

A Case Report Of Fallopian Tubal Carcinoma

G Kanimozhi, D Kotasthane, G Koteeswaran

Citation

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Abstract

Primary adenocarcinoma of fallopian tube is one of the rarest gynaecological malignancies. Its incidence is under estimated because advanced tumors usually spread to ovaries are often wrongly diagnosed as ovarian tumor. We are presenting this rare case of Primary Fallopian Tubal Carcinoma(PFTC).

INTRODUCTION

Fallopian tube cancer is the least common of gynaecological malignancies. It comprises 0.14 to 1.8% of all gynaecological cancers. It is also possible that the true incidence of PFTC has been underestimated because PFTC may have been mistakenly identified as ovarian tumors during initial surgery and or during microscopic examination by a pathologist, as the histological appearance of these tumors are identical(1).

CASE REPORT

A fifty four year old female patient (para 1) presented to the Obstetrics and Gynaecology Out Patient Department with complaints of episodic, intermittent type of abdominal pain in the left iliac region that subsided after pervaginal serosanguinous discharge which was on and off for 6 months. Clinically an adnexal mass was palpable and diagnosed as left adnexal mass

Ultrasound findings showed an atrophied uterus whereas the right tube and ovary appeared to be normal. The left tube and ovary showed a cyst with internal echos. A left adnexal mass was confirmed and the patient was taken for laprotomy.

Total abdominal hysterectomy with bilateral salpingo oophorectomy and omental resection was done and the specimen was sent for histopathological examination (HPE).

Grossly, the uterus was atrophied, measuring 6×4×3 cms. Right tube and ovary were unremarkable. Left tube and ovary measured 5×3×2 cm. The left ovary was unremarkable. The medial 1/3 rd of the left tube was grossly normal, the lateral 2/3rd of the tube was dilated (Fig A). Cut

section of the enlarged tube revealed a tan to yellow, solid tumor that had papillary projections and was partially filling the lumen (Fig B).

Microscopy of the left tube showed features of moderately differentiated adenocarcinoma. The tumour was composed of cells arranged in glandular, papillary pattern and sheets. The cells were columnar and had enlarged hyperchromatic nuclei and some nuclei showed prominent nucleoli and mitotic figures.(fig C). An area of transition from normal benign epithelium to malignant epithelium was seen.(Fig D). The peritoneal fluid was positive for malignant cells. Hence it was diagnosed as moderately differentiated serous adenocarcinoma of left tube –stage IIC.

Figure 1

Fig A -Arrow marks shows medial part of normal left fallopian tube.



Figure 2

Fig B - Lumen of tube shows solid tan to yellow mass with papillary projections partially filling the lumen.



Figure 3

Fig C -shows tumor cells arranged in glandular pattern

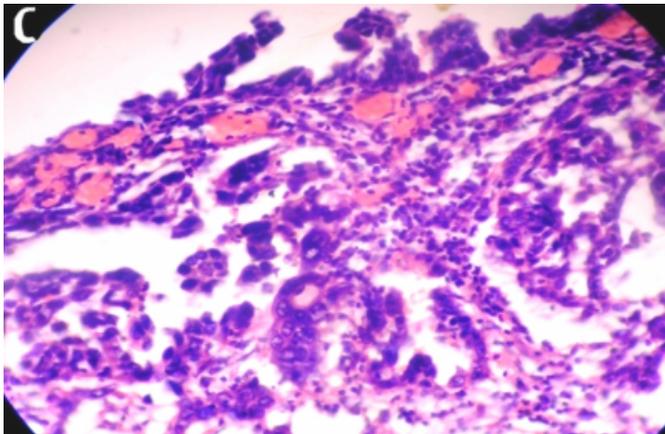
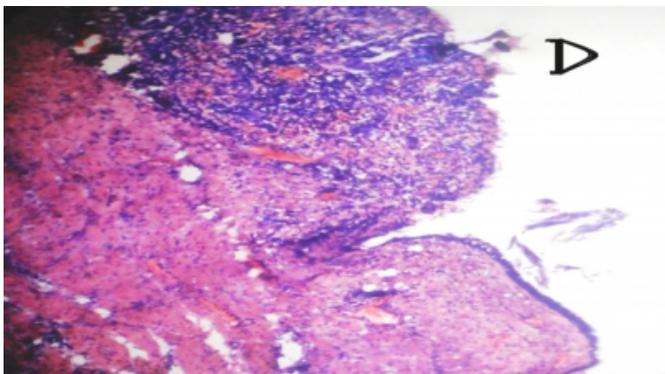


Figure 4

Fig D -Shows area of transition from normal epithelial lining to carcinomatous area and it also shows that the tumor arise from the under lying smooth muscle (endosalpinx).



