Case Report

Fallopian Tube Prolapse after Hysterectomy: A Rare Entity

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Abstract

Prolapse of fallopian tube into the vaginal vault following hysterectomy is a rare complication and an underreported clinical entity as well. Cumulative incidence of fallopian tube prolapse is 0.5 and 0.06% with vaginal hysterectomy and abdominal hysterectomy respectively. Histopathology along with good clinical correlation is the only definite way to confirm its diagnosis.

Keywords: Prolapse, Fallopian tube, Post-hysterectomy complication.

Introduction

Post-hysterectomy fallopian tube prolapse is an exceedingly rare event to occur, which was first reported by Pozzi in 1902.[1] It accounts for usually 0.01–0.05% of all the hysterectomies and can occur after either total abdominal, vaginal or laparoscopic hysterectomy.[2] Failure to recognize this condition often leads to misdiagnosis, under-reporting, and delayed treatment. We are presenting one such case in a 38-year-old female who was clinically suspected for malignancy.

Case Report

A 38-year-old lady presented to gynecology outpatient department with complaint of profuse vaginal discharge since last two months. This was associated with on and off dull aching pain in the lower abdomen. She had undergone total abdominal hysterectomy for fibroid uterus 8 months back. Her post-operative recovery period was uneventful. Per speculum examination revealed a growth of 2×1×1 cm size, protruding into the vaginal vault. It was tender but did not bleed on touch. The growth was excised and sent for histopathological examination. Microscopic sections showed papillary processes lined by columnar epithelium. The underlying stroma showed lymphoplasmacytic infiltrate. Later on, whole resected specimen was also received and examined, which on cut section showed a lumen and histological sections showed features of an inflamed fallopian tube (Fig. 1).

Discussion

Fallopian tube prolapse is more common following vaginal hysterectomy as compared to abdominal hysterectomy[3] and less frequent after interposition or colpotomy.[4] Most of the studies have reported the patients to be in premenopausal age group,[5,6,7] though its occurrence in post-menopausal women is not uncommon.[8,9] There are variety of risk factors that predispose a female to fallopian tube prolapse like postoperative fever, condition increasing intra-abdominal pressure like chronic cough or constipation, hematoma formation, poor physical state of the woman, early resumption of coitus before complete healing, poor prehysterectomy vaginal preparation, difficult surgical procedure, use of intraperitonial vaginal drains/ packs and failure to close vaginal cuff adequately.[10] All these factors may lead to development of a defect between pelvic peritoneum and the vagina.[11] It is also widely accepted that the laparoscopic approach is associated with an increased risk of vaginal cuff dehiscence.[12] Common presenting symptoms are watery or bloody vaginal discharge, dyspareunia, lower abdominal pain and post-coital bleeding although a patient can be asymptomatic.[13]

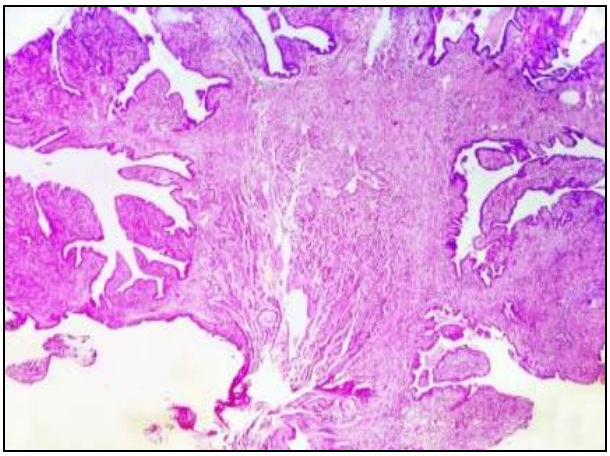

Figure 1.Fallopian Tube Prolapse with Evidence of Salpingitis (H&E, 20×)

Its differential diagnosis includes proliferative granulation tissue related to surgery, vaginal adenosis, endometriosis,[4] and malignant lesion like papillary adenocarcinoma. Many authors have reported that fallopian tube prolapse has been misdiagnosed frequently as benign or malignant growth, as in the present case.[14,15] Squamous metaplasia has been reported to occur in longstanding cases due to chronic irritation and severe inflammation which may later on progress into malignancy. This also imposes a diagnostic treasure as it may hide normal fallopian tube epithelium. In such cases, immune markers like pankeratin antibodies may be used to detect fallopian tube epithelium.[16] In rare instances, fallopian tube prolapse may be associated with angiomyofibroblastic stromal response mimicking aggressive angiomyoxoma or angiomyofibroblastoma posing a diagnostic pitfall.[17]

Conclusion

Post-hysterectomy fallopian tube prolapse is not a frequent complication; therefore, the clinicians may miss the diagnosis when dealing with a patient presenting with vaginal discharge or nonspecific symptoms. Hence, a meticulous search for predisposing risk factor including history of previous surgical procedures should always be done. Histopathological examination is a must for its definite diagnosis. Hence, a good combination of clinical and histopathology correlation is needed to avoid any misdiagnosis.

Conflict of Interest: None

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