Asymptomatic torsion of a normal fallopian tube

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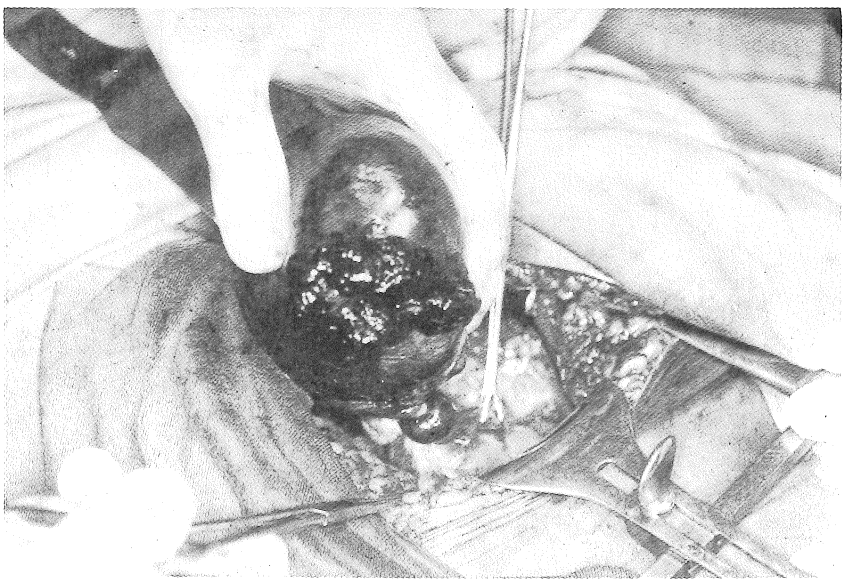
Introduction

Torsion of the fallopian tube is an uncommon condition but cases have been reported fairly often since the first case published by Bland Sutton in 1980. The following case report is presented because we have not found any report in the literature where torsion of the fallopian tube was asymptomatic and only discovered incidentally during Caesarean Section.

Case report

A 24 year old primigravida with breech presentation was admitted with spontaneous rupture of membranes at 37 weeks gestation. Antenatally, she had an uneventful pregnancy and gave no history of any abdominal pain.

On admission she appeared well and abdominal examination was consistent with a 37 weeks pregnancy with the fetus in breech presentation. There was no abdominal tenderness and no signs of peritoneal irritation.



An emergency lower segment Caesarean Section was performed under general anaesthesia soon after admission, the indication being breech presentation in primigravida with spontaneous rupture of membranes at 37 weeks gestation. A healthy baby girl was delivered. On exploring the adnexal structures prior to closure of the abdomen, the lateral portion of the right fallopian tube was found to be blue-black, dilated up to 5 cm by 3 cm, and twisted twice along its mesosalpinx. The left ovary and fallopian tube were normal. A right salpingectomy was performed and her postoperative course was uneventful. Histological examination of the excised tube revealed congestion, haemorrhage and necrosis.

Discussion

Torsion of a normal fallopian tube in pregnancy, although uncommon, does occur as illustrated in the case above. Several authors[1,2,3] have cited a review in the French literature in which 12% of 201 cases of torsion occurred during pregnancy, but information regarding associated adnexal pathology was lacking. In the aetiology of torsion of the fallopian tube, intrinsic and extrinsic predisposing factors have been proposed.[3,4] The former include the presence of a hydro, pyo or haematosalpinx, an excessively long tube, a tubal neoplasm and previous sterilisation. Extrinsic factors include uterine enlargements (for example pregnancy and fibroids), ovarian tumours, adhesions and trauma. Torsion of a normal fallopian tube in pregnancy may be related to alterations in abdominal wall tension and intra-abdominal space, as well as to the changing size of the uterus and fallopian tubes.

Symptoms of torsion of fallopian tube are notoriously varied and vague, but pain has been said to be the only consistent feature.[3,4,5] It is surprising that in this patient, torsion of the fallopian tube was an incidental finding at the time of Caesarean Section. This emphasises the need for routine inspection of the fallopian tubes and ovaries at Caesarean Section. Our patient, apart from being pregnant, did not seem to have any recognised predisposing or precipitating event and the surgical specimen was grossly and histologically normal with the exception of torsion and infarction.

Torsion of the fallopian tube is virtually never diagnosed preoperatively because of its rarity, lack of definitive diagnostic signs and its similarity to other disease processes. In majority of cases with torsion of the fallopian tube, the differential diagnosis will include all cases of intraperitoneal bleeding, inflammatory or neoplastic conditions affecting the abdominal or pelvic organs and in pregnancy, placental abruption and red degeneration of fibroid should be considered.

References

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