Olgu Sunumu / *Case Report*

İzmir Eğitim ve Araştırma Hastanesi Tıp Dergisi (Medical Journal of İzmir Hospital) 24 (1): 79-81, 2020

RARE GYNECOLOGICAL EMERGENCY: ISOLATED HYDROSALPINX TORSION- TWO CASE REPORTS

NADİR GÖRÜLEN JİNEKOLOJİK ACİL: İZOLE HİDROSALPİNKS TORSİYONU- İKİ OLGU SUNUMU

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Anahtar Sözcükler: Tuba uterina torsion, hydrosalpinx, acute abdominal pain
Keywords: Tuba uterina torsiyonu, hidrosalpinks, akut batın

Yazının alınma tarihi: 17.01.2019 Kabul tarihi: 16.02.2019 Online basım: 30.01.2020

SUMMARY

Introduction: *Isolated tubal torsion is a rare gynecological cause of acute abdominal pain. Its incidence is approximately 1/1.500.000. Intrinsic factors (congenital anomalies, long mesosalpinx, hydrosalpinx, tubal spasm, tubal neoplasm, primary tubal factor, etc.) and extrinsic factors (ovarian and paratubal mass, abnormal intestinal peristalsis, pregnancy) can be responsible. There are no specific symptoms and laboratory findings of tubal torsion. It is usually diagnosed intraoperatively.*

Cases:*The first of the two cases with hydrosalpinx describes the hydrosalpinx torsion in the infertile patient after right tubal occlusion. The second one describes bilateral hydrosalpinx torsion after bilateral tubal ligation.*

Conclusion: *Isolated tubal torsion is rare antity. Tubal torsion should be considered if the risk factors are present such as hydrosalpinx or previous tubal surgery for differential diagnosis of acute abdominal pain.*

ÖZ

Giriş: *İzole tuba uterina torsiyonu nadir bir jinekolojik akut batın nedenidir. İnsidansı yaklaşık 1/1.500.000'dir. Bu tabloya intrinsik faktörler (konjenital anomaliler, uzun mezosalpinks, hidrosapinks, tubal spazm, tubal neoplazm, primer tubal cerrahi vs.) ve ekstrinsik faktörler (ovaryan ve paratubal kitle, anormal intestinal peristaltizm, gebelik, travma, adezyon, pelvik konjesyon vs.) sebep olmaktadır. Tuba uterina torsiyonunun spesifik semptomları ve laboratuar bulguları yoktur. Genellikle intraoperatif tanı almaktadır.*

Olgular: *Hidrosapinks mevcut iki olgudan ilki infertil hastada sağ tubal oklüzyon sonrası hidrosalpinks torsiyonunu, ikincisi geçirilmiş bilateral tüp ligasyonunun ardından bilateral hidrosalpinks torsiyonunu ele almaktadır.*

Sonuç: *İzole tuba uterina torsiyonu nadir görülmektedir. Akut batın mevcut hastalarda özellikle geçirilmiş tubal cerrahi risk faktörü mevcut ise tuba uterina torsiyonu düşünülmesi gereken ön tanılar arasında yer almalıdır.*

INTRODUCTION

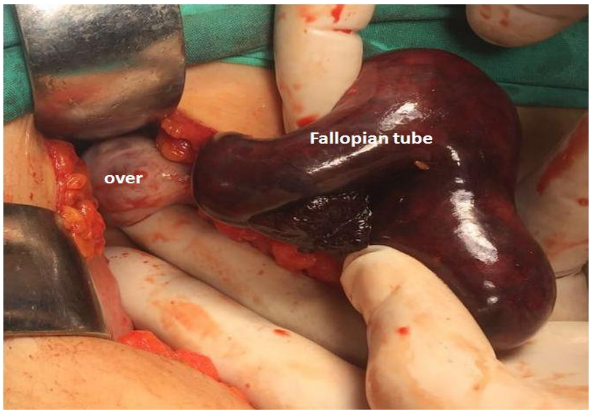
Isolated tubal torsion is a rare gynecological cause of acute abdominal pain (1). Its incidence is approximately 1/1.500.000 and is usually between 20 and 40 years age (2). Intrinsic factors (congenital anomalies, long mesosalpinx, hydrosalpinx, tubal spasm, tubal neoplasm, primary tubal factor, etc.) and extrinsic factors (ovarian and paratubal mass, abnormal intestinal peristalsis, pregnancy) can be responsible (3). Right tubal torsion is three times more common. Because, sigmoid colon on the left side limits the mobilization of the left tuba uterina (4). There are no specific symptoms and laboratory findings of tubal torsion. The most common differential diagnosis are acute appendicitis and ovarian torsion. It is usually diagnosed intraoperatively (5,6). The first of the two cases with hydrosalpinx describes the hydrosalpinx torsion in the infertile patient after right tubal occlusion. The second one describes bilateral hydrosalpinx torsion after bilateral tubal ligation.

