VOLUME - 14, ISSUE - 05, MAY - 2025 • PRINT ISSN No. 2277 - 8160 • DOI : 10.36106/gjra

Original Research Paper | Obstetrics & Gynaecology

A RARE CASE OF PRIMARY BILATERAL HIGH-GRADE SEROUS CARCINOMA OF FALLOPIAN TUBES: A CASE REPORT

Dr. Vishwa Solanki
Dr. Dhwani Desai
Dr. Ragini Verma
Dr. Sakshi Modi* *Corresponding Author

ABSTRACT

Introduction: Primary fallopian tube carcinoma is a very rare gynecological malignancy with an incidence of 0.1 to 1.81 percent of all genital malignancies. This is a case report of bilateral fallopian tube carcinoma in a 40-year-old lady. **Case:** A 40-year-old lady presented to us in Gynec OPD of a tertiary care center in South Gujarat with complaints of abdominal pain, distension, and watery vaginal discharge. Her primary ultrasound showed the possibility of neoplastic etiology of the Fallopian tube hence further investigations were carried out. Her CA-125 was normal. Her MRI showed hydrosalpinx with bilateral fallopian tube lesions/ tube ovarian lesions. All other structures were free from tumors. Further investigations were carried out to rule out underlying infective/ neoplastic etiology. Her Mantoux was positive. Fluid CBNAAT was negative. Thus, we decided to operate the patient and did her staging laparotomy. Her histopathology showed high-grade serous carcinoma of bilateral fallopian tubes. The endomyometrium, cervix, bilateral ovaries, and omentum were free from tumors. She was diagnosed early as FIGO staging 1c and pathological staging pT1b and started on adjuvant chemotherapy (paclitaxel and carboplatin) for 6 cycles. **Conclusion:** Primary fallopian tube carcinoma histologically and clinically resembles epithelial ovarian carcinoma. The treatment approach is similar to that of ovarian carcinoma. Fallopian tube carcinoma is rare and difficult to diagnose, and an early diagnosis becomes a key factor in increasing the survival rate of the patient.

KEYWORDS : malignancy, chemotherapy, survival, primary fallopian tube carcinoma

INTRODUCTION

It is a rare gynecological malignancy. Its incidence is 0.1 to 1.8 % of all genital cancers. The mean age at diagnosis of fallopian tube carcinoma is 58 years, with a range of 26 to 85 years. Only 1500 to 2000 cases are reported worldwide.

Clinically, the fallopian tube carcinoma is similar to epithelial ovarian cancer.[2] Histologically, 80% to 90% of fallopian tube carcinomas are adenocarcinomas. Most of these are serous carcinomas, followed by endometrioid and clear-cell adenocarcinomas. Fallopian adenocarcinomas come to attention due to abnormal discharge, bleeding, or occasionally abnormal cells in a Pap smear.

Case Study

A 40-year-old lady presented to us in gynec OPD with chief c/o watery vaginal discharge for 2 months associated with abdominal pain and distension.

On examination, per abdomen was soft and watery vaginal discharge was present, on per speculum examination cervix and vagina were normal. On per vaginal examination, bilateral forniceal fullness was present. As she was having persistent vaginal discharge which was not managed medically, further investigations were done.

Ultrasound report showed approx. 6 cm long and 2 cm wide anechoic tubular structure with e/o incomplete septations and multiple solid intraluminal polypoidal projections with e/o internal vascularity and solid component noted in right adnexal region suggestive of the possibility of neoplastic etiology of the fallopian tube. Both ovaries were seen separately. Left adnexa was normal. Her CA125 was 41.5(2.0 – 37.0 U/ml) which was borderline raised.

MRI pelvis showed approx. 6*2*2 cm^3 well-defined predominantly cystic lesion with incomplete septations with 2*2*2 cm^3 solid nodular lesion seen within the cystic lesion in the right adnexa. Approx. 5*1*1 cm^3 well-defined predominantly cystic lesion with incomplete septations with 2*1*1 cm^3 solid nodular lesion seen within the cystic lesion in left adnexa. Both ovaries were seen separately. The uterus was normal. This most likely represented hydrosalpinx with neoplastic bilateral fallopian tube lesions/ tubo ovarian lesions. (FIGURE 1)

Mantoux test was strongly positive with 30 mm induration. USG-guided FNAC was done which was inconclusive. Fluid CBNAAT was sent which was negative.

Staging laparotomy (total abdominal hysterectomy with bilateral salpingo-oophorectomy with omentectomy) was done.

