Indian Journal of Basic & Applied Medical Research; March 2012: Issue-2, Vol.-1, P. 153-156

"Carcinoma of the Fallopian Tube: Case Report"

*** Dr. Shilpa Naik**

Abstract:

Reporting a rare case of carcinoma of fallopian tube which posed a diagnostic dilemma due to the rarity of its incidence. Primary carcinoma of fallopian tube is a very rare cancer with 0.3% incidence amongst all female genital cancers (1). Clinical diagnosis is very difficult due to higher index of suspicion of endometrial carcinoma in postmenopausal patients presenting with per vaginal bleeding. The first case was reported by Orthmann of Germany in 1886. To date less than 1200 cases of primary carcinoma of the fallopian tube have been reported in literature. Classical triad of (a) Hydropstubaeprofluens -prominent watery vaginal discharge. (b) Pelvic pain & (c) Pelvic mass, of which vaginal bleeding or discharge are seen in more than 50% cases(2). Treatment includes pan hysterectomy and adjuvant combination chemotherapy.

CASE REPORT: A 65 Years old postmenopausal lady came with chief complaints of per vaginal bleeding and vague lower abdominal pain since 10 months for she had undergone dilatation and curettage where moderately differentiated adenocarcinoma of endometrium was detected. She was referred with a pelvic ultra sonography report which revealed a normal sized uterus with thickened endometrium (10 mm) with right ovarian cyst 4.9 x 4.3 cm with thick capsule, internal echoes and no septae, Left ovary was normal 3.1 x 3.3 cm. Impression -?Haemorrhagic cyst?Functional cyst.

The patient had attained menarche at 12 years of age and her previous menstrual cycles were normal. She was postmenopausal since 15 years. On general examination patient had mild hypertension and she was overweight. Systemic examination and per abdominal examination was within normal limits. Her per speculum examination showed cervix slightly taken up, flushed with vagina and deviated to left side. No per vaginal discharge or bleeding seen. No obvious cervical or vaginal growth was seen. On per vaginal examination uterus was normal

*Associate Professor & Head of the unit,
Department of Obstetrics & Gynaecology.
B. J. Medical College &
Sassoon General Hospitals, Pune.
Phone no: 9850046747
E mail ID---shilunnaik@yahoo.co.in

sized and deviated to left with restricted mobility. A small cystic 3 x 2 cm mass was felt through right fornix, mobile and nontender. On per rectal examination above findings were confirmed.

Further investigations done of which routine investigations were normal. Tumor marker CA-125 was raised to 253.4 u/ml. (Normal up to 35 u/ml), Pelvic ultra sonography&Trans vaginal sonography showed normal sized uterus with thickened endometrium (2 cm), well defined thick walled cystic lesion 6.5 x4.6 cm in right adnexa with 3.3 cm echogenic solid components within it with few fine septations. Left ovary was not visualised. The impression was right complex ovarian cyst.

With this we were in a dilemma and started thinking in terms of carcinoma endometrium with concurrent ovarian tumor. So we subjected the patient for exploratory laparotomy. After opening the abdomen, peritoneal washing were taken. Grossly uterus was normal size. Left sided fallopian tube and ovary were normal. Right adnexal mass was noted 6 x6 cm. Separate identification of fallopian tube and ovary was not possible. (Fig 1) Pan hysterectomy with partial omentectomy was done. No obvious palpable lymph nodes.

The specimen was subjected to histopathological examination. To our surprise, the report was papillary adenocarcinoma of the fallopian tube grade II stage IA (FIGO) with tumorextending in endometrium.

The post operative period was uneventful and patient was advised combination chemotherapy with cisplatin and cyclophosphamide & three cycles were given.

