normal and healthy.

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