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Case Report

Isolated torsion of hydrosalpinx

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Introduction

The uterine adnexa consist of the ovaries, the fallopian tubes, and the uterine ligaments. A hydrosalpinx may be unilateral or bilateral and is primarily a sequel of acute or chronic pelvic inflammatory disease. A hydrosalpinx usually is asymptomatic; however it may be associated with chronic pelvic pain, dyspareunia, and a sense of pelvic pressure. Isolated torsion of the fallopian tube is an uncommon cause of acute lower abdominal pain. The incidence is estimated to be 1 in 500,000 women.¹ It is often found in reproductive age women and is found less in prepubertal and perimenopausal women.^{2,3} We are presenting a rare case of bilobed left twisted hydrosalpinx with haemorrhage within (twisted haematosalpinx) (Figs. 1 and 2).

Case report

40-year-old mother of two children, (non-tubectomised) admitted with history of acute pain in the left lower part of the

abdomen of one day duration. She also gave history of one episode of vomiting. Menstrual cycles were regular with normal flow and duration. She was in the 19th day post-menstrual cycle. On examination, her vitals were stable with pulse rate of 98/min and systemic examination was within normal limits. Per abdomen examination showed 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 5 × 5 cm and cervical motion tenderness was present.

An urgent ultrasound showed large biloculated left sided cystic mass approx 8.6 × 4.6 × 3.5 cm seen superior and left of uterus (Fig. 3) with fluid on the POD. The left ovary was not seen separately from the cystic mass. The uterus and right ovary were normal. Her urine pregnancy test was negative and all biochemical and haematological parameters were within normal limits except TLC of 15,600/mm³. A diagnosis of twisted ovarian cyst was made the patient was shifted for emergency laparotomy.

At laparotomy, contrary to our preoperative diagnosis there was a left twisted hydrosalpinx with haemorrhage within. The left ovary was normal and rest of the pelvic structures did not reveal any pathology (Fig. 4). Left salpingectomy was done. Post-operative period was uneventful and she was discharged on 4th post-operative day. Histopathology showed features consistent with haematosalpinx.

Discussion

The exact cause of fallopian tube torsion is unknown, and various theories have been postulated. Tubal abnormalities including previous tubal surgery, tubal ligation, tubal

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Fig. 1 – Bilobed twisted hydrosalpinx with normal left ovary.

Fig. 3 – Biloculated cystic mass.

reconstruction, and inflammatory disease (hydrosalpinx, hematosalpinx) have been reported. Haematosalpinx has been observed as an unusual complication after medical abortion with oral mifepristone with misoprostol.⁴ Haematosalpinx has been reported in cases of ectopic pregnancy,⁵ even bilateral ones in cases of unilateral ectopics.⁶ In cases of gynaecologic and obstetric disorders presenting 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 cysts.⁷

The most common symptom is pain located in the lower abdominal region or pelvis that may radiate to the flank or thigh. Sudden onset of cramping pain or intermittent pain is possible. Temperature, white blood cell count, and erythrocyte sedimentation rate may be normal or slightly elevated.²

Imaging findings are non-specific in the preoperative diagnosis of torsed fallopian tubes. The ultrasound image associated with hydrosalpinx may reveal an elongated, convoluted cystic mass, tapering as it nears the uterine cornua and the ipsilateral ovary. Doppler evaluation could be helpful in a patient with a history of tubal ligation if high

Fig. 4 – Right and left normal ovaries.

impedance or absence of flow in a tubular structure is noted. Computed tomography or magnetic resonance imaging is also reported to be helpful for diagnosis.^{8,9}

Isolated tubal torsion can be managed with either detorsion or simple salpingectomy. Adnexal detorsion has an extremely low risk of thromboembolic events. However, it should be performed as early as possible to avoid irreversible damage to the tissue. The operative approach could be conventional exploratory laparotomy or laparoscopic surgery.

Conflicts of interest

All authors have none to declare.

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Fig. 2 – Twisted haematosalpinx.

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