Twisted Paratubal Cyst in a Young Girl

Aruna Tantia, *Sikhar* Sircar
Institute of Laparoscopic Surgery, DD-6, Salt lake city, Kolkata – 700 064.

Key words : paratubal cyst, twisted paratubal cyst, teenager

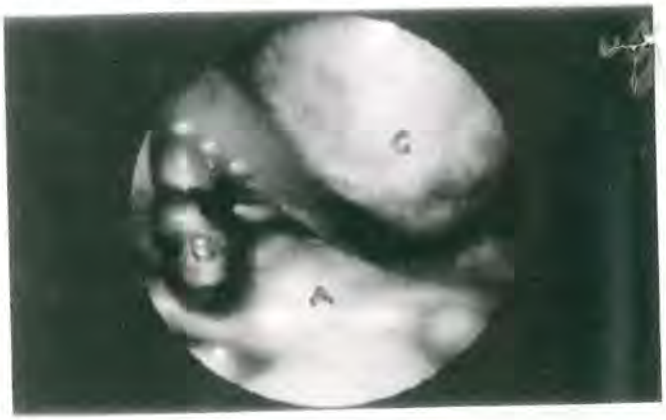
Introduction

Paratubal cyst is not so uncommon in gynecological operations. They are almost always an operative finding. The rarity of the present case lies in that this was an instance when the paratubal cyst was big enough to cause twist and presented as an acute abdomen. Our patient, a 17-year old girl, is the fifth such case being reported.

Miss BB, a 17 year old girl was admitted with features of acute abdomen. She was having severe pain with vomiting for the last two days which was not relieved with medication. During admission she had a tense tender abdomen with marked tenderness in left iliac fossa and a slightly raised temperature. She had tachycardia but other vital parameters were normal. Her periods were irregular but she had history of recurrent pain in abdomen that used to subside on its own for the last two months. An ultrasonography done two months back showed a non-septate left ovarian tumor of 6.2 x 4.8 cm size with partial torsion. Rectal examination was not very helpful and suggested a left sided andexal cyst.

With a provisional diagnosis of left sided twisted ovarian cyst, laparoscopy was done. One entering the abdomen, the pouch of Douglas was seen to be filled with blood. A blue-black cyst was seen in the left adnexa which had twisted on its axis eight times. On close inspection, it was noted that the fallopian tube of the left side was long, tortuous, congested and blackish blue in color and was twisted along with the cyst. (Photograph 1) The ovary was normal in size and position. The cyst was seen to be arising just below the fimbrial end of the left tube. Untwisting was done gently and proper anatomy restored. Per operative diagnosis of twisted paratubal cyst was made. The uterus and right adnexa appeared normal. As the tube was found to be nonviable, decision was taken for cystectomy and partial salpingectomy. Ligation of pedicle was done by endosuturing followed by excision of cyst and tube. The cyst, along with the tube were put in an endobag and extracted out from the umbilical port. Peritoneal toileting was done and ringers solution was left in.

The histopathological report showed that the cyst was lined by low cubiodal to flattened epithelium; cyst wall showed hemorrhagic necrosis. The fallopian tube was adherent to the wall of the cyst. The features were consistent with paratubal cyst of mesonephric duct origin.



Photograph 1 : Laparoscopic view. A: Uterus. B: Twisted pedicle. C: Paratubal cyst

Discussion

Paratubal cysts are common per operative findings, they may vary in size but rarely become big enough to undergo torsion. They are benign lesions but infractions and or twisting might cause pelvic pain. Developmentally, they can be from two sources. Those of mesonephric origin are lined by cuboidal cells and are generally situated near ovarian hilum. They can also arise from paramesonephric cells and columnar tubal cells lying near the fimbrial end. The case is reported because of the extreme rarity of a paratubal cyst large enough to get twisted. Internet and literature search revealed four reports[1,2,3] of twisted paratubal cyst mostly of right side, and to the best of our knowledge ours is the second case of the left side. Acute abdomen due to adnexal torsion should be kept in mind and immediate laparoscopy with detorsion should be performed to save the adnexa if possible.

References

1. Hasuo Y, Higashijima T, Mitamura T. Torsion paraovarian cyst-Report of two cases. *Kurume Med 1991; 38:39-43.*
2. Lurie S, Golan A. Glezerman M. Adnexal Torsion with a Paraovarian Cyst in a Teenage Girl. *J Am Assoc Gynecol Laparosc 2001; 8: 597-9.*
3. Ben Arie A, Lurie S, Graf F et al. Adnexal torsion in adolescents : Prompt diagnosis and treatment may save the adnexa. *Eur J Obstet Gynecol Reprod Biol 199 63:169-73.*

Paper received on 20/06/02 ; accepted on 9/06/03

Correspondence :
Dr. Aruna Tantia
Institute of Laparoscopic Surgery,
DD-6, Salt Lake City, Kolkatta - 700 064.
Fax. 91-33-358-8533