CASE REPORT

A Rare Case of Isolated Twisted Gangrenous Fallopian Tube

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Introduction

Acute torsion of the fallopian tube is a rare event, which has been reported with both normal and pathologic fallopian tubes. Tubal torsion usually accompanies torsion of the ovary as they have a common vascular pedicle. But, isolated torsion as seen in this case is a very rare event.

Case Report

The patient, a 30-year-old lady, a nullipara with 13 years of married life presented with acute pain abdomen and vomiting 1 week ago. Her periods were regular with LMP 1-month ago. She was earlier treated in a private nursing home with antibiotics with which acute pain subsided, but deep-seated pain persisted.

On examination, the vitals were stable. The abdomen was soft, but tender in lower part. Per vaginal examination revealed a uterus of normal size and anteverted, and a mass

of about 8 cm × 5 cm size was found in the right adnexa which was mildly tender.

In ultrasonography, a large heterogenous mass of size 8 cm × 4 cm × 4 cm was found in the right adnexa, suggestive of a tubo-ovarian mass (Fig. 1). On left side, a cystic lesion of 5 cm size was also found.

Laparotomy was done on 01.08.09. The omentum and intestinal loops were adherent to the uterus and both the tubes. On separation of adhesions, a blackish elongated dilated fallopian tube was found on the right side with one twist in it. The right ovary was mildly enlarged and congested (Figs. 2, 3). On left side, the tube was also grossly dilated, but without torsion. Bilateral salpingectomy was done conserving the ovaries. The histopathology report was suggestive of a gangrenous right fallopian tube (Fig. 4). The PCR report came to be positive for tuberculosis. The patient is now getting antitubercular treatment.

Discussion

The entity was first described by Bland-Sutton in 1890 and has a prevalence of one in 1.5 million women. Torsion of the fallopian tube is secondary to an ovarian mass in approximately 50–60 % of patients.

Tubal torsion may be due to increased tortuosity caused by excessive length of the tube or pathologic processes such as hydrosalpinx [1], tubal neoplasms [2], adhesions, trauma, pregnancy, and previous operations, especially tubal ligation.

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Fig. 1 USG showing hydrosalpinx of size 8 × 4 cm

Fig. 2 Gangrenous right-sided Fallopian tube and hydrosalpinx of left side

The most important symptom of tubal torsion is acute lower abdominal pain, which may be associated with nausea and vomiting in two-thirds of the cases. The pre-operative diagnosis of tubal torsion is made in less than 20 % of reported cases. The differential diagnosis includes acute appendicitis, ectopic pregnancy, pelvic inflammatory disease, and rupture or torsion of an ovarian cyst.

With tubal torsion, usually the tubes are gangrenous and must be excised. It may be possible to restore normal circulation to the tube by manually untwisting it if it is viable and not grossly dilated. Although our case is a nullipara, her right tube was gangrenous and left tube was grossly

Fig. 3 Intraoperative picture showing gangrenous right tube, ovary & uterus

Fig. 4 Histopathology showing hydrosalpinx

dilated due to pathological process, so we had to remove both the tubes.

References

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