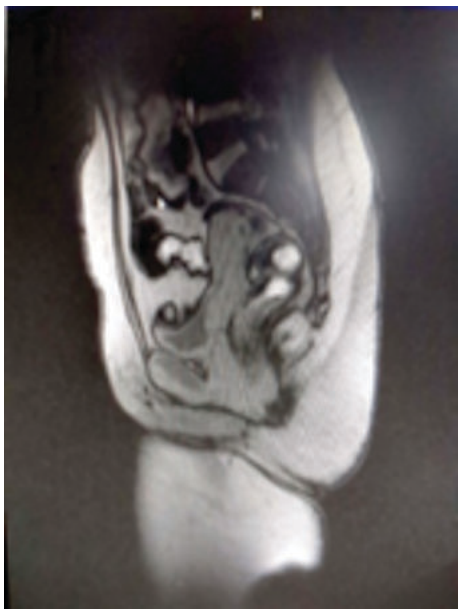

Figure 1: Sagittal section of MRI pelvis suggestive of hydrosalpinx with bilateral fallopian tube lesions/ tubo ovarian lesions.

Intra-op Findings

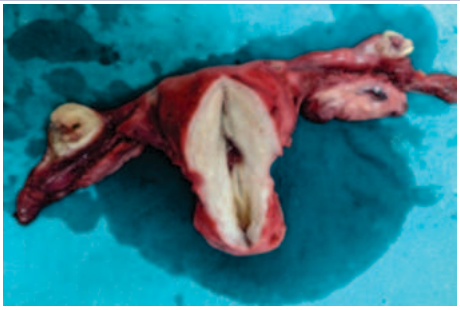

Figure 2: Gross section of the uterus with bilateral fallopian tubes showing bilateral lesions with solid and cystic components.

On laparotomy,

1.) Ascites was present which was sent for cytology, and the report showed CATEGORY 4 – suspicious for malignancy (The International System for Serous Fluid Cytopathology).
2.) The uterus was normal size, with early adenomyotic changes. Both fallopian tubes showed bilateral lesions with solid and cystic components. (FIGURE 2). The serosa was intact on both sides. Bilateral ovaries were normal.
3.) The specimen was sent for histopathology which showed high-grade serous carcinoma of bilateral fallopian tubes. Endomyometrium, cervix, bilateral ovaries, and omentum, were free from tumor.

FIGO Stage: 1C
Pathological Stage: pT1b

Treatment

The mainstay of treatment of PFTC is surgical resection. It means complete cytoreduction, in which all visible diseases should be removed. Routine surgical procedures would be Total Abdominal Hysterectomy, Bilateral Salpingo-Oophorectomy, Omentectomy, and Lymphadenectomy. Most of the patients, more so those with far-advanced diseases, would require adjuvant chemotherapy. Cytotoxic medications mostly include platinum-based compounds, including carboplatin and taxanes such as paclitaxel, which are similar agents applied in treating ovarian cancer. Postoperative radiotherapy is no longer recommended due to its low efficacy and high rate of serious complications. Based on its propensity for a distant microscopic spread and recurrence, chemotherapy seems to have a strong rationale as an adjuvant treatment for patients with early-stage disease[4]. Our patient was started on adjuvant chemotherapy (paclitaxel plus carboplatin) for 6 cycles. Currently, she has completed all cycles of chemotherapy, doing well and is on regular follow-up.

CONCLUSION

Primary fallopian tube carcinoma histologically and clinically resembles epithelial ovarian carcinoma. The treatment approach is similar to that of ovarian carcinoma. Fallopian tube carcinoma is rare and difficult to diagnose, and an early diagnosis becomes a key factor in increasing the survival rate of the patient.

The very early detected carcinomas (stage 1) will have a survival rate of about 65%. The 5-year survival rate is 40% of all cases. Hence, early diagnosis and prompt management remain a mainstay in improving the progression-free as well as disease-free survival rate of primary fallopian tube carcinoma.

REFERENCES

1. Kalampokas E, Kalampokas T, Tourountous I. Primary fallopian tube carcinoma. Eur J Obstet Gynecol Reprod Biol. 2013 Jul;169(2):155-61. doi: 10.1016/j.ejogrb.2013.03.023. Epub 2013 Apr 23. PMID: 23622731
2. Rexhepi M, Trajkovska E, Ismaili H, Besimi F, Rufati N. Primary Fallopian Tube Carcinoma: A Case Report and Literature Review. Open Access Maced J Med Sci. 2017 May 20;5(3):344-348. doi: 10.3889/oamjms.2017.044. PMID: 28698755; PMCID: PMC5503735.
3. Aziz, S., Kuperstein, G., Rosen, B., Cole, D., Nedelcu, R., McLaughlin, J. and Narod, S.A., 2001. A genetic epidemiological study of carcinoma of the fallopian tube. Gynecologic Oncology, 80(3), pp.341-345.
4. Singhal, P., et al. "Primary fallopian tube carcinoma: a retrospective clinicopathologic study." Eur. J. Gynaec. Oncol.-IssN 392 (2006): 2936.