Research Paper

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Primary Adenocarcinoma of the Fallopian Tube

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ABSTRACT

Benign lesions of fallopian tube are quite common ,whereas malignant lesion in a fallopian tube is rare. Incidence of fallopian tube is as low as 0.14 to 1.8%1,3 Adenocarcinoma is the most commonest type of histological presentation of a fallopian tube carcinoma. In this article, we are presenting a case of a fallopian tube carcinoma in a 38 year old female who presented to us with colicky type of pain abdomen . Examination revealed presence of a tubo ovarian mass on the leftside. Staging laparotomy revealed a left adnexal mass which is separate from uterus and left ovary.Abdominal total hysterectomy with bilateral salphingo-oophorectomy was performed and followed up with 6 cycles of aduvant chemotheraphy. Pre-operative diagnosis of fallopian tube carcinoma is seldom made and most of the time the diagnosis is made on the operating table.

INTRODUCTION

Primary carcinoma of the Fallopian tube is the rarest gynaecologic cancer. The incidence ranges from 0.14 to 1.8%[1,3] with reported incidence being 0.3%.[2] Preoperative diagnosis of primary fallopian tube carcinoma is uncommon as the clinical features are non specific and most cases are diagnosed during surgery or after histopathological examination. Adenocarcinoma is the most commonest histological type of fallopian type of carcinoma. Surgery is considered as a primary mode of treatment in treating early cases. Chemotherapy has a role in advanced cases.

CASE REPORT

A 39 yrs old parous woman was admitted from the Obstetric and Gynaecology outpatient department , JSS Hospital, Mysore with the chief complaints of pain lower abdomen since 15 days which was insidious in onset, colicky type, intermittent and non radiating without any aggravating or relieving factors. There were no complaints of white discharge per vagina or any bowel and bladder disturbances. Her LMP was 28 days back and her cycles were regular with moderate flow. She was $para_2$ $living_2$ and both her children were normal deliveries and adequately breastfed. There was no history of any other major illness and her personal and family history were not significant.

On examination, her weight was 64 kgs and her BMI was 28.44 kg/m^2. Vital parameters were stable. General and systemic examination were unremarkable. Per speculum examination revealed a healthy cervix and vagina with minimal mucoid discharge. On per vaginal examination, cervix was firm, directed downwards and backwards. A firm, irregular mass of 8 wks size was felt which could not be made out separately from the uterus. A clinical diagnosis of Fibroid uterus was made.

All routine investigations including renal function tests were within normal limits. Ultrasonography demonstrated a complex solid mass measuring 8 × 6 cms which was adherent to the left ovary. Right ovary and uterus appeared normal. No fibroid seen. Her CA-125 was 138.5 U/ml. CT scan of abdomen and pelvis revealed a moderate sized, irregular, mildly enhancing mass lesion in the left adnexa with normal appearing uterus and right ovary. Impression on CT was inflammatory left tubo-ovarian mass. Malignancy could not be ruled out.

An exploratory laparotomy was planned. A staging laparotomy showed a left tubal mass of 10 × 6 cms densely adherent to omentum and intestines. The left ovary was seen separately from the mass and appeared normal. The uterus, right ovary and tube were normal. (Figure 1) No ascites noted. During dissection of the mass from the intestines, sigmoid colon was injured and repair was done. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done with infracolic omentectomy. Liver and under surface of the diaphragm appeared uninvolved.

Histopathological examination demonstrated features of poorly differentiated Adenocarcinoma of the left fallopian tube with normal ovaries and right tube. (Figure 2) Omental biopsy and cytological analysis of peritoneal washings were negative for tumour.

The final diagnosis was Primary Adenocarcinoma of the left fallopian tube – Stage IC.

Patient was later followed up regularly and 6 cycles f adjuvant chemotheraphy was give with cisplatin and cyclophospamide.



Figure 1:Photograph of the gross specimen showing the left tubal mass with normal ovaries & right tube and the omentum.

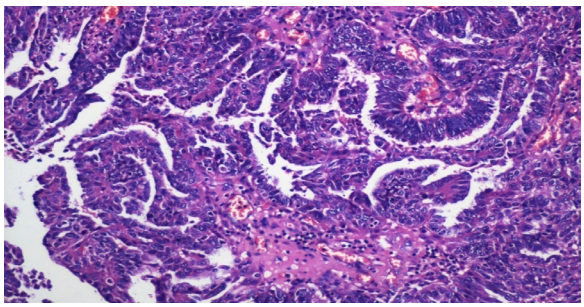


Figure 2- Microscopic photograph of tumour mass showing tumour cells arranged in papillary, glandular and diffuse pattern and numerous mitosis .

