

Isolated Fallopian Tube Torsion in a Virgin Patient: A Case Report

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The twisting of the adnexa; partially or totally around its vascular axis and causing hemorrhagic infarction is called adnexal torsion. Isolated torsion of the fallopian tube is a rare and uncommon pathology that has an incidence as 1 in 1.5 million women especially in the reproductive age. Here we describe an isolated torsion of the fallopian tube case with chronic pelvic pain.

Key Words: Fallopian tube torsion, Adnexal torsion, Pelvic pain

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Introduction

The twisting of the adnexa; partially or totally around its vascular axis and causing hemorrhagic infarction is called adnexal torsion.¹ 2.7% of all gynecologic emergencies are caused by torsion of the ovary, tube or both.² Doppler ultrasound studies are helpful for the diagnosis of adnexal torsion.³ However isolated torsion of the fallopian tube is a rare and uncommon pathology that has an incidence as 1 in 1.5 million women especially in the reproductive age.⁴ Here we describe an isolated torsion of the fallopian tube case with chronic pelvic pain.

Case Report

A 20 -year old, virgin girl admitted to our hospital with a one month of intermittent right lower abdominal pain history. She told that the pain had a severe nature for a week and nausea and vomiting occurred in the last 2 days. She did not have any other urinary or bowel symptoms, or vaginal discharge or bleeding. Physical examination revealed a right adnexal tenderness with rebound. Ultrasound imaging showed 9x5 cm right paraovarian anechoic, thinny walled cystic lesion with no significant vascularization and modest free fluid was observed in the pouch of douglas. She had no fever and her full blood count showed a white cell count of 6.8×10^3 with 65.3%

neutrophils. The hematocrit was 38.9%. Her C-reactive protein was 1.40 mg/L. Tumor markers, Ca-125 was 25 U/mL and b-human chorionic gonadotropin was negative. So laparoscopy performed, that revealed isolated torsion of the right fallopian tube with hemorrhage and necrotic tissue (Figure 1,2). The left fallopian tube, bilateral ovaries, appendix, and uterus were normal. Right total salpingectomy was performed under laparoscopy.

Histologic examination showed a 9 cm long right tuba; 2 cm in diameter and congested with extensive hemorrhage and edema. The patient had no problem postoperatively, and she was discharged 48 hours later.

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Figure 1: Figure shows the laparoscopic image of the twisted right fallopian tube which is without vascularization and necrotic.



Figure 2: Figure shows the tube after laparoscopic excision

Discussion

Most of the patients with tubal torsion attend to the clinic with pelvic pain; that increases in time and causes abdominal tenderness and/or rebound on physical examination. Nausea, vomiting, urgency may be the additional but not specific symptoms for tubal torsion.⁵ The laboratory or imaging findings can not predict the fallopian tube torsion specifically. Doppler imaging may be helpful for diagnosis if high impedance or absence of blood flow is seen; but the detection of blood flow also does not exclude the torsion.⁵

Our patient had a paraovarian cystic lesion on sonography with no significant vascularization and a modest free fluid in douglas so these findings were predictive for adnexal torsion but differential diagnosis also include acute appendicitis, pelvic inflammatory disease, a torsioned or ruptured ovarian cyst, degenerative leiomyoma or diverticulitis and urinary problems.⁶

Fallopian tube torsion is generally seen in reproductive aged women rarely in the premenarchal or menopausal period also seldom in virgin patients.^{7,8} Our patient was in reproductive age but she was virgin.

Isolated fallopian tube torsion has different etiologic causes; intrinsic causes include congenital abnormalities, hydrosalpinx, hematosalpinx, tubal neoplasms, prior pelvic surgery or tubal ligation and extrinsic causes included ovarian and paratubal masses, trauma, adhesions, pelvic congestion or pregnancy.⁹ Our patient had any predisposing factors and she had normal tubular length and the sonographic image of a paraovarian cystic lesion was probably due to the torsioned fallopian tube.

Isolated fallopian tube torsion generally occurs unilaterally and in the right side; the reason for this observational data could be because of the sigmoid colon's being in the left side and preventing excessive left adnexal movement and also right sided pelvic pain is suspicious for the appendicitis for the surgeon.¹⁰ Our patient also had right sided tubal torsion as in the literature.

Laparoscopy is the gold standard for treatment and also early diagnosis, early detection and detorsion may preserve the tube and future fertility desire however if the tube is necrotic and congested like our patient; salpingectomy could be the only procedure to perform.¹¹

In conclusion, isolated fallopian tube torsion is a rare entity, difficult to diagnose and has no specific symptoms and laboratory or imaging findings; Doppler imaging is helpful for the diagnosis and differential diagnosis is extremely wide in range. But chronic isolated tubal torsion could be in consideration if the patient had atypical, long-lasting pelvic pain especially in the reproductive age group with risk factors.

Virgin Bir Hastada İzole Tüp Torsiyonu: Olgu Sunumu

Adneksin parsiyal veya total olarak vasküler aksı etrafında dönmesi ve hemarajik enfarktüsü adneksiyal torsiyon olarak tanımlanır. Fallop tüpünün izole torsiyonu, özellikle reproduktif yaşta nadir rastlanan bir durumdur ve insidansı yaklaşık 1-1,5 milyon kadında birdir. Bu çalışmada kronik pelvik ağrı şikayeti ile tanı alan izole fallop tüpü torsiyonu vakası sunulmuştur.

Anahtar Kelimeler: Fallop tüp torsiyonu, Adneksiyal torsiyon, Pelvik ağrı

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