Case Report

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Laparoscopic Management of Acute Abdomen Due To an Isolated Torsion Right Fallopian Tube Caused By Morgagni Hydatid Cyst in a Virgin Girl with 17 Years Old

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ABSTRACT

Twisted isolated right fallopian tube caused by right paratubal cyst of morgagni is rare, however, it should be kept in the mind of the Gyneacologist when faced any case presenting with acute lower abdominal pain. This case is 17 years old virgin girl who was presented to our gynaecological outpatient department of Lamis Clinic with severe right iliac fosse pain and vomiting. She was diagnosed as twisted paratubal cyst whose torsion was led to spontaneous torsion of right fallopian tube. She was managed by laparoscopic surgery. The para-tubal cyst by ultrasound was measured 8x6 CM with no clear Echo and clear normal bilateral ovaries. A laparoscopy surgery was done which showed a large gangrenous para-tubal cyst with secondary complication of right twisted fallopian tube. The cyst was aspirated and excised completely and the right tube reverses it twisting to the normal. The cyst was benign in nature.

Keywords

Para-tubal cyst, Torsion, Fallopian Tube, Acute Abdomen, Split Sign, Laparoscopy.

Introduction

Isolated Torsion of the Fallopian tube is rare and can cause severe abdominal pain. The acute pain is in the lower abdomen and can be localized in the right or left side, as in this case it was in the right side (Iliac Fosse). The torsion involve the right fallopian tube more than the right one (3:1 in ratio). It can be higher incidence in post menarche girls as in this case.

In our case the significant symptoms is the intolerable pain. The diagnostic procedures are ultrasound and magnetic resonance (MRI) [1,2]. Laparoscopic exploration is the answer [3-5].

Case Report

A 17 years old virgin girl came to our gynaecology clinic (Lamis Clinic) with severe right Iliac Fosse pain which was increasing in intensity, sharp and not tolerable on body movement. She was coming from a city nearby 80km away. She is on her third day of the menstrual cycle. The pain start 14 hour back and progressive in nature became intolerable. It was associated with vomiting 7 times. Medical surgical and drug history nothing to record.

The vital signs are normal. On examination there was only local tenderness on the right Iliac Fosse. Abdominal ultrasound shows adenixal cyst measures about 8x5 cm with no clear content. Rectal ultrasound shows the same size of cyst which looks hazy and the splitting sign is positive between the cyst and the ovary.

Prompt diagnosis of torsion pelvic non ovarian cyst was done and the decision for immediate laparoscopy was taken. Blood investigation including CBC, BG, Blood sugar, Blood Urea and Viral screen were taken and all within normal range. Laparoscopic findings were big right paratubal cyst 8x5cm in size and dark in colour and the right fallopian tube get torsion at the corneal end (twisted three time) as indicated in the picture attached below.

The cyst punctured and aspirated. The aspirated fluid was serous and about 300cc in volume. The cyst was excised and removed through the trochar of 10mm in diameter and the right fallopian tube untwisted safely and within 3 minutes got back to normal colour. Intra-peritoneal wash with ranger lactate was done and all the fluid was aspirated. She has good recover and sent home next morning.

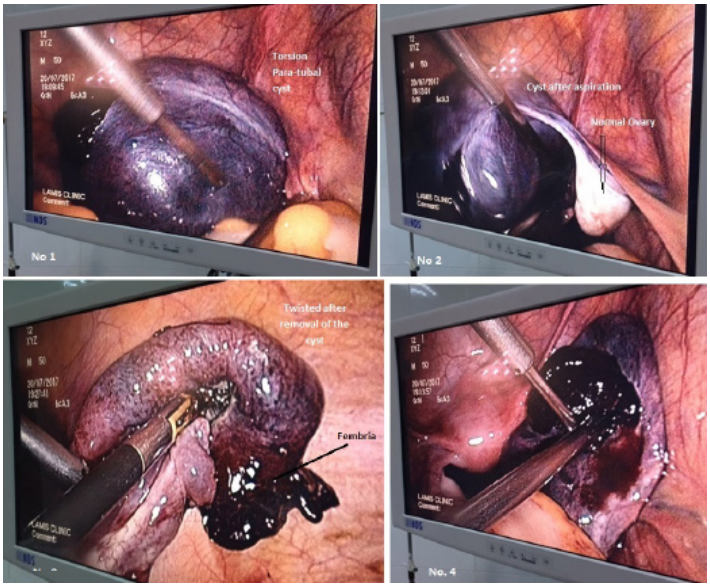
Discussion

Paratubal cysts including hydatid cysts of Morgagni are Mesonephric origin. Fimbrial cysts are usually small, multiple pedunculated and attached to fembria. This can lead to unexplained infertility [6]. These cysts remain a symptomatic and sometimes identified incidentally on ultrasound and MRI for other reasons. These cysts become infected, haemorrhagic rupture or malignant and torsion.

