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Case Report

ACUTE ABDOMEN PRESENTATION OF TORSION OF FALLOPIAN TUBE AND THE FIMBRIAL CYST IN 15 YEAR OLD PATIENT

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ABSTRACT

Pain, tenderness and rebound tenderness in right iliac fossa in 15 years old is extremely difficult to diagnoses of Fallopian tube&fimbrial cyst torsion especially the incidence is about 1 in 1500000 women in age between 21 and 40 years. This case emphasize the need to include tubal torsion in the differential diagnosis of acute appendicitis even in patients with an unremarkable gynecologic/obstetric history.

INTRODUCTION

Torsion of the fallopian tube without ovarian torsion is a rare cause of lower abdominal pain in reproductive-age women with an incidence of 1 in 1.5 million women (Hansen, 1970). The age range is from 21-40 years (Phupong, 2001). Torsion of the fallopian tube and the fimbrial cyst is not only an exceptional event but a significant cause of sudden and severe lower abdominal pain in females that is difficult to diagnose before intervention (Kaido *et al.,* 2009; Thakore, 2012; Masroor and Khan, 2008; Pinkert *et al.,* 2006; Shukla, 2004; Puri *et al.,* 2003 Rizk, 2002). The condition is frequently misdiagnosed with acute appendicitis or ovarian torsion. Our case was 15 year old and misdiagnoses as acute appendicitis.

CASE REPORT

15 year old female presented with right iliac fossa pain for 30 hours duration, continuous, gradual increase in intensity associated with anorexia and vomiting on examination pulse rate was 95 per minute, afebrile, tenderness and rebound tenderness in right iliac fossa, ultrasonic examination was negative, white blood cell count was 16500, the diagnosis was acute appendicitis.

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After preparation of patient, laparotomy done, through gridiron incision heamopretonium was found which need to extend the incision down (Rutherford Morison incision), we found twisted haemorrhagic mass in the right Fallopian tube (figure 1), excision the mass preserving the right ovary. Bisected the mass we found clear fluid i. e. It was twisted cystic lesion in Fallopian tube send for histopathologic study.

DISCUSSION

Various theories have been postulated to explain the cause of Fallopian tube torsion. A survey of 201 cases of fallopian tube torsion by Regad (1933) found a normal appearance in only 24%. Causes of fallopian tube torsion include anatomic abnormalities including long mesosalpinx, tubal abnormalities, hydrosalpinx and hydatids of morgagni. Physiologic abnormalities include peristalsis or hyper mobility of the tube and tubal spasm from drugs (Masroor and Khan, 2008). The diagnosis of isolated torsion of a fallopian tube is particularly difficult and is often delayed because of its rarity. Torsion of fallopian tube together with fimbrial cyst is a very rare coexistent lesion in the same patient. It is seen in adults and its occurrence in an adolescent virgin girl is seen occasionally (Thakore, 2012; Masroor and Khan, 2008). Preoperative diagnosis is not possible as it has no pathognomic symptoms, clinical findings on physical examination and any particular laboratory or imaging diagnostic characteristics.

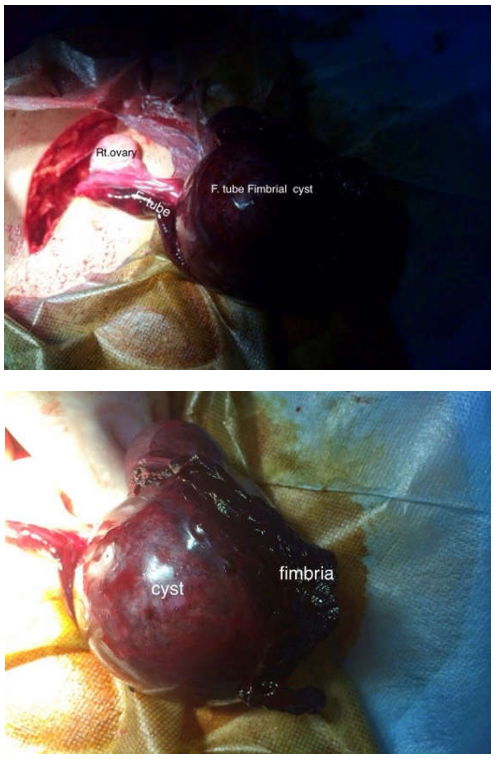

Figure 1. Twisted Fallopian tube-fimbrial cyst

Torsion of fallopian tube in association with fimbrial cyst should be considered presenting with acute pelvic pain even if the ultrasound shows simple cyst, Acute severe lower abdominal pain is always present and often in the per ovulatory period probably because of pelvic congestion and increased tubal motility at mid cycle. The twisted fimbrial cyst was diagnosed only at laparotomy, the diagnosis was acute appendicitis. This is consistent with the findings of others who reported that in only one of their 15 patients was a paraovarian or paratubal cyst suggested before surgery (Barloon *et al.,* 1996). Treatment for Fallopian tube cyst torsion includes laparotomic or laparoscopic detorsion plus salpingotomy, salpingostomy, or salpingectomy depending on when the torsion is discovered, the viability of the tube and whether the patient is systemically compromised. Fixation of the tube may also be done to reduce the risk of further torsion events (Masroor and Khan, 2008; Gross *et al.,* 2005; Benkaddour *et al.,* 2009).

Conclusion

This case emphasize the need to include tubal torsion in the differential diagnosis of acute appendicitis even in patients with an unremarkable gynecologic/obstetric history.

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