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ISOLATED TORSION OF A TUBAL ECTOPIC PREGNANCY: MUST BE KEPT IN MIND

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ABSTRACT

Isolated fallopian tube torsion without involvement of the ovary is a rare condition most frequently presenting during reproductive years. The majority of the diagnoses are made on the operating table. We describe a case of isolated tubal torsion, unique in that localized necrosis and inflammation from the torsion. Its common symptoms are lower abdominal pain, vomiting, and nausea. Because these symptoms are nonspecific, isolated torsion of a fallopian tube may be misdiagnosed, delaying treatment and the opportunity to preserve the tube. The ultrasound-assisted examination was useful, but the specific diagnosis was made after laparotomy and histopathology.

Laparotomy and laparoscopy are important tools in the diagnosis and prognosis of isolated torsion of a fallopian tube, and can help to preserve the fertility of these patients.

Keywords: *Isolated tubal torsion, tubal ectopic pregnancy, ectopic pregnancy, gynaecologic emergency, laparatomy, diagnostic laparoscopy*

1. Introduction

Adnexal torsion is responsible for 2.7% of all gynecological emergencies. Ectopic pregnancy is relatively common, occurring in 2% of all pregnancies. Ectopic pregnancy is an early pregnancy

complication in which a fertilized ovum implants outside the uterine cavity. Implantation may occur anywhere along the reproductive tract with the most common implantation site being the fallopian tube.

The incidence of ectopic pregnancy is 1% of pregnant women, and may seriously compromise women's health and future fertility. Currently, ectopic pregnancy can be often diagnosed before the woman's condition has deteriorated, which has altered the former clinical picture of a lifethreatening disease into a more benign condition in frequently asymptomatic women [1].

Torsion of the fallopian tube can occur at any age and most of the patients are under 30 years of age. Cases have been reported from premenarcheal to postmenopausal age group and are more common in pregnancy. The exact cause of torsion is unknown and various theories have been postulated [2-6]. Proposed theories for tubal torsion can be classified as:

1.Anatomical abnormalities: Long mesosalpinx, tubal abnormalities, haematosalpinx, hydrosalpinx, hydatid of Morgagni.

2.Physiological abnormalities: Abnormal peristalsis or hypermotility of tube, tubal spasm and intestinal peristalsis.

3.Haemodynamic abnormalities: Venous congestion in the mesosalpinx.

4.Sellheim theory: Sudden body position changes.

5.Trauma,

6.Previous surgery or disease (Tubal ligation, Pelvic Inflammatory Disease (PID)

7.Gravid uterus.

Acute abdomen in pregnancy may be due to several genital and non-genital conditions. Isolated torsion of the fallopian tube is an uncommon event with an incidence of about 1/1,500,000 women and it has been described as a rare cause of acute abdomen in pregnancy [7, 8].

Bozkurt and Kara Bozkurt reported very rare conditions related with ısolated torsion of a fallopian tube in a postmenopausal woman. They were also detected high impedance of vascular flow around the cyst wall. In their study they were mentioned that imaging modalities could not provide a definitive diagnosis. Tubal torsion was diagnosed upon laparotomy [9].

2. Case Presentation

30-year-old G4 P3 healthy female presented to the emergency department with generalized abdominal pain.She had one-month amenorrhea, She reported a 1-day history of generalized abdominal pain, nausea, and vomiting, which on presentation to the had localized to her right lower quadrant.On per speculum examination, minimal bleeding through os was seen and per vaginal examination the uterus was anteverted and of normal size with cervical motion tenderness. Vaginal ultrasound on admission revealed an empty uterus, a small corpus luteal cyst in the left ovary and free fluid. MRI results were inconclusive, revealing a fluid collection in the right lower quadrant, but without definitive appendicitis. The radiologist hypothesized ruptured ovarian cyst? or peritoneal inclusion cyst as possible sources of the fluid. Given the persistent nature of the pain and physical exam findings, general surgery agreed to a diagnostic laparoscopy. Serum β-hCG was 500 IU/ml on admission. The patient was admitted for observation and was planned to repeat β-hCG after 48 hours. Urine pregnancy test was positive. Her haemoglobin was 11 gm and other laboratory investigations, total leucocyte count, differential leucocyte count, and urine, were found to be normal. Since the patient was hemodynamically

stable, we proceeded with diagnostic laparotomy under general anaesthesia laparotomy revealed 250 mL of haemoperitoneum. The left fallopian tube was twisted once at the medial end and contained an ruptured ectopic pregnancy in the ampullary region with oozing from the fimbrial end. The right tube and ovary were normal. Left salpingectomy was performed. Postoperative period was uneventful. Histopathology revealed chorionic villi in right tube and serous cystadenoma of left ovary.

