INTESTINAL OBSTRUCTION BY A TUBERCULAR FALLOPIAN TUBE

A Case Report

by

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Cases of pelvic tuberculosis are not uncommon and unfortunately one comes across such cases when the diagnosis is least suspected. Often, cases of so-called chronic pelvic sepsis with blocked tubes and fixed retroversion turn out to be tubercular on opening the abdominal cavity; and, therefore, the diagnosis of pelvic tuberculosis should always be kept in mind in such cases.

Pelvic tuberculosis has been frequently mistaken for other pelvic and abdominal conditions. Lance Townsend has analysed thirty cases of pelvic tuberculosis where the provisional diagnosis was as shown in Table I.

TABLE I

No. of cases	Provisional diagnosis
8	Pelvic or general peritonitis
7	Acute salpingitis
4	Sterility (for investigation)
3	Ectopic pregnancy
3	Fibromyomata uteri
2	Menorrhagia (for investigation)
1	Ovarian cystomata
1	Missed abortion
1	Tubercular peritonitis

From these figures it might be appreciated that the diagnosis of pelvic tuberculosis frequently comes as a surprise to the gynaecologist.

The diagnosis of pelvic tuberculosis before operation is very desirable because the treatment of pelvic tuberculosis is essentially conservative and therefore an unnecessary laparotomy may sometimes be avoided if the diagnosis is made in time.

In arriving at a correct diagnosis endometrial biopsy (with histopathological examination, culture of the endometrium for tubercle bacilli and guinea pig inoculation) and the characteristic appearances of the fallopian tubes on hysterosalpingography prove helpful in many instances.

We have thought of reporting this case because, here too, the diagnosis of pelvic tuberculosis was not entertained pre-operatively, and the case presented clinically as a difficult diagnostic problem.

Case Report

Mrs. K.M., aged about 24 years, was admitted to the Petit Hospital at 12 noon on 4th March 1959 with the following history.

1. Pain in abdomen of three days' duration.

2. Fever with rigors which followed the onset of the abdominal pain.
3. Slight bleeding per vaginam on the previous day.
4. Vomiting and giddiness with the onset of pain.

The pain has gradually increased in severity since the time of its onset. Vomiting has persisted since the time of the onset.

The **bowels** have been regular prior to and during the past-three days, but this morning she passed a loose stool. 8 days ago the patient passed a few round worms in the stool.

Micturition: Normal. No history of frequency or retention.

Menstrual History. The periods have been irregular, following her last delivery two years ago. She has had scanty periods, lasting for a day or two, every two or three months. Her last menstrual period was two months ago.

Previous Obstetric History. Two full term normal deliveries. History of mild puerperal sepsis following the second delivery, 2 years ago. No history of abortions.

History of Previous Illness. Nothing of note.

On Admission (12 noon). Pulse 104/min. Temperature 97.5°, B.P. 104/70 mms. Tongue, pale and moist. The respiratory, cardiovascular and central nervous systems were examined and found to be normal.

Abdominal Examination. There was generalized distension of the abdomen, but it was more in lower abdomen and around the umbilicus. No definite mass was felt. The liver and spleen were not palpable. Kidneys not palpable. The liver dullness was not obliterrated.

The flanks were resonant on percussion except for a small zone in the right iliac fossa.

Peristalsis was distinctly heard.

Bimanual Examination

The cervix was directed downwards and forwards. It was smooth and mobile but not markedly tender on movement.

The uterus was retroverted, of normal size, adherent, and there was considerable tenderness on attempting to correct its position.

There was fullness in the right fornix with a vague, undefined mass situated higher up.

Tenderness was elicited in both fornices but was more marked on the right side.

Per speculum examination and rectal examination—Nothing abnormal detected.

In view of the history of amenorrhoea followed by pain, slight vaginal bleeding, vomiting and giddiness, and the findings of the physical examination, a tentative diagnosis of ectopic gestation was made, and the patient was kept under observation.

Investigations

(1) Blood. Hb 48% (7 Gms %). Total RBCs 207 million/c.mm. Total WBCs 8,900/c.mm.

