TORSION OF THE FALLOPIAN TUBE

(A Case Report)

by

K. KOCHHAR,* M.B.B.S., D.G.O., M.D. (Med.)

Torsion of the fallopian tube is a surgical rarity. The first case was published by Bland Sutton in 1890. Regad (1933) reviewing 201 cases of torsion found 24% of the cases had apparently healthy tubes. Tauber (1949) reported torsion in a 28 years old woman with haematosalpinx which he described as occurring in association with a long mesosalpinx that permitted an abnormal rotation around an adhesive band. Michaelson (1948), Abbas (1955) reported torsion with haematosalpinx. Brady (1961) described a case of twisted haematosalpinx in a 10½ years old girl. This was claimed to have been 4th case of isolated torsion in a girl who had not yet menstruated. Youssef and others (1962) reviewed 6 cases of tubal torsion and stated that it occurred more often in a normal tube than in a diseased tube. Rao (1968), Gulati (1965), Bhattacharya (1970) reported torsion in the healthy fallopian tube. We had one case with this complication which is reported here.

Case Report

Mrs. D. S. 19 years old woman, married 2 years, gravida O, was admitted with a history of acute colicky pain in the lower abdomen of two days' duration. Her menstrual periods were regular and the last period was 28 days ago. There was no history of vomiting although she felt nauseated.

On Examination

She looked pale and in pain. Her pulse was 100/mt. regular, of good volume and tension. Blood pressure was 100/70 mm of Hg., temperature was normal. Abdomen was slightly distended and there was marked tenderness in the lower abdomen, more localised on the left side. There was no guarding or rigidity of the abdominal wall and no mass was felt. Vaginal examination revealed normal sized uterus deviated to the right side and there was an extremely tender ill-defined, cystic mass felt in the left fornix; movement of the cervix was associated with acute pain. There was no abnormality detected in the right fornix. Slight blood-stained discharge was seen on the examining finger and cervix was found to be healthy.

A clinical diagnosis of ectopic pregnancy was made. Under anaesthesia the above findings were confirmed and on aspiration of pouch of Douglas blood-stained fluid was obtained. Laparotomy was proceeded with. There was some blood-stained fluid in the peritoneal cavity. The uterus was normal in size. The left tube was markedly distended, oedematous and reddish-blue in colour covered with a blood clot. The fimbrial end was blocked with a blood clot. The tube was found to have undergone torsion 1½ times proximally. The right tube and ovary were healthy. Left salpingectomy was performed. Her post-operative period was uneventful.

Histopathlogy

The section of the dilated part of the tube revealed blood clot in the lumen and haemorrhage in the wall. Microscopically,

*Reader in Obst. & Gynec. Armed Forces Medical College, Poona.

Received for publication on 4-10-1970.

apart from extravasated blood and partial tissue necrosis there was no evidence of pregnancy, nor were chorionic villi seen in the blood clot.

Discussion

A review of the reported cases illustrates very well the variety and difficulty in diagnosing this condition. The common conditions confused with tubal torsion are acute appendicitis, twisted ovarian cyst, ectopic pregnancy and pelvic inflamatory disease. The severity of the symptoms depends on the degree of torsion and the amount of interference to the blood supply. All 13 cases collected by Savage (1946) and his own case were misdiagnosed and diagnosis was made at laparotomy. Reviewing the literature Keller and Savage discussed many theories leading to the torsion of the tubes.

1. Anatomical theory—malformation in the mesosalpinx i.e. hydatids of Morgagni, Parovarion cysts, persistence of spiral winding normally present in foetal life.

2. Physiological theory—disturbances in the normal peristaltic movements of the tube may result in some spasm and lead to torsion.

3. The haemodynamic theory—The veins of the mesosalpinx are longer and more flexible than the arteries and in the event of venous congestion they may assume a spiral course and favour torsion.

4. Sudden changes in the body position, a sudden acceleration or deceleration of the body may lead to abnormal motion of the internal genital organs.

5. Previous surgery or disease may lead to abnormal situation that would predispose to torsion.

Summary

A case reported in which torsion occurred in a previously healthy tube. Torsion of the tube can seldom be diagnosed before operation. However, it should be kept in mind when dealing with lower abdominal pain.

Acknowledgement

I wish to thank Lt. Col. S. D. Khanna for his help in preparing this case report, for his guidance and comments.

References

1. Abbas, T. M.: Lancet. **1**: 128, 1955.
2. Bhattacharya, V.: J. Obst. & Gynec. India. **20**: 561, 1970.
3. Bland Sutton, J.: Lancet. **2**: 1146, 1206, cited by De-Seldenoff R.
4. Brady, O. F.: Arch. Surg. **82**: 329, 1961.
5. Gulati, B.: J. Obst. & Gynec. India. **15**: 333, 1965.
6. Michealson, E. T.: Am. J. Obst. & Gynec. **56**: 794, 1948.
7. Rao, P.: J. Obst. & Gynec. India. **18**: 1028, 1968.
8. Regad, J.: Gynec. & Obst. **27**: 519, 1933.
9. Savage, J. C.: Am. J. Obst. & Gynec. **32**: 1043, 1946.
10. Taube, R.: Am. J. Obst. & Gynec. **77**: 661, 1949.
11. Yousseff, et al: Act. Obst. & Gynec. **41**: 292, 1962.