3. Discussion

Adnexal torsion accounts for 2.7% of all gynecological emergencies .The most common presenting symptom is pain with other associated symptoms such as nausea, vomiting, bowel and bladder complaints. Temperature, WBC and ESR may be normal or slightly elevated [10]. In the present patient had low-grade fever but normal counts. Imaging findings in torsion of the fallopian tube are nonspecific and clinical correlation is very important. Many reports indicate that torsion of the fallopian tube is more common on the right side than on the left. This may be due to the presence of the sigmoid colon on the left side or to the slow venous flow on the right side, which may result in congestion [4]. Another reason could be that more cases of right-sided pain are operated because of the suspicion of appendicitis, whereas left-sided cases may be missed or resolve spontaneously. This was a rare presentation of torsion of left fallopian tube with ectopic pregnancy. Early surgical intervention is recommended in order to salvage the affected tube and preserve fertility. Torsion of fallopian tube containing an ectopic pregnancy is extremely rare. Tubal torsion should be considered in the differential diagnosis of abdominal pain in young women.

4. Conclusion

Isolated fallopian tube torsion is extremely rare cause of acute abdomen in pregnancy. Early surgical intervention is recommended in order to salvage the affected tube and preserve fertility. Accurate ultrasound flowmetry can also provide a prediction of the surgical procedure needed and can be highly useful in the discussion of the indication. In order to prevent subsequent complications. Isolated fallopian tube torsion is a rare cause of acute abdomen in pregnancy which has to be suspected when ultrasound detects normal ovaries and a pelvic cyst.

References

[1] Barnhart KT. (2009)Clinical practice: Ectopic pregnancy. *N. Engl. J. Med. 361: 379–87.*

[2] Goktolga U, Ceyhan T, Ozturk H, Gungor S, Zeybek N, Keskin U, (2007) Isolated torsion of fallopian tube in a premenarcheal 12-year-old girl. *J. Obstet. Gynaecol. Res. Apr;33(2):215-217* 10.1111/j.1447-0756.2007.00502.

[3] Batukan C, Ozgun MT, Turkyilmaz C, Tayyar M.(2007) Isolated torsion of the fallopian tube during pregnancy: a case report. *J. Reprod. Med.. Aug;52(8):745-747*

[4] Shukla R., Isolated torsion of the hydrosalpinx: a rare presentation.(2004) *Br. J. Radiol. Sep;77(921):784-786 10.1259/bjr/36288287*

[5] Bernardus RE, Van der Slikke JW, Roex AJ, Dijkhuizen GH, Stolk JG., (1984) Torsion of the fallopian tube: Some considerations on its etiology. *Obstet. Gynecol. Nov;64(5):675-678*

[6] Krissi H, Orvieto R, Dicker D, Dekel A, Ben Rafael Z., (1997) Torsion of a fallopian tube following Pomeroy tubal ligation: A rare case report and review of the literature. *Eur. J. Obstet. Reprod. Biol. ;72:107-109* .10.1016/S0301-2115(96)02656-5

[7] Sharp HT.,(2002) The acute abdomen during pregnancy. *Clin. Obstet. Gynecol. ;45:405–13.*

[8] Hansen OH.(1970) Isolated torsion of the fallopian tube. *Acta Obstet. Gynecol. Scand. 49:3–6*

[9] Bozkurt M, Kara D.,(2013) Isolated torsion of the fallopıan tube in a postmenopausal woman; a rare entity. *Proc. Obstet. Gynecol. 03;3(2)*

[10] Schraga E., (2009) Ovarian torsion. eMedline Specialities, Emergency Medicine, Obstetrics and Gynaecology,