Beyond Obstetric Causes of Severe Abdominal Pain at Term: Isolated Fallopian Tube Torsion in the Third Trimester

A Case Report

Honor Mijatovic · Deanne Vagg · Christopher Arthur

GENERAL OBSTETRICS

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1 Background

- Isolated fallopian tube torsion (IFTT) is a rare gynaecological emergency: ~1 in 1.5 million women, under 1% of adnexal torsion cases.
- Occurrence in pregnancy is even rarer; most reported cases occur in the 1st or 2nd trimester — third-trimester presentation is exceptionally uncommon.
- Diagnosis is challenging: nonspecific symptoms and limited imaging reliability in pregnancy.
- Late-pregnancy differentials include placental abruption, uterine rupture, appendicitis, ovarian torsion, and labour-related pain.

Keywords: tubal torsion · pregnancy · caesarean section · placental abruption · haemoperitoneum · adnexal torsion

2 Case Presentation

- 40-year-old, G2P0, 38+2 weeks; pregnancy complicated by advanced maternal age, diet-controlled gestational diabetes, and alpha-thalassaemia trait.
- Presented with severe abdominal pain and uterine tightenings; closed cervix; generalised uterine tenderness between tightenings.
- CTG showed reduced variability with a prolonged deceleration → emergency caesarean section for suspected placental abruption.
- Haemoperitoneum noted before hysterotomy; live infant delivered by breech extraction; clear liquor, no abruption or retroplacental clot.
- Dilated left fallopian tube with large distal clot found; right tube and ovary normal.
- Left salpingectomy performed (LigaSure) for ongoing bleeding and suspected torsion; EBL 300 mL.
- Histopathology: parafimbrial cyst with torsion of the fimbrial end. Uncomplicated recovery; no contraindication to future VBAC.

3 Clinical Findings

Figure 1. *Intraoperative image demonstrating the dilated left fallopian tube with distal clot, identified as the source of haemoperitoneum at caesarean section.*

4 Discussion

- Pathogenesis is multifactorial: intrinsic tubal abnormalities (hydrosalpinx, parafimbrial cysts, elongation, prior surgery) and extrinsic factors from pregnancy (uterine enlargement, adhesions, altered adnexal mobility).
- Clinical picture is nonspecific; imaging and Doppler are unreliable in late pregnancy — preserved flow does not exclude torsion.
- Abnormal CTG can reflect abruption or catecholamine-mediated uterine hypertonicity from other intra-abdominal pathology.
- Absent retroplacental clot and clear liquor excluded abruption; bleeding was traced to the torsed tube.
- Management is guided by tubal viability — detorsion with preservation where fertility is desired, versus salpingectomy when necrosis or active bleeding is present, as in this case.

Why this case matters

- IFTT diagnosed at emergency caesarean is rare, most cases occur pre-term and are managed laparoscopically.
- Haemoperitoneum without retroplacental clot or blood-stained liquor should prompt adnexal inspection.
- Reinforces value of systematic adnexal inspection at caesarean when findings don't correlate with the suspected diagnosis.

LEARNING POINTS

- **IFTT is rare in pregnancy and may mimic obstetric emergencies such as placental abruption.**
- **Maintain a broad differential for abdominal pain with abnormal cardiotocography.**
- **Intraoperative haemoperitoneum warrants careful evaluation of the adnexal structures.**
- **Early recognition and surgical management prevent ongoing haemorrhage and maternal morbidity.**

Gold Coast University Hospital, Queensland, Australia · Presenting author: Dr Honor Mijatovic