PIPADOR REVISION

MRCOG Part 1 Revision Notes

Tubal Disease

CLINICAL MANAGEMENT • LECTURE 486

VISUAL EXAMINATION REVISION NOTES

2026 Edition

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

486 Tubal Disease

Definitions, assessment and management of tubal factor infertility (NICE CG156)

≈ 20%	Chlamydia	HSG / HyCoSy	Salpingectomy
Of infertility	Main cause	If no comorbidity	For hydrosalpinx before IVF

■ KEY FACTS: Learning objectives

- Define tubal factor infertility, hydrosalpinx and proximal vs distal tubal occlusion.
- Describe causes and assessment of tubal patency (NICE CG156).
- Describe surgical and IVF-based management, including hydrosalpinx and reversal of sterilisation.

486.1 Key definitions

Term	Definition
Tubal factor infertility	Infertility due to blocked or damaged fallopian tubes or peritubal adhesions
Proximal occlusion	Blockage at the cornual/isthmic end (may be spasm, debris or fibrosis)
Distal occlusion	Blockage at the fimbrial end — often with hydrosalpinx
Hydrosalpinx	Distally blocked, fluid-filled, dilated tube — toxic fluid reduces implantation
Tubal patency test	HSG (X-ray), HyCoSy (ultrasound) or laparoscopy and dye
Salpingostomy / fimbrioplasty	Surgical opening/repair of the distal tube

■ IN PLAIN ENGLISH: Tubal disease

The tubes must be open for egg and sperm to meet. If they are badly damaged, **IVF bypasses them**; a swollen hydrosalpinx should be **removed or blocked before IVF** because its fluid halves the chance of success.

486.2 Assessment

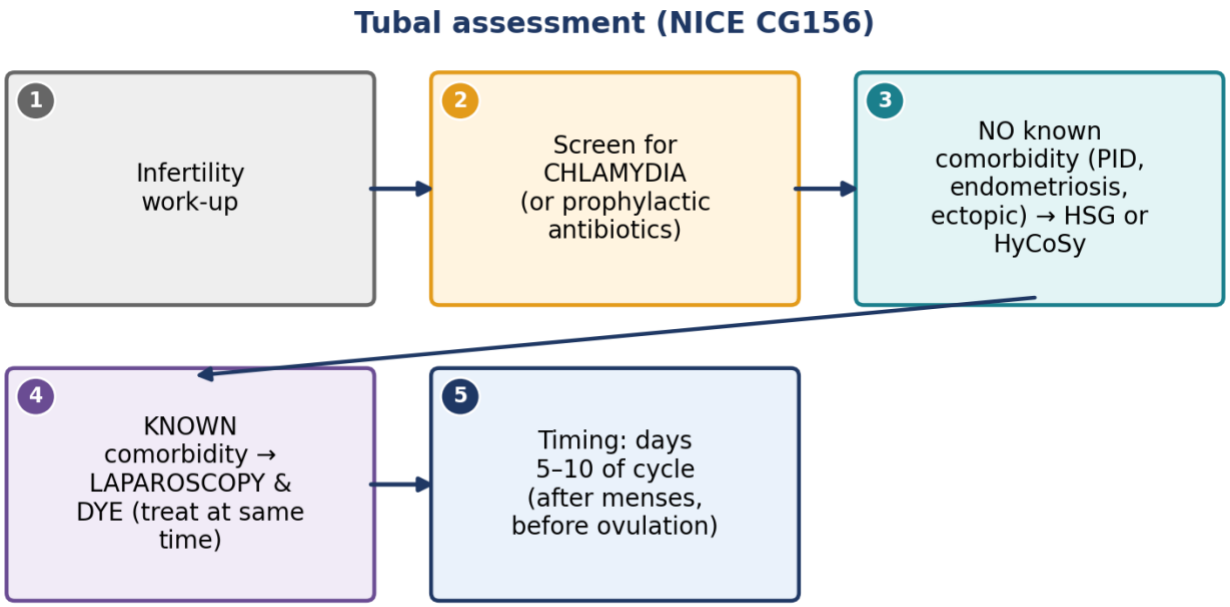


Figure 486.1 — Tubal assessment (NICE CG156)

- Women with no known comorbidities (PID, previous ectopic, endometriosis): **HSG or HyCoSy** (both reasonable; HyCoSy avoids radiation).
- Women with comorbidities: **laparoscopy and dye** so that tubal and pelvic pathology can be assessed (and treated) at the same time.
- Screen for chlamydia (or give prophylactic antibiotics) before uterine instrumentation.

