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PARATUBAL CYSTS: AN UNCOMMON CAUSE OF ADNEXIAL TORSION

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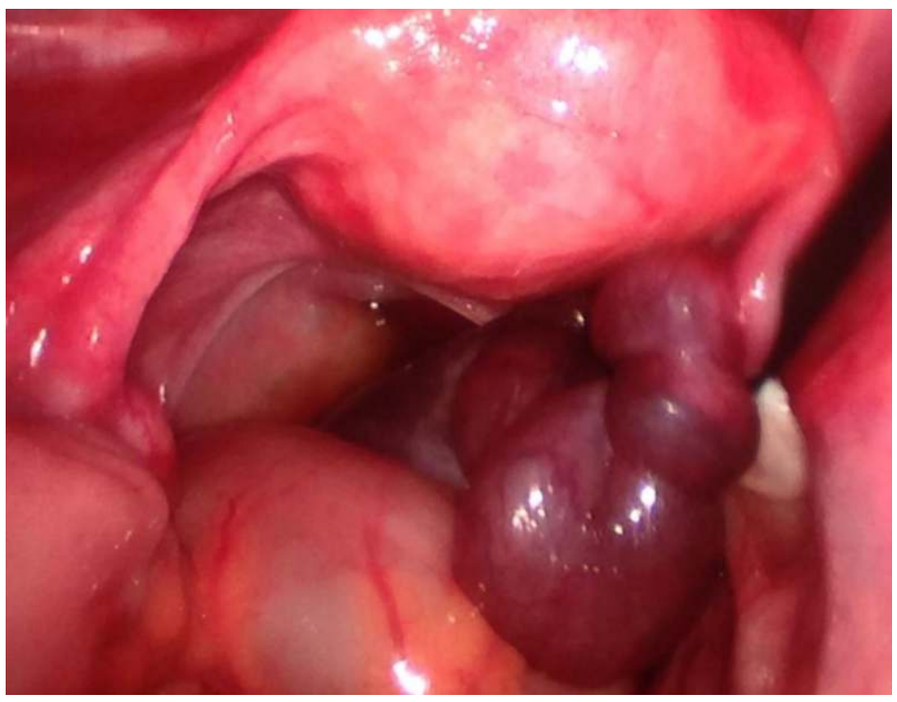
Problem statement: Paratubal cysts, also known as paraovarian cysts or hydatid of Morgagni, represent approximately 10% of all adnexal masses and are believed to originate from the mesothelium or to be remnant of paramesonephric (Müllerian) or mesonephric (Wolffian) ducts. Paramesonephric cysts are the most common, particularly the hydatid cyst of Morgagni, which is attached to the tubal fimbrae and contains serous fluid surrounded by a translucent wall. Small paratubal cysts are mostly common between 30 to 40 years and are often indistinguishable from simple ovarian cysts. Ultrasound scan is the first line exam, whereas magnetic nuclear resonance is useful to clarify the diagnosis. A paratubal cyst is often connected with the mesosalpinx by a stalk, in which torsion rarely occurs, sometimes involving the tube, thus causing acute severe pain requiring emergent surgical intervention. The final diagnosis of torsion is made by direct visualization at surgical evaluation. These cysts can easily be removed, preferentially by laparoscopy, without compromise of the ovary or fallopian tube, thus not compromising fertility.

Methods: We report a case of a paratubal cyst torsion with involvement of the tube, treated by complete laparoscopic enucleation.

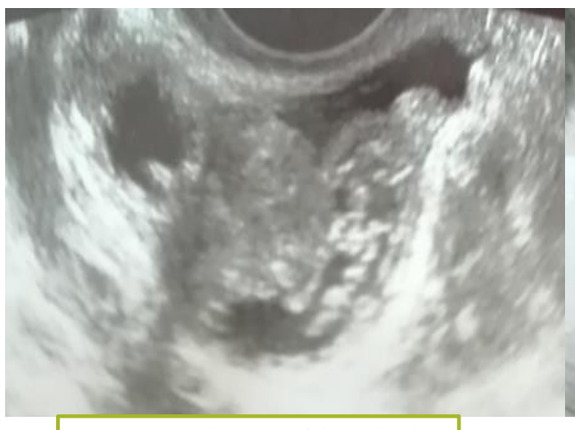
Results:

- **Identification, past medical and obstetric/gynecological history:** A 36-year-old woman, one previous c-section, without other relevant antecedents. She had regular menstruations and she affirmed using a barrier method consistently.
- **History of present illness:** Presented at our urgency department with gradually increasing right iliac fossa pain in the previous 4 days accompanied with nausea and vomiting. A similar episode occurred two months before. There was no anorexia, weight loss or weakness and bladder function was normal.
- **Physical examination:** Abdominal examination: there was no significative pain. Vaginal bimanual examination in Douglas cul-de-sac, a very painful elastic mass was palpated at right.
- **Blood tests:** Showed no infectious parameters. B-HCG and urinalysis were negative.
- **Ultrasound scanning:** Next to right ovary showed a homogeneous anechoic cyst with thin walls that showed hemorrhagic components measuring 42 x 49 mm, confirmed by computed tomography, which excluded appendicitis.

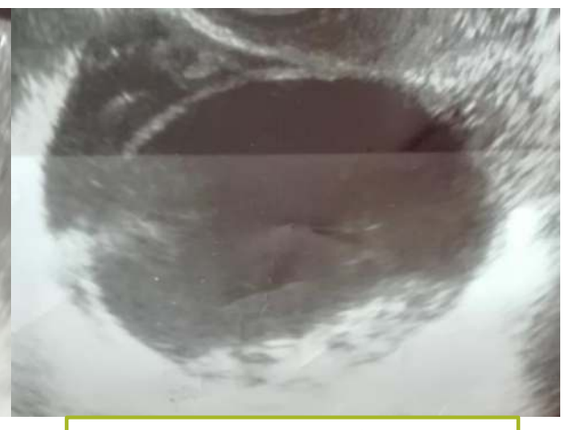
- **Diagnostic Hypotheses:** Paratubal cyst or hydrosalpinx.
- **Treatment:** diagnostic laparoscopy was proposed. A right paratubal cyst was observed which was causing fallopian tube torsion. After tubal torsion removal, the patient underwent cystectomy without rupture, neither compromise of the ovary or fallopian tube.
- **Histologic examination:** Hydatid cyst of Morgagni with hemorrhagic alterations.
- The admission was otherwise uneventful, with discharge at day 2.



3. Laparoscopic Image of the right twisted paratubal cyst



1. Ultrasound image of dilated tube



2. Ultrasound image of the cyst, homogeneous, anechoic, with thin walls

Conclusion: Although twisted paratubal cysts are not common, it should be kept as a differential diagnosis in any woman presenting with acute or intermittent pelvic pain, whenever a cyst near the ovary is detected in the ultrasound. Preservation of the ovaries, while performing the laparoscopic paraovarian cystectomy, is important in order to preserve their fertility.

**References: Marc R Laufer. Ovarian and fallopian tube torsion. UptoDate. Jan 14, 2018
. V. Leanza et al. Laparoscopic removal of a giant paratubal cyst complicated by hydronephrosis- G Chir. 2013 Nov-Dec; 34(11-12): 323–325.

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