A RARE COMPLICATION OF TUBAL LIGATION

by

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Tubal Ligation is being widely performed in an effort to control the population explosion. Female sterilisation particularly during the puerperium is relatively safe though some patients may develop complications like menorrhagia and pelvic pain. However, it is extremely rare to come across an acute abdomen requiring surgery. At the Government Maternity Hospital, Pondicherry we met with such a problem and hence it is being reported.

Case Report

Mrs. A., aged 31 years, para 4 ± 0 underwent puerperal sterilisation by Pomeroy's technique in February 1972 in our hospital. She was perfectly alright for 2 years. Then she began experiencing lower abdominal pain associated with white discharge per vaginam for which she was treated on several occasions.

On the 26th of September 1976 at 4.45 PM the patient was brought to the hospital for right lower abdominal pain of 5 days duration. The pain had become more severe for the last 24 hours. She had vomited once. There was no history of fainting attack. Her last menstrual period was 10 days back. She had no vaginal bleeding on admission.

On examination, the patient appeared ill. There was no pallor. Pulse rate was 100/mt and blood pressure 120/76 mmHg. Cardiovascular and respiratory systems were normal. Breasts were not active. Abdominal examination revealed marked tenderness in the right iliac fossa. There was no mass and no free fluid in the peritoneal cavity. Liver and spleen were not palpable. The cervix was downwards and backwards, firm and smooth; uterus was anteverted and of normal size. In the right fornix a non-pulsatile, tender, cystic mass measuring 8-10 cm was detected. The left fornix was free. All the investigations were within normal limits. A provisional diagnosis of ovarian cyst or hydrosalpinx undergoing torsion was made and a laparotomy performed under general anaesthesia.

Adhesions between the omentum and the anterior abdominal wall were released. The distal parts of both the tubes had hydrosalpin- On the right side the hydrosalpinx measured 10 cm x 10 cm and had undergone torsion four times. The left side hydrosalpinx measured 7 cm x 7 cm and was lying in the pouch of Douglas. The proximal parts of both tubes, both ovaries and the uterus were normal. Bilateral salpingectomy was performed (Fig. 1). The post-operative period was uneventful; the patient was discharged on the 9th post-operative day.

On histopathological examination, the cysts had a single cell epithelial lining and appeared to be markedly dilated hydrosalpinx with flatening of the epithelium.

Discussion

In the present case there was definite history of pelvic infection following tubal ligation. Sepsis was responsible for blockage of fimbrial ends leading to

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hydrosalpinx. According to Uchida (1975) the incidence of cyst formation and adhesion was 15% in cases who had undergone sterilisation by Madlener's or Pomeroy's technique. Dawn *et al* (1968) and Gun (1971) noted an incidence of hydrosalpinx in 4 to 7.6% and 5% respectively.

Acute abdomen was the main feature in our case as also noted by Shinde *et al* (1976) in both their cases. Ringrose (1974) explains chronic pelvic pain following tubal ligation as due to partial torsion of the fimbrial end. According to him fimbirectomy will minimise pelvic pain. Uchida (1975) claims that cyst formation is extremely rare by Uchida's technique. The technique of ligation of fimbrial end may give rise to pelvic infection in the absence of sepsis (Gun, 1971).

Summary

A case of twisted hydrosalpinx following tubal ligation by Pomeroy's method has been reported.

The case has been discussed with regard to diagnostic problems and similar complications of tubal ligation available in the literature.

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See Fig. on Art Paper V