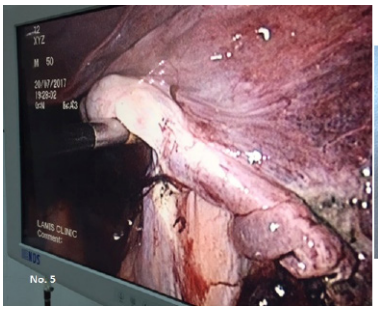
From Literature paratubal cysts can cause secondary torsion to fallopian tube and ovary [7-9]. In this case, the secondary torsion was to the right fallopian tube but the ovary was normal. Any case present with adnexal mass and acute pain, the diagnosis of torsion paratubal cyst should be kept in mind [10].

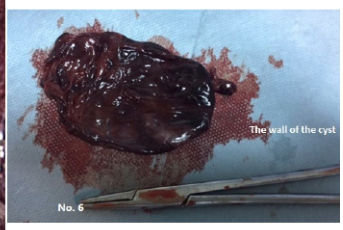
In this case, the diagnosis was taken on severe lower abdominal pain and right side adnexal cyst and the finding were torsion of the cyst and the tube. This early diagnosis and management in time help safe the fallopian tube and preserve patient fertility.

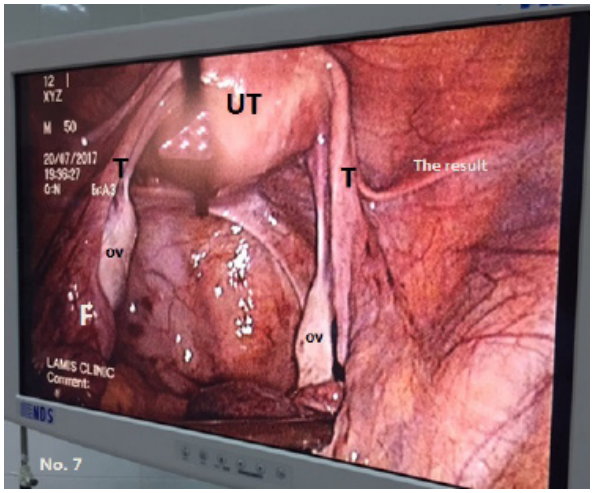
The initial evaluation of an adnexal mass by clinical symptoms and ultra-sonography of abdomen, vaginal or rectal. As in this case, rectal ultrasound was the best option as the patient was virgin with the split sign was taking in consideration.



For discrimination of para-ovarian masses or cyst from ovarian mass or cyst, it was very clear in this case and the diagnosis was paratubal cyst with suspicion of torsion. In general, this sign carries a low sensitivity 14 – 47% as this could be due to the experience of the examiner and the quality of the ultrasound used [11,12]. A high degree of awareness of possible complication from adenixal cyst or mass by gynaecologist is needed to avoid compromising functional integrity of tubes and ovary.







Conclusions

The difficulty of diagnose acute abdominal pain in presence of adenixal mass or cyst can be answered by laparoscopic management by knowing the cause of the pain, also, will save the patients from secondary complications if the adnexal mass such as torsion and losing functional integrity of fallopian tube or ovary.

References

1. Orazi C, Inserra A, Lucchetti MC, et al. Isolated tubal torsion: a rare cause of pelvic pain at menarche. Sonographic and MRI findings. Pediatr Radiol. 2006; 36: 1316-1318.
2. Ghossain MA, Hachem K, Buy J-N, et al. Adnexal Torsion: Magnetic resonance findings in the viable adnexa with emphasis on stromal ovarian appareance. J Magn Reson Imaging. 2004; 20: 451-462.
3. Lineberry TD, Rodriguez H. Isolated torsion of the fallopian tube in an adolescent: a case report. J Pediatr adolesc Gynecol. 2000; 13: 135-138.
4. Rizk DE, Lakshminarasimha B, Joshi S. Torsion of the fallopian tube in an adolescent female: a case report. J Pediatr Adolesc Gynecol. 2002; 15: 159-161.
5. Goktolga U, Ceyhan T, Ozturk H, et al. Isolated torsion of fallopian tube in a premenarcheal 12-years-old girl. J. Obstet. Gynaecol. 2007; 33: 215-217.

6. Riddle N. Fallopian tubes. Pathology Outlines.com. 2013.
7. Dotters-katz SK, James AH, Jaffe TA. Paratubal/Paraovarian Masses: A study of surgical and Non-surgical Outcomes. Med J Obstet Gynecol. 2014; 2: 1019.
8. Chauhan S, Blacker C. Paratubal cyst: a case report. W V Med J. 2005; 101: 176.
9. Dani A, Gandi SR. Torsion of parapvarian cyst resulting in secondary torsion of ovary. J Evol Med Dent Sci. 2015; 4: 4901-4903.
10. Kiseli M, Caglar GS, Cengiz SD, et al. Clinical diagnosis and complications of paratubal cysts: review of the literature and report of uncommon presentations. Arch Gynecol Obstet. 2012; 285: 2304-2308.
11. Muolokwu E, Sanchez J, Bercaw JL, et al. The incidence and surgical management of paratubal cysts in a pediatric and adolescent population. J Ped Surg. 2011; 46: 2161-2163.
12. Savelli L, Ghi T, De Iaco P, et al. Paraovarian/Paratubal cysts: comparison of transvaginal sonographic and pathological findings to establish diagnostic criteria. Ultrasound Obstet Gynecol. 2006; 28: 330-334.