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Intestinal Obstruction Caused By Leftover Fallopian Tube after Abdominal Hysterectomy

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Abstract: *Abdominal hysterectomy is the most commonly performed procedure for various reasons. Small bowel obstruction after abdominal hysterectomy due to leftover fallopian tube is a rare possibility with almost no previous case reports. In this study we report a case of post operative intestinal obstruction caused due to constriction formed by leftover fallopian tube in a patient who has undergone abdominal hysterectomy.*
Keywords: *Abdominal hysterectomy, intestinal obstruction, leftover fallopian tube.*

I. Introduction

Abdominal hysterectomy is one of the common procedures done in India most commonly for dysfunctional uterine bleeding. The rate of major complications after the hysterectomy has been reported to be about 4%.The common complications being accidental injury to bladder, rectum or bleeding. In the early post operative period besides the general complications of the peri operative period patient can have abdominal distension. This is mainly due to paralytic ileus, electrolyte imbalance or due to undetected intra operative injury to the bowel .The physiological ileus usually subsides in 48-72 hrs. The delayed onset obstruction or persistent distension can be due to localised peritonitis, vault infection causing ileus. The anatomical intestinal obstruction if seen can be due to adhesions or obstructive intestinal hernia at a later stage.

Hysterectomy can be done as open, total laparoscopic or lap assisted procedure. Irrespective of the method, in younger patients salpingo-opherectomy was not done to prevent complications of early onset hormone deficiency. The latest reviews suggest it is better to do salpingectomy rather than only simple hysterectomy in patients being operated for benign conditions to avoid complications caused by the fallopian tube .[1]

In this study we report a case of post operative intestinal obstruction caused due to constriction formed by leftover fallopian tube in a patient who has undergone abdominal hysterectomy .

II. Case Report

A 37 Yr old female who was admitted in our hospital underwent open abdominal hysterectomy for dysfunctional uterine bleeding. The pelvis was normal with no anomalies and adhesions. Intra operative procedure and early post op period was uneventful. Her abdomen was soft and she was passing flatus. She was allowed liquids orally and soft diet on the 2nd post op day as per the protocol.

However on the 4thpost operative day patient started complaining of abdominal discomfort and distension .Clinically her abdomen was distended but with no tenderness, guarding or rigidity, bowel sounds were present but sluggish . She was investigated to rule out the common causes of paralytic ileus due to dsyelectrolytemia, localised peritonitis due to vault infection or due to accidental bowel injury which may have been missed in the operative period . Her electrolytes reports were normal and her erect x-ray abdomen showed gaseous dilated bowel loops. On USG the bowels were swollen and oedematous but no free fluid was seen. Findng out no obvious cause she was managed conservatively for the first 24 hours and kept under observation. However after 24 hrs of conservative management abdominal distension progressed and she became more toxic and hence it was decided to re-explore the patient.

A midline incision was taken and abdomen opened from the symphysis pubis to supra umbilical region. The small bowel was found to be hugely dilated with patchy bluish discoloration of the jejunum with a distal collapse suggestive of a anatomical obstruction. On table examination of the intestines, showed that around 10 cm from the ileocaecal junction there was constriction band type of thing formed due the coiled right side fallopian tube.

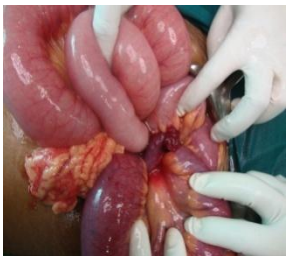

Fig 1:-Dilated jejunum with areas of bluish discolouration and fallopian tube as constriction band.

The constricting fallopian tube and the ovaries were removed and obstruction was relieved. There were a few patchy bluish areas present on the bowel. After giving 100% oxygen and application of warm saline, the colour gradually improved and showed peristaltic movement. Hence, it was decided to conserve and not to resect the segment and carefully monitored the patient in the post operative period. In order to avoid further chances of any obstruction due to the opposite fallopian tube, bilateral salpingooopherectomy was done.

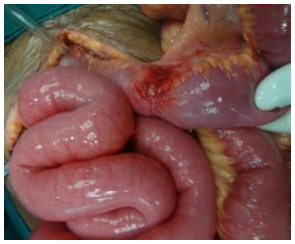

Fig 2 (a):- immediate improvement in the colourand peristaliticmovement after removal of the band

She was shifted to the surgical ICU. For the first 24 hrs she was kept on 6 lit/min oxygen with mask. Her distension gradually decreased. She was allowed orally after the 3rd post op day. Her rest of the hospital stay was uneventful. At 1 year follow up the patient was taking hormonal therapy and has developed an incisional hernia, at present not willing to undergo surgery for it.

III. Discussion

Hysterectomy for various reasons are very common surgical. For a young patient undergoing hysterectomy for a benign cause was to do a simple hysterectomy preserving the fallopian tube and ovaries to decrease the hormonal imbalance in young patients. The functional ovary preservation was required but the preserved fallopian tubes have shown to have no added functional benefit [2]. These tubes after getting detached from the uterine end coil on to themselves , folding toward the ovarian attachment and may later become fibrotic There are reports of complications of the remnant fallopian tube like hydrosalpinx , prolapsed of the fallopian tube through the vaginal vault which can be mistaken for malignancy , and the increased risk of ovarian malignancy which has been shown to arise commonly from the fimbrial end of the tube.[3] The entrapment of the bowl loops as in our case an extensive literature search didn't reveal any such previous reported case. The obstruction caused by anomalous fallopian tube has been reported in children. It may cause intestinal obstruction or malnutrition due to the chronic ischemia presenting in the children as abdominal pain and malnutrition. [4]These complications has led to many centres now promoting salpingectomy with hysterectomy to prevent them .

Though in this case the viability of bowel was restored, any further delay in exploring would have led to disastrous consequence like bowel gangrene This could have led to another major surgery and increased morbidity. Hence possibility of mechanical intestinal obstruction by fallopian tube should be kept in mind. This case does not validate the need to undertake the salpingooopherectomy in all the patients. But awareness of the possibility is needed.

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