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Case Report

Post hysterectomy fallopian tube prolapse: a rare case

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ABSTRACT

Fallopian tube prolapse into the vaginal vault is a very complication of hysterectomy where the adnexa is preserved. The overall occurrence after all routes of hysterectomy is 0.01-0.05%. Several factors have been suggested to contribute to the condition such as vault hematoma, improper closure of vault, early resumption of sexual activity. Due to the misdiagnosis, there is often delay in the diagnosis and its management. The only means of definitive diagnosis is histopathology. A 30-year-old P₂L₂ presented to us after 3 years of post-hysterectomy with abdominal pain and bleeding pv on and off. On examination prolapsed fallopian tube was found in the vaginal vault on speculum. Biopsy was done in the outside hospital and was confirmed to be the tube. Patient underwent combined laparoscopic and vaginal method. Vaginal excision of the tube was done. Prevention by prophylactic salpingectomy and by suturing the adnexa high up in the pelvis in abdominal hysterectomy.

Keywords: Fallopian tube prolapse, Post-hysterectomy, Vaginal vault

INTRODUCTION

Fallopian tube prolapsed was first reported by Pozzi in 1902, he had described after 2 cases of Vaginal hysterectomy.¹ The condition is more commonly observed following vaginal hysterectomy compared to abdominal hysterectomy.

The first two cases to occur after abdominal hysterectomy was described by Funnel et al, in 1955.² The condition is a very rare complication with this being reported to be about 100 cases in literature. This can present anytime from as early in the postoperative period to as late as 32 years.

It is often misdiagnosed as granulation tissue leading to delayed treatment. Fallopian tube prolapse should be considered in all cases of pelvic or abdominal pain accompanied by vaginal bleeding or discharge after hysterectomy, with or without granulation tissue in the vaginal vault. This can present after abdominal,

laparoscopic and even vaginal hysterectomy.³ Cause being multifactorial including postoperative fever, poor condition of patient, vault hematoma and non-closure, early resumption of sex, insufficient vaginal preparation preoperatively, difficult surgical procedure, profuse postoperative vaginal discharge, use of intraoperative vaginal drains and packs, tissue fragility, chronic cough, diabetes mellitus, constipation, steroids, malignancy are a few to mention. The easy passage of probe into the tubal lumen aids in the diagnosis. Early recognition with proper diagnosis comes to be the treatment of the same. The literature has reported the recurrence of symptoms and requirement of second and even third surgery to relieve patients' symptoms.⁴ The fallopian tube unlike other abdominal viscera is sensitive to touch, cutting and crushing.⁵ Dense adhesions may involve the structures like ovary, bladder and bowel causing most authors to have performed partial salpingectomies, though total salpingectomy is preferred, due to the constant traction on the remaining part of the tube and hence agonising symptoms.⁶

CASE REPORT

A 30-year-old P₂L₂ presented to our hospital with abdominal pain and bleeding per vagina on and off for 3 months. She had undergone abdominal hysterectomy for fibroid uterus 3 years back in another hospital. On examination, per speculum a polypoidal foul smelling friable mass was seen through vaginal vault, measuring 3x3cm (Figure 1).



Figure 1: Reddish polypoidal mass seen through vault.

Before presenting to us, patient had gone to another hospital where the vault mass was biopsied and confirmed as fallopian tube, but as patient had severe pain abdomen also to rule out intestinal obstruction presented here. Was treated with intravenous antibiotics. Investigations were done showing normal abdominopelvic scan. Patient developed severe pain abdomen, vomiting, surgical opinion was taken. Pancreatitis was ruled out with serum amylase, lipase. Also underwent erect X-ray abdomen, CT-scan of abdomen showed nonspecific mesenteric lymphadenitis. Was given proctoclysis enema, following which pain decreased. Patient underwent diagnostic laparoscopy to rule out subacute intestinal obstruction, also to visualize the adnexa. There was a normal right fallopian tube and ovary, with a small stump of left fallopian tube measuring 1.5x 1.5cm. Vault was intact. Vaginally the prolapsed fallopian tube of 3x 3cm was clamped and excised.

DISCUSSION

The fallopian tube prolapse being a very rare complication post hysterectomy is being under reported to about 100 cases. In literature about 2/3rd of cases have occurred after abdominal hysterectomy and more in premenopausal women. The prerequisite for the condition to occur is the communication between peritoneal cavity and vagina, the sufficient length and mobility of the fallopian tube, defective operative technique, difficulty in closing the vaginal vault. In addition, the left fallopian tube may move close to a small opening in the vaginal cuff, and the pressure gradient between the abdominal cavity and vagina may facilitate the tubal prolapse. It is

mostly believed that laparoscopic approach is associated with the vaginal cuff dehiscence.⁷

Patient usually present with profuse vaginal discharge either watery, purulent, foul smelling, or bloody discharge associated with pain abdomen, contact bleed, dyspareunia. The main factor causing it is the age 7, where in the younger age women with the early resumption of sexual activity is identified to cause dehiscence of the vault and hence the case. Often it is misdiagnosed with the most common being, granulation tissue and others are vaginal adenosis, endometriosis, primary metastatic adenocarcinoma. A diagnosis of formation of vaginal vault granulation should be reconsidered if the tissue observed is resistant to cauterization.

Histopathological examination helps in the definitive diagnosis.⁸ Intact fimbrial structures normally covered with columnar epithelium can be recognized grossly or microscopically, even if there is remodeling of tubal structure with pseudo glandular or polyp like formation. When the fallopian tube epithelium is not visualized it is the immunohistochemistry that helps. IHC for pancreatin is used.⁹ Cystoscopy could be the other investigation to rule out the vesicovaginal fistula. There is no ideal surgical method that is described. An excisional biopsy constitutes the definitive diagnostic procedure and adequate treatment. Total salpingectomy with closure of vault defect is considered the optimal management.

There are chances of recurrence following the treatment for fallopian tube prolapse due to the choice of surgical repair technique (surgeon's experience, possibility of performing salpingectomy), hence treatment is decided on case to case basis. Awareness of the complication will initiate more prompt referral and prevent inadequate treatment, which avoids prolonging patients distress.¹⁰

CONCLUSION

Prophylactic surgeries are preferred during conservative hysterectomies as it is associated to prevent such complication, also for tubal and ovarian serous carcinoma. But it is also required to ensure absence of effects on ovarian function.

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