Differential count. Polymorphs 60%, lymphocytes 30%, eosinophiles 6%, monocytes 4%.

ESR. 65 mms. after 1 hour.

(2) Urine. Albumin—trace. Sugar—nil. Acetone—present. Microscopic (catheter sample)—Numerous pus cells. No. RBSs or casts.

2-15 P.M. Simple enema administered. Only the enema fluid was returned. No faecal matter was present. This raised doubts about the case being one of intestinal obstruction.

5-30 P.M. A flatus tube was passed; no escape of flatus. Ryle's tube was introduced into the stomach and 8 ounces of greenish yellow material was aspirated. An intravenous 5% glucose in normal saline drip was begun.

6 P.M. The abdominal distention had increased and there was a suggestion of free fluid in the abdominal flanks. Shifting dullness was elicited. The pulse, temperature and blood pressure had remained the same as on admission.

It was decided to perform a laparotomy and the patient was operated at 7 p.m. under general anaesthesia with endotracheal intubation.

The abdomen was opened by a midline subumbilical incision, and on opening the peritoneum, distended coils of small bowel bulged out of the incision. A moderate amount of serous fluid was sucked out of

the peritoneal cavity. Intestinal obstruction was now clearly evident and on trying to locate the site of obstruction a tight band was found emerging from within the pelvic cavity with its other end adherent to the anterior abdominal wall a little to the left of the umbilicus.

On exploring the pelvic cavity it was found that the uterus was slightly bulky, retroverted and adherent in the pouch of Douglas. The adnexa on the right side were matted together to form a mass. The adnexa on the left side were also thickened and matted but the left tube could be traced upwards out of the pelvis as the obstructing band mentioned above. Hydatids of Morgagni present at the fimbrial attachment above dispelled any further doubts as to the nature of the obstructing band. The tube was thickened and contained caseous material (Fig. 1).

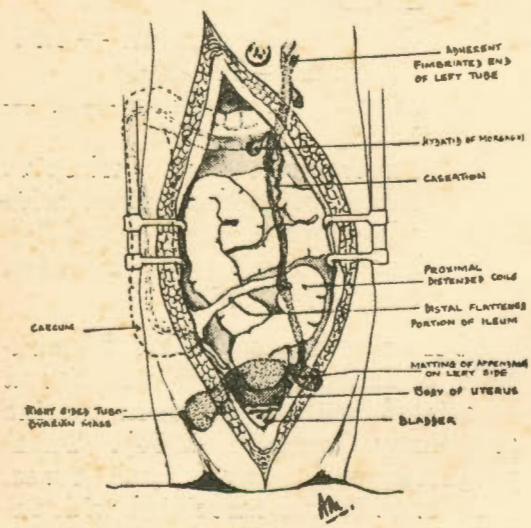

FIG. 1.

Left salpingectomy was performed and the obstruction released. The bowel was found to be in a viable condition and was returned to the abdomen and the cavity closed.

Anti-tuberculous line of treatment was instituted and the patient made an uneventful recovery.

Specimen Report

A part of the left tube was sent for histo-pathological examination and a diagnosis of "Tuberculous Salpingitis" was returned.

Endometrial biopsy was performed two weeks after the laparotomy and it was found to be positive for tuberculosis.

Discussion

A perusal of the available literature has failed to reveal any report of a similar case.

What surprised us considerably was the finding of the fimbriated end of the fallopian tube adherent so high up to the anterior abdominal wall.

This can be explained if one presumes that the patient possibly developed tuberculosis during the last pregnancy, and the fallopian tube became adherent to the anterior abdominal wall while the uterus was high up in the abdominal cavity.

Can there be any other explanation for such an unusual finding?

Summary

1. A case of intestinal obstruction due to tubercular fallopian tube has been described.
2. Diagnostic pitfalls in tuberculosis of the pelvis have been mentioned.
3. A possible explanation for the high attachment of the fimbriated end of the fallopian tube has been given.

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References

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