CASE 1

A 24-year-old primary infertile (for 5 years) female patient was admitted to the emergency department with complaints of right lower quadrant pain, nausea and vomiting started one day ago. The patient had a right tubal occlusion operation due to right hydrosalpinx. In the abdominal examination, rebound and defence positivity were observed. There were mild leukocytosis. Pregnancy test was negative. Uterus and bilateral adnexes were normal in transvaginal ultrasonography. Free fluid was not observed in Douglas. Laparotomy was performed for acute appendicitis by general surgeon. Appendix was normal but the right tuba uterina was double torsioned arround. It was necrotic and edematous. Right salpingectomy was performed (Picture1, 2).

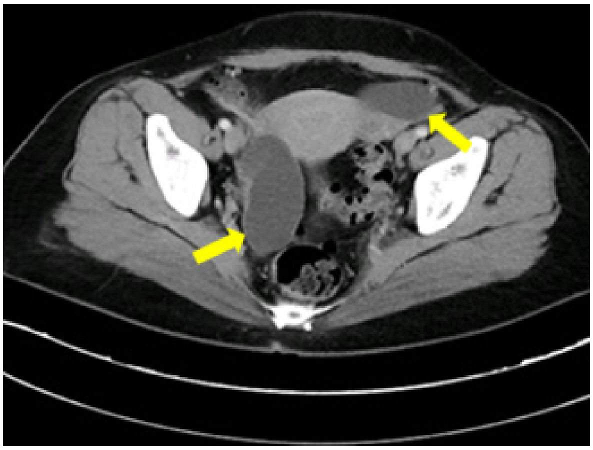
CASE 2

A 33-year-old patient with gravida 2, para 2 had two cesarean section, and bilateral tubal ligation (1 year ago) was applied to emergency department with complaints of right lower quadrant pain, nausea and vomiting. Abdominal examination revealed right lower quadrant tenderness. Defence and rebound were not observed. Transvaginal ultrasonography showed 8 mm hydrosalpinx both in the right and left tubal uterus. CT confirmed the preliminary diagnosis of hydrosalpinx. No clear evaluation could be made with doppler ultrasonography. The patient had mild leukocytosis, no CRP elevation, and the pregnancy test was negative. The patient was hospitalized. Ceftriaxone and metranidazole parenteral treatment were started. The patient was electively operated on the 4th day of dual antibiotherapy. During the operation, 7x4 mm in the right tuba uterine and 8x5 mm serous fluid in the left tuba uterina were observed. No necrosis was observed. Bilateral salpingectomy was performed (Picture3,4).

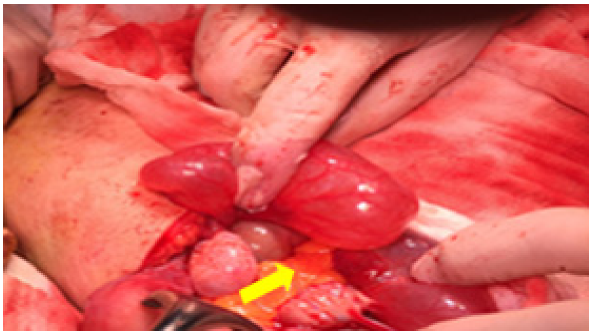


Picture1. Case 1 Intraoperative view

Picture2. Case 1 Post-Operation Specimen



Picture 3. Case 2 Preoperation CT view



Picture 4. Case 2 Intraoperative view

DISCUSSION

Tuba uterina torsion is similar to ovarian torsion in clinical presentation. It usually presents with lower quadrant pain accompanied by nausea and vomiting (3). Tubal torsion is frequently associated with additional pathologies such as hydrosalpinx, pyosalpinx, morgagni cyst of tuba uterina.It is usually on the right side. Although cystic structure of hydrosalpinx is identified by ultrasound, diagnostic distinction from ovarian torsion is difficult. It is usually diagnosed during operation (5,6).

CONCLUSION

Isolated tubal torsion is rare entity. Tubal torsion should be considered if the risk factors are present such as hydrosalpinx or previous tubal surgery for differential diagnosis of acute abdominal pain.

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Sorumlu yazar

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