DISCUSSION

Primary carcinoma of the Fallopian tube was first described by Renaud in 1847. From then, there have been nearly 1500

cases documented in the literature (1,2). PFTC is the least common of all gynaecologic malignancies and annual incidence is about 3.6 per million per year.(3) It accounts for approximately 0.14-1.8% of all female genital malignancies (4) The peak incidence is between the ages of 60 and 64 years, with the mean age of incidence being 55 years (age range: 17 to 88 years) (3).

In a retrospective study of 151 patients, it was noted that the patients usually present with abnormal vaginal bleeding (47.5%), lower abdominal pain (39%), abnormal watery vaginal discharge (20%) and a palpable pelvic/abdominal mass (61%).(5). The patients presents with the typical clinical symptoms termed as “Hydrops tubae profulens” i.e, they will have pelvic pain, lower abdominal mass and serosanguinous vaginal discharge(1,2). The pain is colicky in nature and considered to be related to distension of a partially blocked fallopian tube by fluid which is then relieved by passage of blood or discharge. Latzke triad of symptoms, consisting of intermittent profuse serosanguinous vaginal discharge, abdominal and/or pelvic pain, is reported in 15% of cases.(6)

Preoperatively the lesion may be misdiagnosed as ovarian tumor or hydrosalpinx. The diagnosis of PFTC is rarely considered preoperatively and it is usually first appreciated at the time of operation or after operation by the pathologist .A correct diagnosis of PFTC was made preoperatively in only 4.6% of cases in the series of Alvarado-Cabrero et al. (7).

There are no known predisposing factors, but it has been found to be associated with nulliparity and infertility, as well as with pelvic inflammatory disease (4)

Making the preoperative diagnosis of PFTC could be assisted by measurement of the serum levels of CA 125, which is elevated in 65% of PFTC patients (8). Therefore, CA 125 should be used in the diagnosis and follow up.

The echographic appearance of the fallopian tubes is non-specific and it mimics other pelvic diseases such as tubo-ovarian abscess, ovarian tumor and ectopic pregnancy. The echogram may show a cystic mass with spaces and mural nodules, a sausage-shaped mass or a multilobular mass with a cog-and-wheel appearance (9). Transabdominal ultrasound is an essential imaging technique in the diagnostic workup of patients with possible tubal pathology. Transvaginal ultrasound examination with color Doppler can detect areas of neovascularization within the fallopian tube and thus may

aid in the preoperative diagnosis of PFTC(9).

Criteria to diagnose PFTC include all of the following(10).

PFTC spreads by local invasion, transluminal migration and via the lymphatics and the bloodstream(4). Patients with PFTC have a higher rate of retroperitoneal and distant metastases than those patients with epithelial ovarian cancer(4). Therefore lymphnode sampling is considered a mandatory procedure of surgical staging and many of the stage I–II patients were probably understaged because of the lack of surgical retroperitoneal assessment(2). The staging system used for primary fallopian tube carcinoma is similar to that of FIGO staging used for the ovaries. Peritoneal washings should be taken at the time of surgery as positive peritoneal washings suggestive of extratubal spread increase the risk of lymphnode metastases with an adverse effect on prognosis(1).

In our case, the 54 year old female patient came with the history of colic-like abdominal pain which was on and off and subsided after serosanguinous discharge which she had for six months. It was preoperatively diagnosed to be a left adnexal mass probably an ovarian tumour or a hydrosalpinx and PFTC was not suspected until post-operatively confirmed by histopathology. Peritoneal wash showed cells which were suspicious of malignancy. The PFTC and ovarian carcinomas have many things in common like age, nulliparity, histological pattern but the diagnosis of tubal carcinomas can be made much earlier due to pain. So early detection can help the patient in better prognosis and can increase the rate of survival.

PFTC should be taken into account for making the differential diagnosis of a suspicious adnexal mass or a presumptive tubo-ovarian abscess in all post-menopausal women and also in the pre-menopausal women who fail to respond to antibiotic therapy and drainage.

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Author Information

G Kanimozhi, PG student

Department of Pathology, Mahatma Gandhi Medical College and Research Institute

Dhananjay Shrikant Kotasthane

Professor and HOD, Department of Pathology, Mahatma Gandhi Medical College and Research Institute

G Koteeswaran

Associate Professor, Department of Pathology, Mahatma Gandhi Medical College and Research Institute