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CASE REPORT

RIGHT UTERINE TUBE TORSION: CASE REPORT

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ABSTRACT

Although adnexal torsion is a condition with low incidence, this emergency is considered of great gynecological importance, either due to the difficulty of early diagnosis, or to the potentially serious complications. Thus, the present report aims to present a case of cyst with uterine tube torsion.

KEYWORDS: UTERINE TUBE, FALLOPIAN TUBES, TORSION, DIAGNOSIS, ULTRASONOGRAPHY, COMPUTERIZED TOMOGRAPHY, MAGNETIC RESONANCE, LAPAROSCOPY.

INTRODUCTION

Adnexal torsion is a gynecological emergency caused by torsion of the ovary and/or uterine tube, and may be partial or total[1]. Although isolated torsion of the uterine tube has a low incidence - it is estimated to occur in 1 in 1.5 million of women, making it a very unusual condition[2]. If not relieved, persistent vascular occlusion can lead to infarction and necrosis of the adnexal structures, causing even more serious complications such as peritonitis and infertility.

Thus, the early recognition of this condition is extremely important, even though its diagnosis is often hampered by the absence of specific clinical signs, manifestations or biomarkers[1].

CASE REPORT

GALC, female, 25 years old, with no history of previous pregnancies. The patient underwent laparoscopy, under general sedation, after burning pain in the left hypochondrium that radiated later to severe pain in the right flank and right iliac fossa one week before the procedure. Magnetic resonance imaging shows a cystic mass in the region of the right iliac fossa (figure 1). During surgery, an 8 cm tumor was noted in the right uterine tube with terminal torsion. At the time, the biopsy of the finding and its resection with tube distortion were also performed (figure 2).

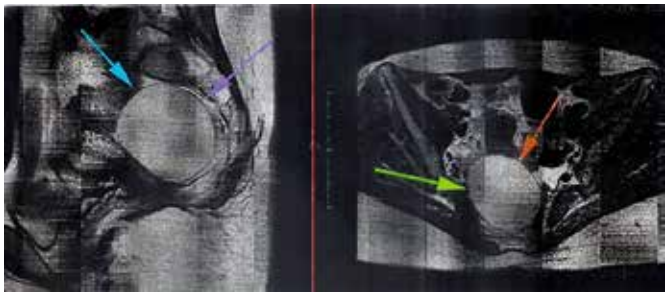

Figure. 1- Magnetic resonance imaging shows an image with hyposignal suggestive of a cyst in the right iliac region.

Figure 2. Images from videolaparoscopy surgery.

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The result of the anatomopathological analysis of the material showed a brownish elastic irregular hemorrhagic paratubal cyst, measuring 8.0 x 3.0 x 1.5 cm in its largest dimensions. Microscopically, there was also a cystic structure of delicate fibrous walls, covered by flattened cells, without atypia, accompanied by areas of necrosis and absence of signs of malignancy. Thus, a histopathological picture compatible with a serous cyst with foci of infarction was concluded.

Finally, the onco-parasitic cytology did not show atypical cells in the 15ml sample of hemorrhagic fluid from the right paratubal cyst, containing only an amorphous background, hair cells and leukocytes in the smears analyzed.

DISCUSSION

Uterine tube torsion is a rare condition whose possible risk factors include abnormalities of the uterine tubes, such as neoplasia, ectopic pregnancy, hydrosalpinx, tubal ligation device, congenital anomaly and paratubal cyst. In addition to the previous intrinsic factors, abnormalities in organs close to the attachments, such as endometriosis, adhesions, infections and ovarian mass can also influence[2].

As described in a series of cases, torsion of the right uterine tube is more commonly diagnosed compared to the left, and the possible explanations may be related to the fixation of the left tube in the left hemipelvis by the sigmoid colon and mesentery or to the more frequent right pelvis image evaluations due to the diagnostic hypothesis of appendicitis[3].

The clinical presentation of a torsion of the uterine tube can be somewhat nonspecific, being, therefore, a challenge for the physician to recognize and differentiate it from other etiologies. It is worth remembering that acute pain in the lower abdomen is an ever-present sign, which may be accompanied by nausea, vomiting and, more rarely, fever. Laboratory findings are generally nonspecific[4].

Ultrasonography (US) is the primary imaging technique most often used in women with acute pelvic pain and suspected adnexal torsion, due not only to its low cost-effectiveness, but also to the absence of radiation exposure and its non-invasive character. However, low rates of detection of the test still make it difficult to distinguish torsion from other diseases, such as hemorrhagic cysts, endometriosis, ovarian tumors or pelvic inflammatory disease[1,3].

Therefore, computed tomography (CT) may be useful if the adnexal torsion is doubtful at US or the lesion is not well represented on ultrasonography, in addition to being an important exam for the exclusion of appendicitis. Typical CT image findings in cases of torsion of the uterine tube include an enlarged fluid-filled structure and thick wall enhancement[1-3].

Magnetic resonance imaging (MRI), in turn, is used, in some cases, for the preoperative diagnosis of acute conditions in young or pregnant patients, as in the case of the reported patient. This is due to the excellent contrast of soft tissues and the absence of radiation exposure[3].

Finally, laparoscopy is considered the gold standard for establishing diagnosis and therapy for patients, since it is minimally invasive, with rapid recovery and low morbidity rate. Thus, in addition to confirming the diagnostic hypothesis through visualization of the twisted segment, the procedure assesses the involvement of the affected tube, the possibility of surgical treatment with resection of the mass found and simple reverse rotation of the twisted pedicle, preserving, whenever possible, the uterine tube[3].

FINAL CONSIDERATIONS

Tubal torsion has nonspecific clinical signs, making the diagnosis even more challenging. Ultrasonography and computed tomography can demonstrate alterations that strongly suggest tubal torsion. However, a definitive diagnosis with appropriate treatment, require exploration surgery, with laparoscopy as the best option. Thus, the importance of clinical suspicion and early intervention is emphasized as a means of preserving the integrity of the uterine tube, and, consequently, female fertility.

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