



Ruptured Tubal Cyst Torsion and Successful Surgical Treatment

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Abstract

Tubal torsion is extremely rare in pregnancy. Shortly before the labor is a more rare condition. The symptoms are nonspecific. If it becomes uncomplicated and complicated, it is really dangerous for the mother and the baby. In this case report, we wanted to draw attention to this issue by transferring the isolated right fallopian tube torsion and successful surgical treatment that was noticed during caesarean section.

Keywords: Intrauterine device; Rupture; Intestine

Introduction

Isolated fallopian tube cyst torsion, which is masked by close labor in the 3rd trimester of pregnancy, is a very rare event [1]. The predisposing factors for tuba torsion are hydrosalpinx, previous tubal operation, pelvic congestion, trauma, ovarian and paraovarian masses [2,3]. The most common symptoms are abdominal pain, nausea and non-specific symptoms. The right side is affected in 90% of the cases. Although sensitivity is generally present, acute abdomen findings are faint. Findings suggesting torsion-related necrosis, such as leukocytosis, increased CRP, and mild hyperpraxia, may be seen as laboratory findings [4]. Therefore, the diagnosis is usually made during surgery. Treatment is also necessary at all times salpingectomy.

In this case report, the right torsion of the right fallopian tube and the successful surgical treatment of caesarean section were performed.

Case Presentation

She was admitted to our clinic with complaints of mild nausea and pains in the primigravida of 38 years. There was no problem in routine pregnancy follow-up. Systemic disease, previous operation, renal stone, gallbladder diseases and gastric diseases were not found in the patient's history. It was learned that there was no drug use except multivitamin and iron supplementation. Physical examination and vital signs were normal: fever was 37.1, pulse was 85/min, and blood pressure was arterial (TA) was 110/70 mmHg. On gynecological examination, there was 1 cm opening in the cervical arm and 50% softening. No amniotic fluid leakage was observed. In obstructive ultrasonography; BPD (Biparietal Diameter) 38 weeks, FL (Femur Length) 38 weeks, AC (Abdominal Circumference) 39 weeks, EFW (Estimated Fetal Weight) 3300 gr. Amniotic fluid index was normal and placenta fundal grade 2 and head developed. NST (non-stress test = basal cardiotocography) was reactive, variability normal, fetal heart beats 110 beats/min to 160 beats/min, active fetal movements were present, flowing positive, irregular uterine contractions were present. The patient was hospitalized in the obstetrics clinic for follow-up. TA 100/60 mmHg and pulse 88/min. Hemoglobin was 11.5 mg/dl, white blood cell count was 13×10^6 K/mm³, AST 20 IU/L, urea 10 mmol/L, platelet count 190,000, serum electrolytes normal, protein negative in whole urine analysis, leukocyte negative. Since the patient had irregular uterine contractions, low-dose labor induction (oxytocin) was started. After 2 hrs, the patient was re-evaluated. Her vaginal examination was uneventful. However, all quadrants in the abdomen had increased widespread tenderness. Sensitivity was more pronounced, especially in the right lower quadrant. Abdominal Ultrasonography (USG) showed minimal minimal free fluid in the liver. Liver and kidney examination was normal and appendix and ovaries could not be visualized due to large gestational week. Fetal heart beats were normal, NST was reactive. In control obstetric USG, there were no signs of detachment in grade 2, located in placenta fundal; but possible silent detachment was considered. Other intraabdominal effects of tuboovarian torsion, ovarian cyst rupture, atypical appendicitis, gallbladder and hepatic events were considered in the diagnosis. His biophysical profile was 10 points in obstetric examination. The patient was followed up for 2

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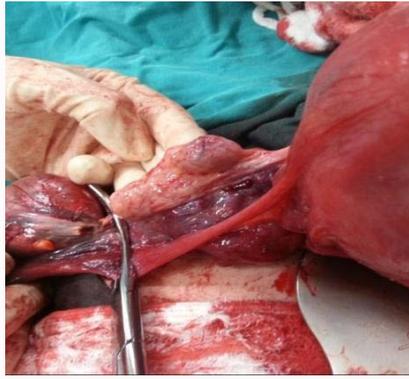


Figure 1: Ovarian tissue intact. Appearance of the edematous, conjugated tuba and tubal cyst.



