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Short Communication

CONSERVATIVE MANAGEMENT FOR RIGHT-SIDED ISOLATED TORSION OF FALLOPIAN TUBE WITH CYST

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Abstract

A rare case of tubal torsion associated with anechoic mass in 36 year old woman is reported. The patient was admitted to our university-hospital reporting intermittent right pelvic pain and lumbar troubles. Transversal minilaparotomy according Pfannestiel was carried out. The fallopian tube appeared uncommonly long (18 cm) with three torsion twists. Successful conservative treatment of adnexa was carried up.

Keywords: fallopian tube torsion/ Tubal cyst /tubal mass/fertility

Introduction

Isolated torsion of fallopian tube with cyst and tubal elongation is unusual. Congenital abnormalities, excessive length, pathologic process, hydrosalpinx, hematosalpinx, cysts, previous tubal ligation are the most common causes. Benign cysts are associated with torsion in a range of 65-95% and malignant tumours of 5-15% [1]. Although tubal torsion can happen in every period of life, women in fertile age are more involved. In literature, isolated torsion of fallopian tube in premenarcheal girls [2,3], as well as in menopause[4], has been reported. Pre-surgical diagnosis of isolated tubal torsion is very challenging. Symptoms are unspecific and depend on severity of the torsion. When the torsion is soft, the woman often complains mild pelvic pain. When the torsion is important, peritoneal irritation signs appear. Differential diagnosis with Pelvic Inflammatory Disease (PID), tubal pregnancy, appendicitis, ureteral colic should be taken into account. Torsion without necrosis is difficult to recognize at the ultrasounds (US). Severe torsion can be suspected when tubal enlargement and fluid abdominal effusion is visualized. A rare case of association of a isolated tubal twisting and benign infudibular cyst of an elongated fallopian tube (18 cm) occurred in a 36 years old woman treated with conservative management is reported (Fig 1).

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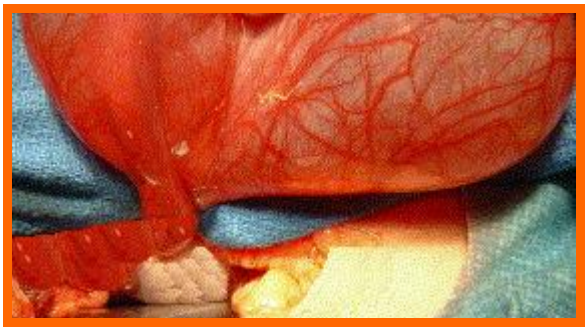

Figure 1: Infundibular cyst with elongated fallopian tube torsion

CASE REPORT

The patient was a 36 years old female, gravida, para , who was admitted to our university hospital for persistent right adnexal cyst. Her medical history included a subclinical hypothyroidism treated with levothyroxine. Her obstetric history was consistent with a previous CS (two years before) for breech presentation, after which a keloid scar developed. The patient complained intermittent right pelvic and lumbar troubles of one year duration. She never suffered from acute abdominal pain. A year before a transvaginal ultrasound (TV-US) showed a 3.1 x 2.8 cm adnexal anechogenic right cyst, while uterus and left ovary appeared regular. The patient was given oral contraceptive for four months, but, despite medical treatment, clinical signs and instrumental pictures remained unchanged. The pelvic pain was located on the right side and irradiated to lumbar tract. It arose suddenly without any correlation with the period and disappeared spontaneously. Neither fever nor nausea or vomiting had been observed. At admission a deep lower abdominal palpation caused a light pain. On bimanual vaginal examination a slight painful right adnexal mass was appreciated, while uterus and controlateral adnexa were regular in size and painless. Before the surgery a further TV-US confirmed right adnexal cyst without alteration of the ovarian parenchyma. For these reasons the cyst was considered belonging to the tube. No free fluid in the Douglas pouch was noted. Neither abnormal length of the tube nor torsion was visualized instrumentally. Another smaller 2 cm adnexal cyst referred to the left tube was detected. Initially a laparoscopic approach was proposed, however the patient requested a traditional Pfannestiel laparotomy in order to remove the previous keloid scar during the surgery for cosmetic purpose. In accordance with patient desire, a suitable informed consent was filled out and this kind of surgery was performed. At the opening of the abdominal cavity the right tube was abnormally long (18 cm) with a 4 cm serous infudibular cyst; three loose twists of torsion were observed, but tubal structure was not significantly compromised. The infudibular cyst of the left tube was confirmed. Both ovaries and uterus appeared normal. Detorsion of the right tube and bilateral enucleation of the cyst were carried out. The cysts were extracted intact. Removal of the keloid and intradermal suture ended the surgical procedure.

The post-operative course was regular and the patient was discharged after three days. The cosmetic result was obtained and the patient was greatly satisfied.

Discussion

The diagnosis of tubal torsion is easy when the twists are very tight and signs of acute abdomen are present. In this case many abdominal and genital pathologies must be considered as differential detection. When the torsion is loose clinical features are nonspecific [5].

The TV-US diagnosis of tubal cysts is supposed when the mass lies next to an echostructurally normal ovary. A correct diagnosis of tubal torsion is done in less than 20% of cases [1]. Regarding the cysts, clinical and instrumental identification is very simple; furthermore the association with torsion is very unusual but must be considered in presence of pelvic troublesome disorders. Intra-operative visualization for final diagnosis of tubal torsion is mandatory and histological results for adnexal mass are determinant in order to establish either benignity or malignity [6] of the lesion.

Concerning the modality of the approach, the laparoscopic one is preferred by many authors [7,8,9], furthermore when a previous abdominal surgery has been performed both traditional and laparoscopic routes can be considered [10,11]. In our case the traditional approach gave the advantage to take off the previous keloid avoiding other new scars.

Conclusion

When necrosis due to fallopian tube torsion is found, salpingectomy is unavoidable and the female fertility is reduced; but when the mass is benign and there are no ischemic signs, in spite of torsion, conservative tubal management should be preferred. In our case report, a preservative genital tract surgery was a successful treatment.

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