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Fallopian tube cyst: a rare complication of tubal sterilization

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CASE REPORT

FALLOPIAN TUBE CYST: A RARE COMPLICATION OF TUBAL STERILIZATION

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Tubal sterilization is one of the most commonly employed permanent method of contraception, although it is considered very safe, rarely a cyst may develop in the fallopian tube after sterilization which may undergo torsion resulting in patient presenting with acute abdomen. We are presenting a case of a middle aged women presenting to emergency room with severe lower abdominal pain, she had past history of tubal ligation done 12 years back. Pelvic ultrasound showed right sided ovarian cyst, emergency laparotomy was performed for suspected torsion of ovarian cyst, which revealed normal ovary, however a right sided fallopian tube cyst was present which had undergone torsion, right sided salpingectomy was performed and the patient was sent home in stable condition on the fourth postoperative day.

Keywords: complication, tubal sterilization, tube cyst

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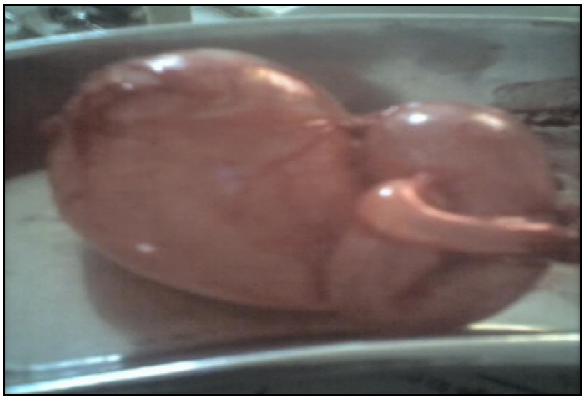
INTRODUCTION

Tubal sterilization is one of the most commonly used contraceptive methods,[1] although generally regarded as a safe and effective method it can cause various complications. Author presents a case of a fallopian tube cyst complicated with torsion, in a patient with history of tubal sterilization presenting with acute abdomen.

CASE REPORT

A 45 years old P6+0, presented in emergency room complaining of severe colicky abdominal pain for the last four days duration, pain was non radiating more towards the right lower quadrant having no associated symptoms, her last delivery was by caesarean section 12 years back and bilateral tubal ligation was done at that time. Abdominal examination revealed tenderness at right lower quadrant with no sign of guarding and rigidity and no evidence of free fluid, on bimanual examination, a tender 5×4 cm, mobile mass palpable in Rt. Adnexa, Left adnexa was clear.

Lab workup was in normal range. Ultrasonography revealed enlarged and cystic right ovary. Doppler ultrasound showed possibility of early signs of torsion. Provisional diagnosis of torsion of right sided ovarian cyst was made. A midline exploratory laparotomy was performed which revealed a 6×7 cm serous cyst of Rt. Sided fallopian tube, which had undergone partial torsion (Figure-1 & 2), cystectomy and right sided salpingectomy was performed and the specimen was sent for histopathology which showed , features of right sided fallopian tube cyst. Postoperative course was uneventful.



Fiure-1: Fallopian tube cyst (near look)

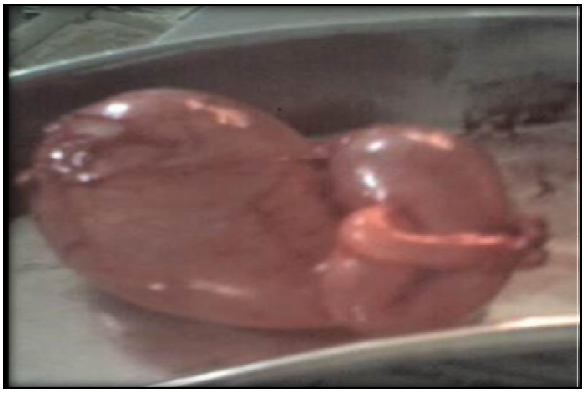


Figure-2: Fallopian tube cyst (far look)

DISCUSSION

Surgically sterilized tubes may exhibit few pathological changes after few years, 50% of the patients may develop dilatation of proximal stump lumen, fibrosis of the distal stump, hydrosalpinx[3], epithelial plical attenuation and formation of psuedopolyps, rarely a cyst may develop in the fallopian tube which may take 10–12 years. Possible underlying pathophysiology suggest that in some

cases due to inadequate obliteration, tissue oedema or other unknown reasons, the occluded portion of the fallopian tube does not interrupt the blood flow completely, resulting in vasodilatation, oedema and accumulation of tubal fluid to form tubal cyst, which may precipitate torsion of the fallopian tube.[4] The patient mostly complains of abdominal or pelvic pain which may radiate to flank or thigh, other clinical features may include nausea, vomiting, bowel and bladder complaints.[5,6]

Bimanual examination may reveal cervical excitation with a tense and tender adenexal mass.[7] Because of lack of path gnomonic features other conditions like, ectopic pregnancy, pelvic inflammatory disease, ovarian cyst accidents, acute appendicitis, urinary tract disease, renal colic, degenerative fibroid must be excluded.[5,6] Ultrasound have been used as a diagnostic tool in cases of torsion of fallopian tube cyst.[8] In our case the sonogram and clinical picture led to the initial diagnosis of an ovarian cyst which has undergone torsion but on exploratory laparotomy, the diagnosis of torsion of fallopian tube cyst was made. Early recognition followed by prompt surgery either through laparoscopy or laprotomy is the optimum management strategy.[5,6]

The literature review revealed few cases of isolated torsion of fallopian tube with or without pregnancy and a case series on fallopian tube cyst [4] the author is presenting the isolated first case report.

CONCLUSION

Although the torsion of a tubal cyst is quite rare, it should be included in a patient with past history of tubal ligation presenting with acute abdomen having an adnexal mass.

REFERENCES

1. Henry A, Rinehart W, Piotroco PT. Revising female sterilization. Pop Reports 1980;C(8):97–123.
2. Pati S, Cullins V. Female sterilization. Evidence. Obstet Gynecol Clin North Am 2000;27(4):859–99.
3. Stock RJ. Histopathological changes in fallopian tubes subsequent to sterilization procedures. Int J Gynecol Pathol 1983;2(1):13–27.
4. Lin HH, Hwang WJ, Ho HN, Hshieh FJ, Lee TY, How SW. Tubal cyst following tubal sterilization: a delayed complication. Asia Oceania J Obstet Gynaecol 1989;15(3):271–6.
5. Milki A, Jacobson DH. Isolated torsion of the fallopian tube. A case report. J Reprod Med 1998;43(9):836–8.
6. Provost MW. Torsion of normal fallopian tube. Obstet Gynecol 1972;39(1):80–2.
7. Krissi H, Orvieto W, Dicker D, Dekel A, Ben Rafael Z. Torsion of a fallopian tube following Pomeroy tubal ligation:a rare case report and review of the literature. Eur J Obstet Gynecol Reprod Biol 1997;72(1):107–9.
8. El chalal U, Caspi B, Schachter M, Borenstein R. Isolated tubal torsion: clinical and ultrasonographic correlation. J Ultrasound Med 1993;12:115–7.

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