TORSION OF THE FALLOPIAN TUBE — A LATE COMPLICATION OF STERILISATION

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SYNOPSIS

A case of torsion of the right fallopian tube is reported. This occurred 5 years after a Pomeroy's method of bilateral tubal ligation was performed. In those patients with a history of sterilisation, torsion of the fallopian tube should be considered in the differential diagnosis of acute lower abdominal pain.

INTRODUCTION

Torsion of the fallopian tube following sterilisation is a rare complication which is seldom diagnosed pre-operatively. Since Sutton (1) reported the first case of torsion of the fallopian tube in 1890, isolated case reports have appeared in the literature (2, 3). The following is a report of torsion of a tube following Pomeroy tubal ligation.

CASE REPORT

A 45 year old Indian female (Gravida 2, Para 2) had both her babies delivered by lower segment Caesarean section, the last one being 5 years ago, when in addition a Pomeroy's method of bilateral tubal ligation was performed. She has been having regular periods; the last menstrual period was from 10.8.1974 to 17.8.1974. Ten years ago she had an appendicectomy operation for acute appendicitis. On 21.8.1984 she presented with a history of pain in the right iliac fossa of 10 days duration. Minimal tenderness was felt in the right iliac fossa. Pelvic examination revealed no bleeding or discharges. The cervix and uterus were normal and displaced to the left. A markedly tender, elongated adnexal mass, measuring 6cm × 3cm × 3cm was palpable on the right side. A pre-operative diagnosis of right adnexal torsion was made.

At laparotomy the distal segment of the right fallopian tube was twisted thrice on the distal mesosalphinx and appeared tense and gangrenous, measuring 6cm × 5cm × 4cm (Figure 1). The right ovary was normal and a 2cm gap was noted between the proximal and distal segment of the tube. The left tube and ovary were normal except for the absent mid-segment of the tube. Both tubes were excised. Histopathology showed haemorrhagic infarction of the right tube consistent with torsion.

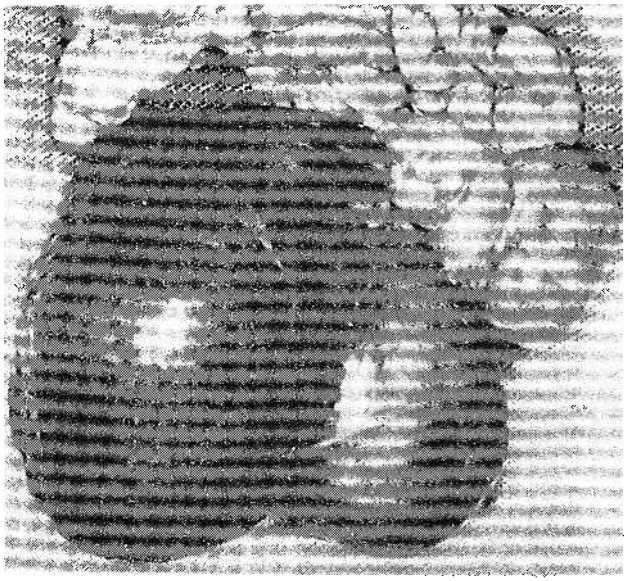

Figure 1. Right salphingectomy specimen showing dilated, gangrenous, fimbrial end of the tube that had undergone torsion, with omental adhesion.

DISCUSSION

Torsion of an intact fallopian tube unaccompanied by torsion of the ipsilateral ovary, although uncommon, does occur, as illustrated in the case above. The Pomeroy method of tuba ligation can be considered a good procedure, but the gap in the tube allows the distal mesosalphinx to act as a pedicle; and with a long mesosalphinx, the fimbriated segment of the tube lies free and may thus swing and twist producing torsion. In addition, as others (4) have postulated, a vascular disturbance leading to venous congestion, oedema and increase in weight of the free fimbrial end of the tube will encourage the occurrence of such a torsion.

As the complication is an unusual one, the correct diagnosis is rarely, if ever, made pre-operatively. Pain, which is the only constant feature, is located in the quadrant of the involved tube and may radiate to the thigh or flank. The right tube is involved more often than the left, possibly because of the inhibiting influence of the sigmoid colon in the left.

Torsion of the fallopian tube has also been reported following other methods of tubal occlusion, such as tubal cautery (4), falope ring (5) and the use of clips (6). Although rare, gynaecologist should suspect the diagnosis of torsion of a tube, when symptoms as noted in the case above are present. Immediate laparotomy is essential. Generally, by the time a decision is made to operate, the affected tube is gangrenous and msut be excised.

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