TORSION OF FALLOPIAN TUBE

(Report of 3 Cases)

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Torsion of fallopian tube is a rare condition and 3 cases were observed within a very short period of one month-August 1977 which prompted us to report the same.

Case 1

Mrs. D.R. aged 35 years was admitted for acute abdominal pain in right iliac fossa and vomiting since morning. Pain was severe and was localised in right iliac fossa. She had also constipation 4 days prior to admission.

Her past menstrual history was normal but she had amenorrhoea since last one year. She was nulliparous. She had consulted gynaecologist for her amenorrhoea and at that time she was advised to undergo an operation for some lump in her abdomen; but she had not undergone the treatment for the same.

On admission her general condition was fair with normal temperature, pulse rate 100 per minute and blood pressure 130/80 mm. of Hg. Hb. was 9.5 gms%.

On abdominal examination, tenderness was marked in lower abdomen but no lump was palpable. On vaginal examination cervix was downwards and backwards, uterus was not felt separately and there was a firm, round, 4" in diameter, tender mobile mass in posterior formix.

Provisional diagnosis of twisted ovarian cyst was made and laparotomy was decided upon. On opening the abdomen it was noticed that there was twisted right ovarian cyst along with right fallopian tube which had terminal hydrosalpinx. Haemorrhage was present in the cyst as well as in the hydrosalpinx. Left tube showed hydrosalphinx and left ovary was adherent. Uterus was normal. Around the twisted tube and ovary, flimsy adhesions were present.

Subtotal hysterectomy with bilateral salpingo-oopherectomy was performed. Postoperative period was uneventful.

Macroscopically the mass was 5½" in diameter. Fallopian tube was dark in colour, distended and about 3½" in diameter. It contained haemorrahagic fluid.

On top of the fallopian tube, enlarged ovary was present, which was about 2" in diameter, fleshy and dark in colour.

Whole mass was twisted in clockwise direction through 2½ turns.

Histopathological report showed that ovary had a simple cyst with marked haemorrhage. Tube showed the evidence of hypdrosalphinx. Myometrium was normal. Endometrium was in proliferative phase.

Case 2

Mrs. J.P. aged 30 years was admitted for acute pain in abdomen and vomiting since 4 days and fever since 1 day. Pain started suddenly when she tried to lift up a vessel full of water. Pain was localised in the right iliac fossa. Along with pain she had vomiting. She started bleeding per vaginam after 3 days of onset of pain.

Her past menstrual history was normal but since last 3 months she had polymenorrahoea. Her last menstrual period was 15 days back.

She was third gravida and second para with history of last delivery 2 years back and last abortion 5 months back.

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Accepted for publication on 24-4-1978.

Her general condition was fair with pulse rate 120 per minute, temperature 99.4 F., blood pressure 120/80 mm. of Hg. and Hb. 9.0 gms%.

On abdominal examination there was fulness in suprapubic region, more on right side, with guarding. A well defined lump arising from the pelvis. 2½ to 3″ in diameter. cystic, tender, slightly mobile and dull on percussion was palpated.

On speculum examination slight bleeding was seen coming from cervical canal. On vaginal examination cervix was downwards and forwards, uterus was retroverted, deviated to left and normal in size. In front of uterus and in right formix there was a cystic, tender, well defined lump of about 3″ x 3″ in diameter and free from uterus. Provisional diagnosis of twisted right ovarian cyst was done. At emergency laparotomy it was found that there was a dark, blackish mass in uterovesical pouch. Flimsy adhesions were present between the loops of intestine and mass. Adhesions were separated and the mass was delivered out. It was hydrosalpinx and consisted of infundibular and outer part of isthmic portion of right fallopian tube. The fimbrial end of the tube was well defined on the outer aspect of this mass.

The mass was twisted in clockwise fashion and had taken 3 turns. Medial half of the isthmic part of right fallopian tube was normal.

Mass was untwisted and right salpingectomy was done. Histopathological report showed that the mass had fibrous wall and no muscular tissue. It contained serosanguinous fluid.

Case 3

Miss F.N. aged 17 years was admitted with severe abdominal pain in abdomen and vomiting since 3 days. Pain started in left hypochondrium and later on was localised in left iliac fossa and in suprapubic region. Vomiting was more on the first day (10 to 15 times) but reduced in number as time passed on.

She had continuous dull aching pain in lower abdomen since last two months. This pain was increasing at the time of menstruation and on micturition.

Even though unmarried, she gave history of sexual relations before 3 years.

Her past menstrual history was normal. But she had dysmenorrhoea since last 2 months. Her last period was 7 days back.

