CASE REPORT

Isolated Fallopian Tube Torsion: A Rare Cause of Acute Abdomen

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Abstract

We present a rare case of acute abdominal pain in a nulliparous woman: Isolated fallopian tube torsion (IFTT). A 39 years nulliparous woman came with a two-day history of acute, constant left lower abdominal pain. The pelvic ultrasound was suggestive of a tubo-ovarian abscess. On laparoscopy, a torted left gangrenous fallopian tube was noted. The histology was suggestive of salpingitis-isthmica-nodosa.

Keywords: Acute abdomen, Case report, Fertility, Gynecological laparoscopy, Gynaecology, Hydrosalpinx, Torsion, Tubo-ovarian abscess.

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We present a case where a 39 years nulliparous woman came with a 2 days history of acute, constant left lower abdominal pain. She denied any urinary, or bowel symptoms, fevers, or vaginal discharge.

She had a history of prior admission around 2 months back with similar complaints, and at that time pelvic ultrasound was suggestive of left-sided hydrosalpinx which was managed empirically with antibiotics.

However, this time, the pain was constant and worse. On admission, she was apyrexial, tender in the left iliac fossa with guarding. Inflammatory markers were normal. The pelvic ultrasound was suggestive of a 58 × 17 × 47 mm tubo-ovarian complex/abscess (Fig. 1).

In view of worsening pain, and imaging s/o of tubo-ovarian abscess, she consented to laparoscopy and proceeded. Laparoscopic findings revealed minimal haemoperitoneum-50 mL, and a large blue-black gangrenous left fallopian tube, which appeared to be torted at the cornual end, and distended with blood (Fig. 2). There was no associated ipsilateral ovarian involvement and the right tube was blocked with no evidence of hydrosalpinx.

The right ovary and the rest of the pelvis appeared normal.

Since the tube was gangrenous, she had left a complete salpingectomy. Postoperatively the patient recovered uneventfully and was discharged home the following day. The histology was suggestive of salpingitis isthmica nodosa with infarction secondary to torsion of the fallopian tube.

Results

In women presenting with acute abdominal pain isolated fallopian tube torsion (IFTT) is an important differential to consider, and early retort to laparoscopy where feasible will prevent damage to the tube and preserve fertility.

Discussion

Isolated fallopian tubal torsion is an uncommon cause of lower abdominal pain in women of reproductive age with a reported incidence of 1/1.5 million. It may occur due to intrinsic factors such as congenital anomalies, long or spiral tubes, hydrosalpinx, pelvic inflammatory disease, or extrinsic factors such as adhesions and ovarian or para-ovarian masses.[1,2]

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Patient consent statement: The author(s) have obtained written informed consent from the patient for publication of the case report details and related images.

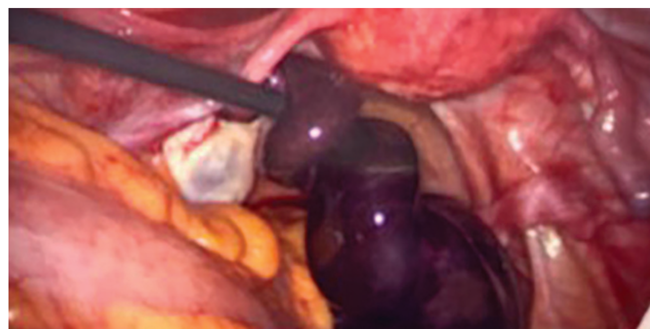

Fig. 1: Torted fallopian tube with normal ovary

Laparoscopy is the gold standard for accurate diagnosis and management. However, the diagnosis is rarely made and surgery is often delayed due to extremely difficult preoperative diagnosis. Laparoscopic de-torsion of the tube is the treatment of choice whenever feasible to preserve fertility.[3] Complete or partial salpingectomy is indicated if the tube is irreversibly ischemic.

Data Availability Statement

Data and materials presented in the paper are freely available to publish.

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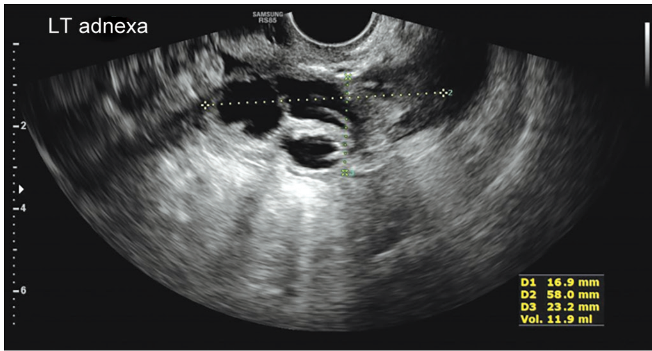

Fig. 2: Pelvic ultrasound

Author's Contribution

AP and JM: Writing the manuscript; NA: With retrieving notes and data.

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References

1. Krissi H, Shalev J, Bar-Hava I, et al. Fallopian tube torsion: Laparoscopic evaluation and treatment of a rare gynecological entity. J Am Board Fam Pract 2001;14(4):274–277. PMID: 11458970.
2. Antoniou N, Varras M, Akrivis C, et al. Isolated torsion of the fallopian tube: A case report and review of the literature. Clin Exp Obstet Gynecol 2004;31(3):235–238. PMID: 15491073.
3. Jokić R, Lovrenski J, Lovrenski A, et al. Isolated fallopian tube torsion – A Challenge for the timely diagnosis and treatment. Srp Arh Celok Lek 2015;143(7–8):471–475. DOI: 10.2298/sarh1508471j.