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Case Report

Bilateral Congenital Absence of a Part of the Fallopian Tubes: A Case Report

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Abstract

The bilateral absence part of fallopian tube is rare. The etiology is not clear and the true incidence of this condition is not reported yet, but till now very few cases of tubal anomalies have been reported in the literature. Here, we report a case of a nulligravid post menopause female, who was presenting in an outpatient department and diagnosed to have symptomatic myoma and intraoperatively, incidentally found to have bilateral absent mid- tubal segment of fallopian tube during laparotomy.

Keywords: *Congenital; Fallopian Tube; Partial Tubal Agenesis; Mullerian Anomalies*

Introduction

The bilateral agenesis and/or absence of parts of the fallopian tube are rare. Incidence of this condition is not known but there are very few cases reported in literature. Anomalies of ovaries and fallopian tube are proposed to have two etiopathogenesis the first is an asymptomatic torsion of one or both adnexa during adult life or childhood, or even in the fetal stage. The second cause may be that the absence is congenital [1,2,12]. Here, we report a rare case of bilateral partial absence of fallopian tube in a nulligravid post menopause female, which was diagnosed incidentally during laparotomy.

Case Report

A 50 years old null gravid female presented to the Gynaecology Outpatient department of a Jimma University Medical center with a complain of lower abdominal swelling of one year duration associated with lower abdominal pain. She was amenorrheic for the past one year and had no previous history of any kind of menstrual irregularity. Patient was married for thirty years, staying regularly with the husband and never pregnant but she was not evaluated for infertility. She had no past history of surgery and treatment for vaginal discharge and lower abdominal pain. She is a known hypertensive patient for the past one year and on treatment otherwise had no other chronic medical illness. Pelvic ultrasound shows multiple intramural myoma and renal ultrasound did not show any abnormality. Total Abdominal hysterectomy planned for diagnosis of symptomatic myoma plus post menopause.

During laparotomy, the uterus is enlarged which is 14 weeks in size, with normal round ligaments. There is big intramural myoma measuring 6cm by 6cm on anterior uterine wall and other multiple small myomas otherwise no uterine anomaly seen. The left and right fallopian tubes appeared like a stump measuring approximately 1cm and 1.5 cm respectively was seen at cornual end followed by absent mid-tubal segment (about 4 cm in isthmic and ampullary portion) followed by normal fimbrial end and the two portions were connected by a fold of mesosalpinx on both sides. Both the left and right ovaries appeared normal with normal ovarian and suspensory ligament. There is no pelvic adhesion.

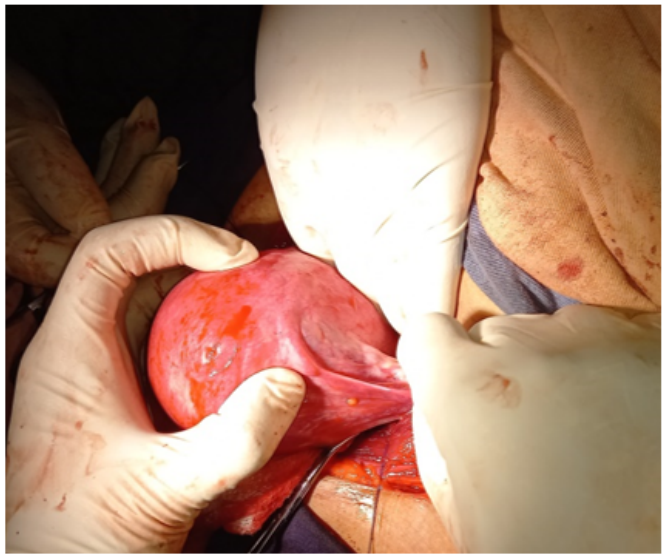

Figure 1: *Absent mid portion of left fallopian tube.*

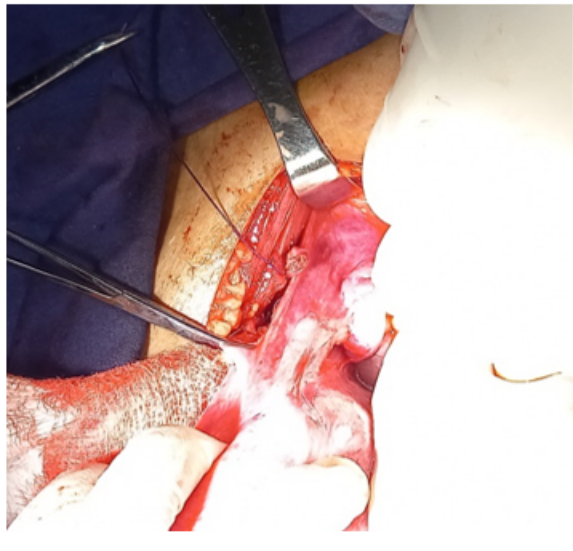

Figure 2: *Absent mid portion of right fallopian tube.*

Discussion

Anatomical abnormality of fallopian tube is of very rare occurrence, which mainly includes accessory ostia, multiple lumina, duplication, complete absence or partial atresia or segmental deletion of different regions of the tube [1]. These are usually asymptomatic and

diagnosed incidentally on laparoscopy for some unrelated indication. Majority of case reports of bilateral absence of fallopian tube reviewed literatures identified during laparoscopy for evaluation of primary infertility [1-4,8,10]. Our patient typically has primary infertility even though she is not investigated but diagnosed incidentally during laparotomy for other indication.

According to the VCUAM classification [3] which include tubal and ovarian malformations; our case belongs to class- A1b i.e. bilateral tubal malformation, ovaries normal.

The mechanisms by which segmental tubal deletions or absence may potentially occur include environmental factors, acquired infectious obstruction, or they may be secondary to vascular compromise due to torsion. Despite these diverse possibilities, congenital ampullary atresia is a frequently reported cause of segmental absence of the ampulla which spares fimbria [5,11].

In literature review of 20 cases, of which (12 bilateral and 8 were unilateral) [5-9] there is absence of mid portion of tubes with coexistence of fimbrial Tissue.

In all of the 8 cases reviewed and reported by Tallon., *et al*. (2013), there was no history of acute undiagnosed pelvic pain to suggest acute torsion. The pathognomonic findings of congenital ampullary atresia at laparoscopy and a total lack of intra-peritoneal infectious stigmata and the author conclude that the fimbria may have a unique association with the ovary that is distinct from the remainder of the fallopian tube and the etiology is more likely to be congenital. Our case also has similar finding with the above reviewed case series.

In the literature, both unilateral and bilateral tubal atresias have been described; these are isolated findings in 30% of cases. The other 70% are associated with Müllerian anomalies [11,12]. It is notable, in our case; there are no identified uterine anomalies associated with bilateral absence of parts of fallopian tube.

Conclusion

Bilateral absence of a part of the fallopian tube is very rare condition. These cases are usually diagnosed incidentally on laparotomy or laparoscopy for some other reason. It could either be congenital or secondary to asymptomatic torsion. Yet it is challenging to conclude, since there is no history of any episode of severe pain abdomen in the past, its bilaterality, coexistence of fimbrial tissue and intraoperative absence of evidence for infection, the likely cause of the absence of a part of fallopian tube in our case could be congenital, though we did not identify other abnormalities.

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