Her general condition was fair with pulse rate 110 per minute, temperature normal, Hb 9.0 gms% and blood pressure 120/80 mm. of Hg.

On abdominal examination there was no guarding or rigidity. Peristalsis were present. Tender mass was present in suprapubic region arising from the pelvis. It was well defined and dull on percussion.

On speculum examination slight discharge was present and on posterior lip of the cervix there was an erosion.

Vagina easily admitted 2 fingers. On vaginal examination cervix was downwards and forwards, uterus was retroverted and normal in size. A tender, cystic, mobile mass of about 6″ x 6″ in diameter was present in anterior and right fornix.

Provisional diagnosis of twisted right ovarian cyst was done and emergency laparotomy was decided upon. On opening the abdomen, 15 to 20 cc. of serous fluid was present. Two blackish masses smaller one on the top of larger one were present in uterovesical pouch. Larger mass wos elongated, dark in colour and consisted of left fallopian tube which was distended. It was 5″ x 1½″ in diameter. Smaller mass, left ovary, was dark and was 2″ in diameter.

The whole tubo-ovarian mass of left side was twisted in clockwise fashion for 3½ turns. As the whole mass had gone on right side and in front of uterus, uterus was also found rotated 90° and left corner was directing anteriorly.

The mass was untwisted and left salpingo-oophorectomy was done. Right tube and right ovary were normal. Histopathological examination revealed marked haemorrhage in the wall and in the cavity of ovary. Fallopian tube contained haemorrhagic fluid.

Discussion

Table I gives the list of authors and number of cases reported by them.

It is observed that all the 3 cases presented here have come with different clinical picture. The striking features are discussed.

Age of patients varied from 17 years to 35 years.

All 3 patients had different menstrual pattern. First had one year amenorrhoea which may be due to associated ovarian

TABLE I

Name	Year	No. of cases
Jadhav, M. V.	1958	1
Achari	1962	1
Tamasker	1964	1
Narayan Rao, A. V.	1965	6
Gulati	1965	1
Padma Rao	1968	1
Bhattacharjee	1970	1
Nirmala Sen	1974	1
Banker, R. N.	1975	1
Yagnik & Parikh (Present Series)	1977	3
	Total	17

pathology. Second had polymenorrhoea and third had dysmenorrhoea which may be due to associated pelvic inflammation.

No definite relationship can be established between torsion of fallopian tube and obstetric history. Out of 2 married women, 1 was sterile and 1 was multiparous having last abortion only 5 months ago. According to Rao (1968) patients are either sterile or of low parity.

Onset was acute in all cases. In patient No. 2, it started soon after she lifted the vessel full of water. Thus sudden change in intra-abdominal pressure may have its influence in initiating torsion.

Pain and vomiting were common features and did not affect the general condition very much.

In all 3 cases, provisional diagnosis of twisted ovarian cyst was done. Other conditions like ectopic and acute appendicitis should also be considered.

Immediate laparotomy was performed in all cases. Commonest features were hydrosalpinx in all the 3 with flimsy adhesions and twisting in clockwise direction. Right tube was involved in 2, whereas in 1 case left tube was affected. In case 1, right fallopian tube along with right ovarian cyst had undergone torsion. In case 2, only tube was twisted, while in case 3 tube along with normal ovary had twisted.

In reviewing Indian literature hydrosalphinx was present in 70.5% of cases. Anaspach (1964) has also reported that out of 95 collected cases, 62 (65%) had hydrosalpinx.

Treatment differred in each case according to associated pathology and obstetric carrear. In first case subtotal hysterectomy with bilateral salphingo-oophorectomy was done because inflammation had involved both adnexa and there were no chances for conception. In case 2, as only tube was involved, salpingectomy was done. In case 3 ovary was also involved. It was dark in colour and haemorrhagic. On untwisting normal colour was not regained and hence salphingo-oophorectomy was done on affected side. In all cases immediate laparotomy is the suggested line of treatment. The affected tube should be preserved if on untursting its colour changes. Ovary should not be removed unless it is grossly involved.

Histopathologically all tubes showed changes of hydrosalphinx.

Summary

Three cases of torsion of Fallopian tube are presented because of rarity of such cases. These 3 cases are discussed along with the review of such cases found in Indian literature. It is observed that torsion of Fallopian tube occurs during child bearing age from 14 to 46 years with majority of them at 25 to 35 years. Onset is always acute. Pain and vomiting are more frequent. Torsion is more common in right Fallopian tube, more common in clockwise fashion and more common in hydrosalphinx tube than in normal tube.

Views of different authors regarding treatment are discussed.

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