TORSION OF A HYDROSALPINX

(Case Report)

by

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Torsion of a hydrosalpinx, though uncommon to warrant reporting, is not a rarity; cases are reported in the literature with fair regularity.

A study of the recorded cases of torsion of the fallopian tube shows that the commonest lesion is a hydrosalpinx, although a normal tube may undergo this complication.

Bland Sutton (1890) reported the first case, Anspach (1912) was able to collect 95 cases and, in 62 of them the lesion of the tube was a hydrosalpinx. Eastman (1927) brought the number of cases of torsion of hydrosalpinx upto 91 and Goldberg and Olim (1938) increased the figure to 108. Torsion of a normal fallopian tube was reported by R. deSoldenhoff in 1949; the same year R. E. Shaw reported bilateral hydrosalpinx with torsion of both tubes. In 1951, J. Wolf reported torsion of a tubercular pyosalpinx bringing the total number of reported cases of torsion of fallopian tube to about 120. The condition is therefore not very rare.

The following is a report of the case seen in the K.E.M. Hospital, Bombay:

A female aged 25 years was admitted on 3-6-58 with history of pain in the left iliac fossa, vomiting and fever for 3 days.

Her menstrual history was 3-4/35-60 days, moderate, irregular and painless for the last 2 years. Her last menstrual period was 3 days ago.

Obstetric History: 1 premature stillbirth 6 years ago and 1 abortion of 5 months 2½ years ago.

On examniation the general condition was good. Tongue was pink and moist. Temp. 99.6 deg.F. Pulse—90/min. B.P. 110/70 mm. Hg.

Cardiovascular system and Respiratory System: Nothing abnormal detected.

Abdominal Examination: Tenderness in the lower abdomen, guarding present, no rigidity.

Vaginal Examination: Cervix was directed downwards and forwards, smooth, firm and mobile. Uterus was retroverted normal in size, smooth, firm and mobile. In the left fornix, a cystic mass 3″ in diameter was felt, extending anteriorly, not very tender. Some degree of tenderness in the right fornix.

Investigations

Haemoglobin: 70% W.B.C. 14,000 c/mm. Urine: N.A.D.

The patient was diagnosed as a case of salpingo-oophoritis with a hydrosalpinx on the left side, and was treated conservatively. Patient had temperature upto 100 deg. F. in the ward for 2 days. She was discharged on 6th day and asked to

come for short-wave diathermy in the out-patient department. She completed her short-wave diathermy sittings.

Patient was readmitted on 24-7-1958 at 9-30 p.m. with history of pain in the left iliac fossa since 12 noon; pain was severe since 4 p.m. and she had 4-5 vomits since then. Her last menstrual period was on 8-7-58. On examination, general condition was good. Tongue, pink and moist. Temp. 98 deg. F., P. 80/min. B.P. 105/65 mm. Hg.

Abdominal examination: Slight degree of tenderness in the left iliac fossa. No guarding or rigidity. Per vaginam: Cervix was downwards and forwards, smooth, firm and mobile. Uterus was pushed behind by a cystic mass 3″ in diameter in the anterior fornix, mobile, no tenderness. Investigations: Haemoglobin 76%; W.B.C. 7,940/mm.; Urine: N.A.D.

A provisional diagnosis of twisted ovarian cyst was made and an exploratory laparotomy was decided to be performed the next day. Abdomen was opened under spinal anaesthesia by Pfannenstiel incision; there was a hydrosalpinx 4″ x 2″ on the left side, blue in colour which had undergone two twists in the clockwise direction. It was clamped and removed. On the right side also the fallopian tube showed a terminal hydrosalpinx, the tube was about 5″ in length. Although salpingostomy was contemplated in the proximal portion of the tube, it was found to be nodular and blocked, right upto the cornual end, the attempt was therefore given up and a salpingectomy was performed. Patient made an uneventful recovery.

Comment

The torsion in this case was undoubtedly due to the extra length of the tube with presence of a freely mobile tumour, viz. the hydrosalpinx. The fallopian tube on the opposite side also was extra long, about 5″ in length. The first episode of pain may have been due to partial torsion of the hydrosalpinx which settled down spontaneously after causing enough tissue reaction to account for the temperature and leucocytosis.

Diagnosis of a twisted tube is always a difficult matter; correct diagnosis is rarely made before operation. The clinical picture more or less resembles that of a twisted ovarian cyst, for which it is usually mistaken but differs, quoting Shaw (1949), "in that the symptoms are much less severe and also in that shock is not a feature of the condition."

The mild nature of the symptoms and absence of shock were well illustrated in the case mentioned above. Hence urgency for operation in these cases is not great.

The twisted tube must be differentiated from ectopic pregnancy, acute appendicitis (if on the right side) and salpingitis.

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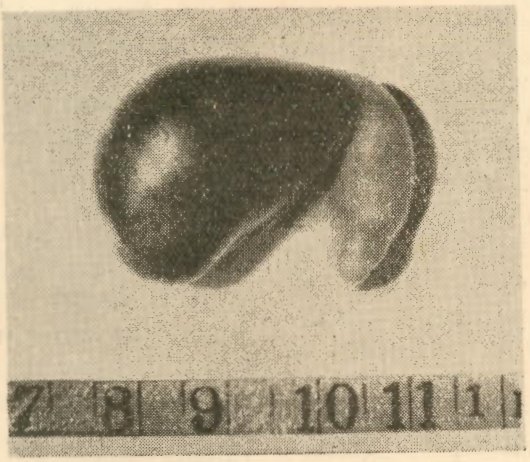

Fig. 1

Hydrosalpinx showing congestion