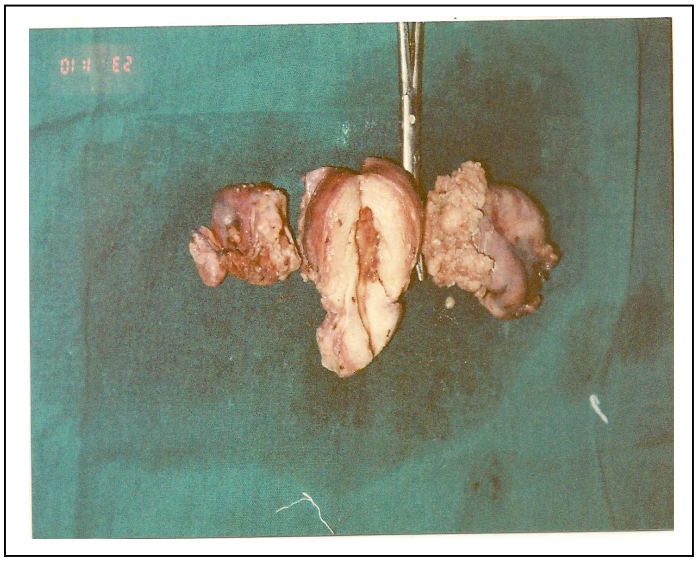

Figure 1 – Showing gross specimen from posterior aspect. Arrow pointing towards the mass with artery forcep medial to the mass

DISCUSSION: Fallopian tube cancer has an incidence ranging from 0.5% to 1.8%. The first case was reported by Orthmann of Germany in 1886 (2). To date less than 1100 cases of primary carcinoma of the fallopian tube have been reported in literature. It is commonly seen between 5^{th} and 6^{th} decade with an average age of 55 years. Salphingitis is often quoted as being of etiologic importance. Patients usually present with classical triad of signs and symptoms (a) Hydropstubaeprofluens-prominent watery vaginal discharge. (b) Pelvic pain (c) Pelvic mass of which vaginal bleeding or discharge are seen in more than 50% cases. The diagnosis of this cancer is very rarely made preoperatively(3). It is thus still a clinical dilemma and requires high index of suspicion. The D & C done may be negative for malignancy, Pap smear is hardly contributory also CA- 125 is never >300 u/ml but presence of postmenopausal bleeding with negative D & C should raise suspicion.

Papillary carcinoma is the most common type & the spread is usually by contiguous growth through the tube to the serosa and then dominant spread is by surface metastasis. Extension of the tumor to the serosa of the fallopian tube is very ominous finding (4). This diagnostic criteria are used to diagnose primary cancer (a) maximum tumor arising from tubal epithelium (b) maximum bulk is located in the tube (c) histological features resemble a tubal pattern (d) demonstrable area of transition between normal and malignant salphinx (5). Uterus and ovaries are normal or contain less tumor than the tube. Patient prognosis is worst in stage IV disease (outside the pelvis), presence of neoplastic cells in peritoneal washings and amount of residual disease at primary surgery. Treatment includes pan hysterectomy adjuvant combination chemotherapy if serosa is involved. Role of radiotherapy is still unclear (6). The 5 year survival rates for stage I, II, III and IV are 65%, 50 %, 10-20% respectively(1).

REFERENCES:

1) Karl.C.Podratz, Edward Podezaski Primary carcinoma of fallopian tube. American Journal of Obst&Gynaec 1986 Vol 154 No 6 : 1310-1326
2) OrthmannEG primareskarzinomEinertuberkulosonZtshrGeburtshGynaek 1888 ;15-212
3) B.L. Kneale, H.D.Attwood, Primary carcinoma of fallopian tube. American Journal of Obst&Gynaec 1966 Vol 94 No 6 : 840-848

4) Douglas.W.Hershery, Robert Fennel. Primary carcinoma of fallopian tube. American Journal of Obst&Gynaec 1981 Vol 157 No 3 : 367-370
5) Gerald.E.Kinjel. Primary carcinoma of fallopian tube. American Journal of Obst&Gynaec 1976 Vol 125 No 6 : 816-820
6) Ben-Hur H, dgani R, Ben Arie A Diagnostic dilemma and current therapy of fallopian tube cancer. Eur J Gynaecol- oncol 1999;20(2); 108-109

Acknowledgement:
Dr.S.R.Rane , Associate Professor, Department of Pathology, B.J.Medical College, Pune 1.

Date of manuscript submission: 10 November 2011
Date of initial approval: 27 December 2011
Date of Peer review approval: 29 January 2012
Date of final draft preparation: 22 February 2012
Date of Publication: 2 March 2012
Source of Support: Nil, **Conflict of Interest:** Nil

PISSN: 2250-284X, EISSN: 2250-2858