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TORSION OF FALLOPIAN TUBE, FIMBRIAL CYST: A RARE CASE REPORT

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ABSTRACT

Fallopian tube torsion or fimbrial cyst torsion is rare, therefore diagnosis may be delayed. Isolated twisting of fallopian tubes is an uncommon event. The frequency is 1/1,500,000 women. Right fallopian tube is most commonly affected. The condition is frequently misdiagnosed with acute appendicitis or ovarian torsion. The torsion of fallopian tube and para-ovarian cyst is usually seen in reproductive age group. The aim is to report a case of huge fimbrial (paraovarian) cyst in a 35 year old nulligravid women, which presented with acute abdominal pain suggestive of torsion of ovarian cyst and also to increase the awareness of surgeons for better diagnosis and immediate intervention.

INTRODUCTION: Torsion of the Fallopian tube is a rare cause of acute pelvic pain which is difficult to diagnose pre-operatively. Its incidence is estimated at 1 in, 1,500,000 [1].

Paraovarian cysts (POC) represent approximately 10% of adnexal masses [2]. They are more common in women aged 30-40 years. Fallopian tube torsion is a rare gynecologic cause of acute low abdominal pain. Several hundred cases have been reported in the literature since the original description by Bland-Sutton in 1890.(3). Lack of pathognomonic symptoms, clinical findings on physical examination, and specific imaging or laboratory characteristics makes this entity difficult to diagnose preoperatively.

Case report: we present a case of 35 year nulligravidae referred from a private nursing home with history of pain in the lower abdomen and vomiting since morning. She is married for 15 years with no living issues with past regular menstrual cycles. Her last menstrual period was 30 days back. Haemoglobin was 12gms% and B positive blood group. On examination her vitals were stable examination. Per abdomen examination revealed tenderness present in the right iliac fossa with guarding and rigidity. Per vaginal examination revealed cystic mass occupying the Pouch of Douglas and left fornix with severe tenderness. Urine pregnancy negative and ultra sound suggested torsion of left ovarian cyst with absent vascular flow on Doppler. She underwent an emergency laprotomy. A huge right twisted, gangrenous fimbrial cyst measuring 12x16 cm with hypertrophied and gangrenous right ovary was noted intra-operatively.

FIG. 1: RIGHT TWISTED FIMBRIAL CYST WITH GANGRENOUS OVARY

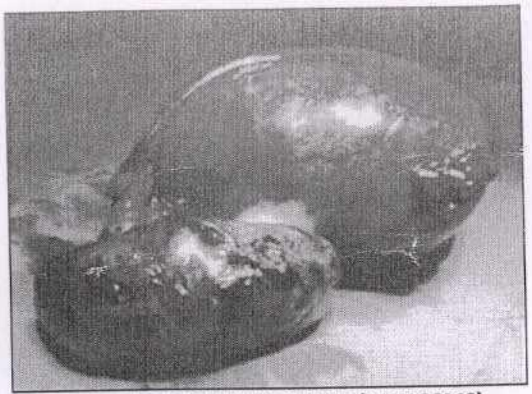

FIG. 2: FALLOPIAN TUBE CYST (12X16CMS)

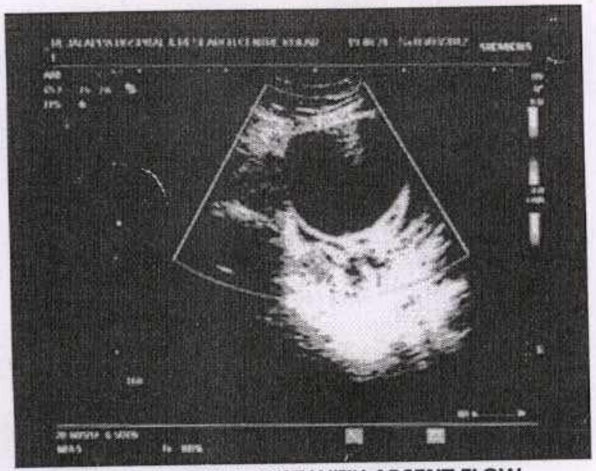

FIG. 3: FIMBRIAL CYST WITH ABSENT FLOW

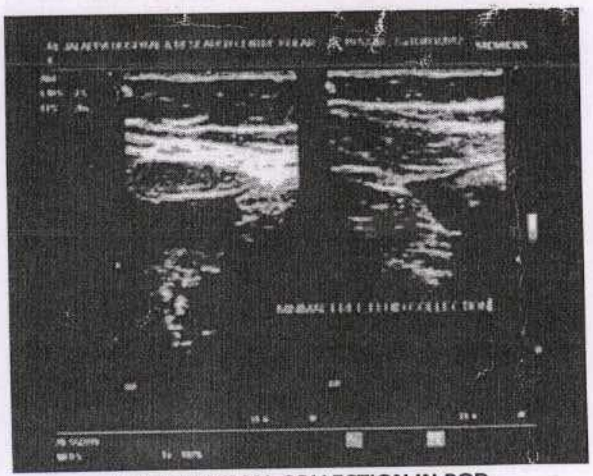

FIG. 4: MINIMAL COLLECTION IN POD

DISCUSSION: Torsion of the Fallopian tube is a rare cause of acute pelvic pain which has never been diagnosed pre-operatively. Unfortunately, it is not often considered initially when a patient presents with abdominal pain. (Diagnostic accuracies range from 18% to 64%). Adnexal torsion occurs predominantly in women of reproductive age. Pregnant women have a greater risk of torsion of the adnexa than non-pregnant women (12% - 18% of ovarian torsion occurs during pregnancy). Women treated with fertility drugs who develop ovarian hyper-stimulation syndrome have a greater risk of torsion with pregnancy (16%) than those who do not become pregnant. The exact cause of fallopian tube torsion is unknown. Some studies have postulated theoretical explanations. Torsion is unlikely with an intact tube and is more often the result of an ovarian cyst or tumor.

Regad [4] surveyed 201 cases of fallopian tube torsion and found a normal appearance in only 24%. In many of the patients, no pathologic reports were available. Hydrosalpinx was found in 18%, and infection in 13%. Pelvic tumor and normal or ectopic pregnancy was reported in the remainder. Fallopian tube torsion has also been described after surgical sterilization (mainly with the use of the Pomeroy technique [5], in primary carcinoma of the fallopian tube, [6] with hematosalpinx, [7] during labor, [8] and in a premenarchal girl with endometriosis [9].

The lack of specificity of the clinical signs and symptoms and the numerous pathologic findings in the pelvis and lower abdomen often fail to alert the physician to the condition, making diagnosis difficult. The available laboratory or imaging studies cannot confirm fallopian tube torsion. They can, however, rule out other abdominal conditions with similar clinical characteristics, such as nephrolithiasis, cholelithiasis, appendicitis, extrauterine pregnancy, tubo-ovarian abscess, and pancreatitis.

Complete physical and vaginal examination, color Doppler transvaginal sonography can be indicative of the diagnosis. This technique has been replaced by laparoscopy, which is currently the most specific diagnostic tool for evaluating torsion. The definitive diagnosis of tubal torsion is still made retrospectively, usually after diagnostic laparoscopy.

CONCLUSION: Physicians need to maintain a high index of suspicion for this uncommon and often difficult to diagnose cause of abdominal pain.

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