A VERY RARE CASE OF SUBACUTE ISOLATED TUBAL TORSION IN A POSTMENOPAUSAL WOMAN

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SUMMARY

Isolated tubal torsion is a very rare entity with a reported incidence of 1:1.500.000. In postmenopausal period it is even more rare. In this case report we present a postmenopausal patient with subacute pelvic pain and adnexal mass whose definitive diagnosis at laparotomy was isolated tubal torsion. Until now, to our knowledge, only 3 cases of postmenopausal isolated tubal torsion has been described in the literature. One-month duration of symptoms indicating the subacute nature of torsion was also unique in this case. Intraoperatively, the right tube was twisted 7-8 times just beside a paratubal cyst which is in the form of a 10x8x8 cm hemorrhagic necrotic cystic mass. Total abdominal hysterectomy, bilateral salpingoophorectomy and appendectomy procedure was undertaken.

Key words: *isolated tubal torsion, menopause, subacute*

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POSTMENOPOZAL BİR KADINDA ÇOK NADİR BİR SUBAKUT İZOLE TÜP TORSİYONU OLGUSU

ÖZET

İzole tüp torsiyonu literatürde bildirilmiş 1: 1.500.000 insidansı ile çok nadir görülen bir durumdur. Postmenopozal dönemde daha da nadir görülmektedir. Bu olgu sunumunda subakut pelvik ağrı ve adneksiyal kitle bulguları olan ve laparotomide izole tüp torsiyonu tanısı konan postmenopozal bir hastayı sunmaktayız. Bilgilerimiz ışığında literatürde bugüne kadar bildirilmiş 3 adet postmenopozal izole tüp torsiyonu olgusu bulunmaktadır. Olgumuzda semptomların bir aydır devam etmesi torsiyonun subakut bir süreçte geliştiğini göstermesi bakımından önemlidir. İntraoperatif olarak, sağ tüpün, 10x8x8 cm'lik hemorajik, nekrotik, kistik kitle şeklindeki bir paratubal kist ile temas noktasından 7-8 kez torsiyone olduğu görüldü. Total abdominal histerektomi, bilateral salpingooforektomi ve appendektomi işlemi uygulandı.

Anahtar kelimeler: *izole tüp torsiyonu, menopoz, subakut*

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INTRODUCTION

Isolated tubal torsion (ITT) is the torsion of the fallopian tube without involvement of the ovary. It is rarely seen with an estimated incidence of 1:1.500.000[1]. Most reported cases are found in reproductive age women. Postmenopausal occurence of the condition is extremely rare[2].

In this case report we present a postmenopausal patient with subacute pelvic pain and adnexal mass whose definitive diagnosis was ITT. To the best of our knowledge this is the fourth reported case of ITT found in postmenopausal period in the literature. Our case was also unique due to the one-month duration of symptoms indicating the subacute nature of torsion.

CASE REPORT

A 74 year-old female patient was referred to our clinic with the findings of right adnexal mass and right lower quadrant pain lasting for one month. She had 4 living children and an unremarkable past medical history. The pain had begun suddenly one month ago, decreased in severity with time and worsened for the last 3 days. History of epigastric pain, changes in bowel habits, vaginal discharge or bleeding, nausea or vomitting were not found. Her vital signs were normal. Right lower quadrant tenderness was detected in abdominal palpation, pelvic examination revealed right adnexal mass and minimal right adnexal tenderness. A 107x74x85 mm anechoic, multiseptated cyst in the right adnexal region and minimal free fluid in Douglas pouch was found in transvaginal sonograhy. Doppler flow examinations in the adnexal areas were normal. Tumor markers, serum biochemistry and complete blood count were in normal limits.

The preoperative diagnosis was torsion of right adnexal mass. An infraumbilical midline laparotomy was carried out because the malignancy couldn't be ruled out due to advanced age of the patient. During exploration; uterus, left tube and bilateral ovaries appeared atrophic, but the right tube was seen as 7-8 times twisted from the contact point with the adjacent 10x8x8 cm paratubal cyst which is in the form of a hemorrhagic, necrotic, cystic mass (Figure 1a). The right ovary appeared atrophic and normal (Figure 1b). Appendix seemed congested and erectile. So total abdominal hysterectomy, bilateral salpingooforectomy and appendectomy was performed. Frozen section examination of the twisted right tube and paratubal cyst complex was reported as twisted, hemorrhagic and necrotic tubal wall and benign cystic mass (Figure 1c). In the postoperative period no complications were encountered and the patient was discharged home four days after the operation. Final pathology report revealed endometrial polyp in uterus, congested appendix sections, benign fibrous cyst wall with intensive hemorrhagic necrosis and congestion in which covering epithelium can not be seen (Figure 1c) and disseminated hemorrhagic necrosis in twisted tube segments, granulation tissue which developed in tubal wall of which epithelium could not be distinguished.