Figure 3: The baby was removed during the caesarean section and the umbilical cord was cut.



Figure 2: Ruptured cyst.

more hrs and underwent caesarean section due to uncontrolled labor and discordant pain with possible labor and possible intraabdominal pathologies. The abdomen opened with a pfannenstiel incision. A healthy 3,200 gr. The infant was delivered to a male infant. Placenta is full. In the observation of abdomen, the right ovary is normal, and the right tibia is 8 cm to 0 cm. There was a tubal cyst with ruptured hemorrhage. The right tuba was edematous and congested. Both ovaries were normal (Figure 1-3). Right salpingectomy with cyst was performed. The material was sent to pathology. Bleeding control was achieved. Uterus incision was closed in one layer. Then it was closed to the anatomy of the abdomen. The patient was discharged on the 3rd postoperative day. The pathological material sent during surgery was compatible with tubal cyst and right tubal edema, hemorrhage and congestion.

Discussion

Torsion of fallopian tube was first described by Bland-Sutton in 1890 [5]. Tubal torsion is a very rare event in the third trimester of pregnancy and especially during the delivery of labor. Clinical presentation is generally nonspecific and diagnosis is more difficult in the abdomen of pregnancy. In some patients, nausea, vomiting, small amounts of vaginal bleeding and dysuria may be seen as clinical symptoms. Due to the lack of specific imaging and laboratory findings, the physician should be suspicious in the diagnosis. If left untreated, torsion can cause maternal morbidity with fetal loss [6]. Careful attention to unusual conditions in the clinical follow-up of the patient prevents early possible obstetric complications.

As it is rarely seen during pregnancy, it can be mixed with ovarian torsion or acute appendicitis [7,8]. This is because the appendicitis manifests itself in the right lower quadrant pain. Again, the torsion of

the ovarian torsion with the ultrasound findings is similar. However, as we have seen in our case, this condition (torsion) should be included in the differential diagnosis of lower abdominal pain during pregnancy as the pregnancy itself increases the risk of torsion of the fallopian tube.

Various adjunctive diagnostic methods may be used in imaging depending on the time of pregnancy of the patient. For example, in patients with Trimester 1 and 2, magnetic resonance imaging may be used if the patient agrees. Also, ultrasonography may be useful for clarifying the diagnosis. Sonographic characteristics of isolated fallopian tube torsion include tubal thickening, enlarged Fallopian tube, hematosalpinx, adnexal masses of various echogenicity [9-11]. Two methods are non-invasive. It carries a minimum risk for pregnant women. But no diagnostic method will work in a patient with a labor. In this case, we think that the best method is to open and look at the west. Already in our patient, we could only use ultrasonography before laparotomy. However, since the size of the uterus is large, it was not possible to view the ovaries.

Laparotomy is a common, traditional surgical procedure and is now the most specific tool for diagnosis and treatment. Alternatively, laparoscopy can be performed. However, if the pathology is considered to be düşünül complicated me during laparoscopy, it is more likely that it will turn into a laparotomy. In addition, laparoscopy in third trimester pregnancies is not suitable for use due to the large uterus of the patient. Laparotomy in term pregnancies enables the intervention of pathologies such as caesarean, tuba and ovary in the same session. In this case, we performed a laparotomy because we could not use radiological diagnostic methods. We removed the baby by cesarean section. We performed salpingectomy for tubal cyst. As a result, we have seen that this strategy works well for both the patient and the child.

While there were very few cases of tubal cyst torsion during pregnancy, including the 3rd trimester, we think that our case was one of the first 10 cases identified in the labor force. We also think that the first case of torsion and rupture developed at the same time in the literature.

In conclusion, in this case report, the causes of other abdominal pain in the differential diagnosis should be considered without delay in the differential diagnosis of tachycardia due to pain and in the cases of birth, in which no regular contractions are observed in the abdomen during the follow-up period. In these cases, we believe that

giving a caesarean decision on normal delivery without stubborn protects the mother and the baby from complications.

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