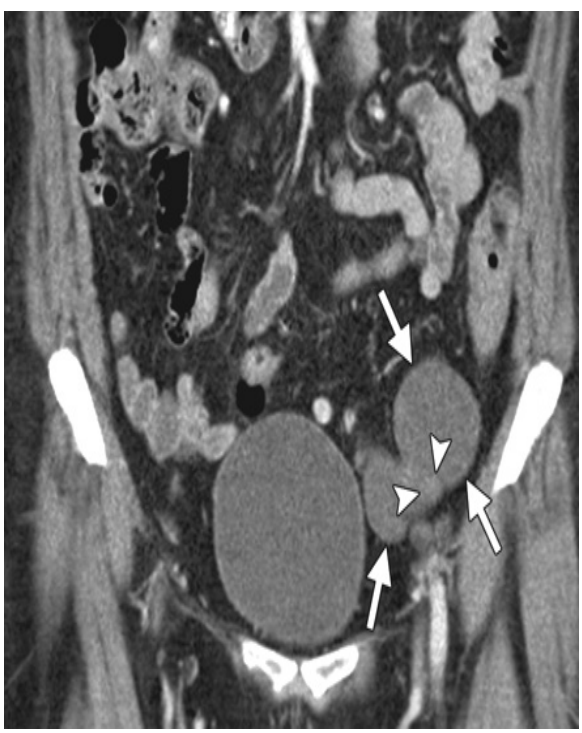


Fig 3:-CT scan of abdomen and pelvis - moderate sized, irregular, mildly enhancing mass lesion in the left adnexa with normal appearing uterus and right ovary

DISCUSSION

Primary Fallopian tube carcinoma is a malignancy of the tubal epithelium. Adenocarcinoma is the commonest histological subtype followed by endometrioid, mixed, undifferentiated, clear cell, transitional and mucinous tumours. [1,2,7]

PFTC is known to be insidious in onset and asymptomatic for prolonged and variable periods of time. Most frequently occurs between the 4th and 6th decades of life.[1,2] The symptoms are nonspecific. Latzkos triad of symptoms consisting of intermittent profuse serosanguinous vaginal discharge, colicky pain relieved by discharge, and abdominal or pelvic mass has been reported in 15% of cases.[1,4] Hydrops tubae profluens, a pathognomic feature, implies intermittent discharge of clear or blood tinged fluid spontaneously or on pressure followed by shrinkage of an adnexal mass and occurs in 5% of patients.[1] The most common finding on physical examination is a palpable pelvic or abdominal mass which has been observed in 60% of the patients.[1,4] PFTC is rarely asymptomatic but in most cases, pre operative diagnosis is seldom made prior to surgery . Primary ovarian neoplasm is the most common preoperative diagnosis made in these patients.

Ultrasonography shows a cystic mass with spaces and mural nodules, a sausage shaped mass, or a multilobar mass with a cog and wheel appearance[2]. Low-impedance vascular flow within the solid components has been reported. The lesion can have the appearance of a small, solid, lobulated mass on CT scan or on MRI.[1] The CA-125 antigen is often expressed by PFTC. Although CA-125 per se is not diagnostic for PFTC, more than 80% of patients have elevated pretreatment serum CA-125 levels.[1,2]

PFTC spreads principally by transcoelomic exfoliation of cells that implant thoughout the peritoneal cavity.[4] Bilateral tubal involvement has been reported in 10 – 27 % of cases.[1] PFTC is richly permeated with lymphatic channels that drain into the para-aortic and pelvic lymph nodes.[5] Metastases to para aortic lymph nodes is documented in atleast 33% of patients with all stages of disease.[4,5] Nodal spread is more common in PFTC when compared to epithelial ovarian tumours.

The staging of PFTC is based on the surgical findings at laparotomy.[2-4] The International Federation of Gynecology and Obstetrics (FIGO) staging system has been adapted to apply to PFTC.[2,4] Surgery, clearly the mainstay of treatment, is also the first approach to diagnosis. Surgical principles are the same as those used for ovarian cancer.[2,6] The procedure of choice is total abdominal hysterectomy with bilateral salpingo-oophorectomy followed by staging operation. That is adequate evaluation of retroperitoneal lymph nodes and peritoneal cytologic studies and biopsies along with an infracolic omentectomy.[2]

As the tumour closely resembles ovarian malignancy, it is important to differentiate it from primary ovarian tumour. Sedlis described the following criteria[2,3,6] to label a tumour as PFTC (i)The cell of origin is endosalpingeal and the bulk of the tumour must be in the tube, (ii)A zone of transition from benign to malignant epithelium is present, (iii)There should be no nexus between tubal and ovarian disease.

The role of chemotherapy is limited to advanced stage disease. Patients with stage IA and IB may not require adjuvant therapy.1 In addition, early-stage patients with tumours infiltrating the serosa or with pre- or intraoperatively ruptured tumours should receive chemotherapy.[1] They are treated with platinum based combinations.[4] Various regimens for chemotherapy combine cisplatin or carboplatin with paclitaxen or cyclophosphamide for six cycles.[1,4] The prognostic factors that directly correlates with survival is stage of the disease at the time of surgery.

Thus, Primary Fallopian tube carcinoma is a rare gynaecological cancer and its pre operative diagnosis is seldom made. Most often the diagnosis is made on the operating table or by histopathological examination.

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