486.3 Causes and management

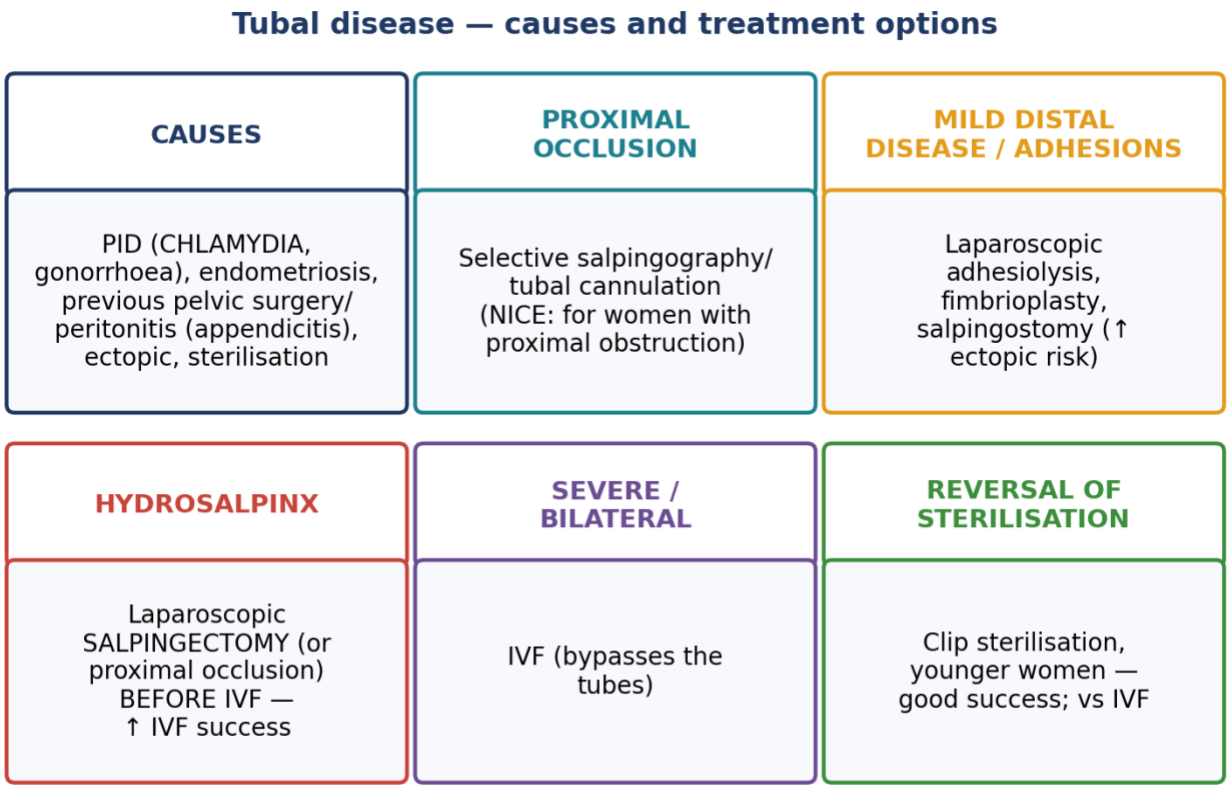


Figure 486.2 — Causes and treatment options

Situation	Management
Mild tubal disease	Tubal surgery may be more effective than no treatment in specialist centres (NICE) — adhesiolysis, fimbrioplasty
Proximal obstruction	Selective salpingography plus tubal catheterisation, or hysteroscopic tubal cannulation
Hydrosalpinges	• Laparoscopic salpingectomy (preferably) before IVF — improves live birth • Proximal tubal occlusion if salpingectomy difficult (adhesions)
Severe/bilateral disease	IVF
Previous sterilisation	• Reversal (microsurgical) if clips, younger woman, normal tubal length and partner semen • Otherwise IVF — NHS funding often not available for either
After tubal surgery	↑ Ectopic pregnancy risk — early scan in pregnancy

486.4 Prevention

- Prevention of PID: chlamydia screening (young women), safer sex, prompt treatment of STIs and partner notification.
- Prophylactic antibiotics or screening before uterine instrumentation (HSG, IUD insertion, surgical TOP).

■ COMMON PITFALLS

Relying on a single unilateral proximal block on HSG (spasm).
Proceeding to IVF without addressing hydrosalpinges.
Forgetting the increased ectopic risk after tubal surgery.

486.5 Must-know summary

■ EXAM TIP

- Tubal factor ≈ 20% of infertility; main cause PID (chlamydia); others: endometriosis, surgery, ectopic.
- HSG/HyCoSy if no comorbidity; laparoscopy & dye if comorbidity; chlamydia screen/prophylaxis first.
- Hydrosalpinx → salpingectomy (or proximal occlusion) before IVF.
- Mild disease: surgery; proximal block: cannulation; severe: IVF; ↑ ectopic after tubal surgery.

■ MNEMONIC / MEMORY AID

'Hydro — Remove before you transfer'.