TORSION OF FALLOPIAN TUBE DURING PREGNANCY

(Report of Two Cases)

by

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Introduction

Torsion of ovaries pathological or normal is fairly common, not so the torsion of fallopian tube. Though torsion of it may occur in children and young women (Schultz *et al*, 1943) with a previously normal tube (Desoldenoff (1949), Shaw (1949), most of the cases reported occur with pre-existing hydrosalpinx. Very few of the cases reported have occurred in association with pregnancy and puerperium. Fourteen cases have been reported in the Indian literature.

CASE REPORT

R. B., 24 years, third gravida was admitted with 18 weeks' pregnancy, pain in right side of lower abdomen and vomiting for 2 hours. She had 1 full term normal delivery 2 years before and 1 abortion at 3 months, 10 months earlier.

During her third month of pregnancy an attempt was made for evacuation and was diagnosed as ectopic pregnancy. She did not agree for laparotomy.

On examination, general condition was good, pulse 96/mt. regular, temp. + normal, BP 130/80 mm of Hg. Systemic examination was normal.

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On abdominal examination the uterus was of 18 weeks size and tenderness was present in right iliac fossa. On pelvic examination, cervix was soft, os closed, uterus 18 weeks size and no tenderness in fornices. A provisional diagnosis of pregnancy with appendicities was made. Patient was kept on intravenous fluids, ryles tube suction and antibiotics. Twentyfour hours after admission she had another attack of pain and laparotomy was done.

On laparotomy, uterus was 16-18 weeks size, left tube and ovary were normal. There was hydrosalpinx on the right side which had undergone torsion with the normal looking ovary and tube appeared gangrenous. Torsion was undone and tube with ovary was removed. Postoperative period was uneventful, pregnancy continued normally.

Histopathology showed marked haemorrhage and oedema of all coats of the fallopian tube with infiltration by neutrophils, lymphocytes and plasma cells, picture consistent with infarcted hydrosalpinx.

Case 2

G. D., 38 years, 8th gravida was admitted with 32 weeks pregnancy, pain in abdomen for 5 days, fever for 4 days and loss of foetal movements for 2 days. Her previous obstetric history was normal. In the fifth month of the present pregnancy, she had acute pain in lower abdomen for which fomentation had been done at home.

On examination, the patient looked ill and in pain. Pulse was 112/mt. regular, temp. normal and BP 110/70 mm of Hg. Systemic examination was normal.

On abdominal examination, guarding was present in lower abdomen, upper border of

uterus was consistent with duration of amenorrhoea, lateral borders of uterus could not be defined. Foetal parts were felt but presentation could not be decided. Foetal heart sounds could not be heard. Percussion note was dull on the left flank and no shifting dullness was normal.

On pelvic examination, cervix was fully effaced, admitted one finger and membranes were absent. Head was presenting and there was foul smelling discharge.

In view of fever, absent membranes, foul smelling discharge and guarding in lower abdomen, a provisional diagnosis of peritonitis with early labour was made.

The patient delivered a premature baby of 3 lbs., 4 hours after admission. Twenty-four hours later, gaurding was persisting in left iliac fossa with marked tenderness. No definite mass besides the uterus could be defined per abdomen and on vaginal examination. On fourth day after admission, a cystic mass could be defined in the left lumbar region and X-ray abdomen revealed soft tissue shadow separate from the kidney. Laparotomy was decided with a provisional diagnosis of twisted ovarian cyst.

On laparotomy, uterus and right adenexa were normal left ovary was normal, medial 7 cm. of the left tube looked normal, the lateral position ended in a bluish cystic mass about 8-13 cms. in size lying in left lumbar region and had few adhesions. The mass could be excised easily. Histopathology showed the medial portion and contralateral tube were normal. Mass was consistent with hydrosalpinx.

Discussion

Acute pain in abdomen during pregnancy is difficult to differentiate from ectopic pregnancy, appendicitis, twisted ovarian tumour, acute salpingitis and urinary tract infection. The diagnosis is usually made at laparotomy. The relatively mild nature of symptoms and absence of shock in a case resembling twisted ovarian tumour should lead one to suspect this condition. Cases reviewed in Indian literature suggest torsion is likely to occur either in early pregnancy or during puerperium. Our both cases had acute pain in third and fifth month of pregnancy. Torsion of fallopian tube associated with pregnancy could be due to softening and elongation of attachments during pregnancy.

Many theories are put forward regarding the mechanism of torsion. Causative factors for torsion have been reviewed by Jacob and Bhargava (1971). Torsion of hydrosalpinx following sterilization is reported by Iyer *et al* (1978).

Youseff *et al* (1962) believe that torsion affects more commonly the normal tube than the abnormal tube and that the pathological distention of the organ is often the result than the cause of torsion. This was clearly demonstrated in case 2 with medical end of tube looking normal. In case 1, there was already existing pathology in the tube as detected on clinical examinations at 3 months gestation.

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