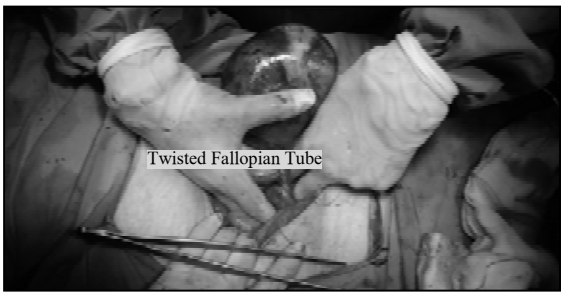

Figure 1a: *Intraoperative appearance of twisted right fallopian tube adjacent to the hemorrhagic and necrotic paratubal cyst.*

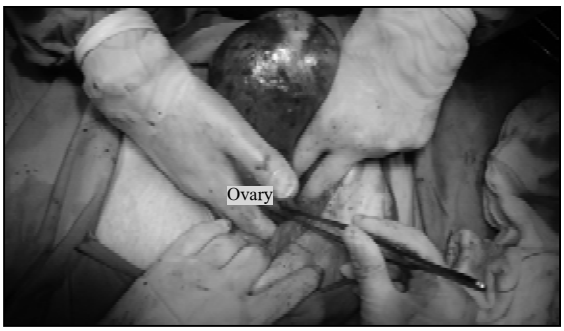

Figure 1b: *Normal appearing, postmenopausal atrophic ovary at the same side with the twisted fallopian tube.*

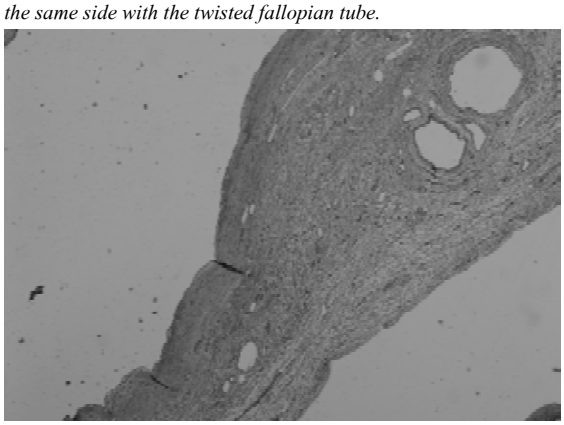

Figure 1c: *Benign fibrous cyst wall with intensive hemorrhagic necrosis and congestion, covering epithelium.*

DISCUSSION

Isolated tubal torsion is a very rare clinical entity. In postmenopausal period it is even more rare. Only 3 cases of postmenopausal ITT has been described in the literature[2-4]. ITT with chronic symptomatology is also scarce. To the best of our knowledge, until now only three cases of chronic isolated tubal torsion has been reported[5-7]. This is an extremely rare case of postmenopausal ITT with subacute clinical findings.

Most of the time to find the exact etiology underlying ITT is impossible. But anatomical abnormalities like hydrosalpinx, paratubal cysts or long mesosalpinx, history of previous tubal surgery, rapid uterine enlargement due to pregnancy or tumor, peritubal adhesions, ovarian or paraovarian masses, hemodynamic abnormalities like venous congestion in mesosalpinx, sudden changes in body positions and trauma are some of the proposed etiological factors in the literature. These predisposing factors are the pathologies mostly seen in reproductive age group. Therefore ITT is more commonly encountered in reproductive period[8]. In our case, the paratubal cyst in contact with the twisted fallopian tube shows that; the torsion process started in the setting of a paratubal cyst and progressed chronically with continuing torsion episodes. Additionally, one-month duration of symptoms before surgery indicating the subacute nature of torsion was an interesting finding. It is known that undiagnosed torsion may undergo alternative states of mild torsion-detorsion that finally bring the condition to chronicity[5]. Chronic ITT cases in the literature typically submitted emergency units several times with the chief complaint of intermittent pain resolving spontanously and they received various treatments according to their misdiagnoses[5-7]. This patient had also submitted emergency departments several times with the complaint of pain before referral to our unit. Tubal torsion is usually seen in right tube as in this case. Possible reasons for this are reported as; the presence of sigmoid colon on the left side prevent the tube from twisting around the mesosalpinx due to mass effect, relatively insufficient venous flow at the right side, performing laparatomy more often with right sided pelvic pain due to right sided localization of appendix[6].

Preoperative diagnosis of isolated tubal torsion is extremely rare. The main reasons for this are nonspecific clinical signs and symptoms and insufficient findings in imaging studies. Moreover, rarity of the condition causes clinician not to bring in mind the possibility of ITT contributing to difficulty of diagnosis[9]. So it is often diagnosed intraoperatively as in our case. Clinical history, pelvic examination findings, laboratory and sonographic findings and the awareness of the possibility of this condition all together should be taken into consideration for an early diagnosis.

During the differantial diagnosis of an acute pelvic pain, the sonographic and doppler findings of a dilated fallopian tube with a normal appearing ipsilateral ovary and a history of previously mentioned predisposing factors especially the presence of previous tubal surgery or prior evidence of adnexal pathology (hydrosalpinx, paratubal cyst, ovarian cyst or other adnexal mass) should remind the clinician the possibility of ITT. However, the absence of these predisposing factors should not obviate the surgeon from proceeding with surgery for the diagnosis and treatment, because most of the time patients beyond the reproductive period would not have any of these risk factors[8]. Chronicity of torsion process in our case lead to the formation of 7-8 times twisted necrotic and atrophic tube segments adjacent to a paratubal cyst instead of findings of dilatation and hematosalpinx in twisted tube segments. Despite its very low incidence, in postmenopausal patients applying with acute pelvic pain and adnexal mass, ITT should be considered among the differential diagnoses.

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