Inguinal Lymphadenoathy As A Rare Presentation Of Carcinoma Of Fallopian Tube

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Citation

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Abstract

The most common presenting symptom for carcinoma of the fallopian tube is post menopausal bleeding, however some may present as pelvic pain, pelvic mass, and watery discharge. [1] Presentation primarily as inguinal lypmhadenopathy alone is rare. We report a case, presenting with a tender lump in the groin, suspected to be a strangulated femoral hernia, hence explored. At surgery, tender mass turned out to be a lymph node and there was no hernia. Histological examination revealed metastatic adenocarcinoma. Laparotomy following preoperative chemotherapy revealed fallopian tube carcinoma.

CASE REPORT

A fifty seven year old lady presented in 2005 with painful swelling in right groin of 2 weeks duration. There was some nausea and vomiting, but no bowel problem. She had had hysterectomy with ovarian conservation 20 years ago. There was no family history of ovarian or breast cancer. Her general condition was fair, however in the right femoral triangle, there was a 2 cm tense, tender, irreducible lump. Other systems on examination including the breasts were unremarkable. Blood tests, chest and abdominal X-ray were normal. A diagnosis of strangulated right femoral hernia was considered.

Exploration of the right groin revealed the tender lump to be an enlarged lymph node. There was no femoral or inguinal hernia. The node was excised and sent for histological examination and it revealed metastatic adenocarcinoma. It was CK7 positive, CK20 and TTF1 negative, weakly estrogen receptor (ER) positive but strongly positive for progesterone receptor (PR). However, mammography was normal. CT of the chest, abdomen and pelvis was done to find out possible primary and it showed 6x3cm septated cystic mass lying right of urinary bladder, most likely ovarian tumour. There was 15mm lymph node on right side of aorta behind inferior venacava, just bellow origin of right ovarian artery. Tumour marker CA-125 was 2710u/ml (normal value for the lab 0-23u/ml), CEA was 3mcg/l (0-4mcg/l) and CA19-9 was 128u/ml (0-33u/ml). Investigations suggested primary ovarian cancer.

She received six cycles of carboplatin and taxol chemotherapy, followed by a repeat CT scan. This showed a decrease in size of primary ovarian lesion and the lympnode seen adjacent to the aorta remained unchanged. At subsequent surgery omentum, right ovary, and remaining part of adherent fallopian tube were removed. Histology revealed grade III adenocarcinoma of fallopian tube with omental involvement. Postoperative period was uneventful. At present she remains well and CA-125 is normal.

DISCUSSION

Fallopian tube carcinoma is one of the rare gynaecologic tumours, accounting for 0.2–1.8% of all tumours of the female reproductive tract. This carcinoma is associated with infertility, low parity and chronic salpingitis, with a peak in the sixth decade of life. Cytogenetic studies show that the disease is associated with over expression of p53 (81%), HER2/neu (89%), and c-myc (61%). There is also some evidence that BRCA1/ BRCA2 mutations have a role in tumouigenesis.[1] Most tubal cancers spread by exfoliation of the cancer cells into the lumen of the fallopian tube and then through direct extension to the adjacent uterus, ovaries, and intraperitoneal cavity. Lymphatic and haematogenous spread is also seen.[2] CA-125 per se is not diagnostic of fallopian tube cancer but more than 80% patients have elevated pre-treatment serum CA-125 levels. 87% of tumours stain positively for CA-125. The pre-treatment serum CA-125 level is an independent prognostic factor for disease-free and overall survival. Elevated CA-125 levels also adequately defines the response to chemotherapy. In 90% of patients, an

increase in serum CA-125 level preceded clinical or radiological diagnosis of recurrent disease with a median lead-time of 3 months (range, 0.5–7 months). Hence, serum CA-125 is useful in follow up after definitive treatment. [2]

Winter-Roach et all reported a case similar to ours, where a 69 year old lady presented with inguinal swelling and on excision was confirmed to be metastatic adenocarcinoma. Further laparotomy confirmed it to be fallopian tube cancer. [3]

When strangulated hernia is suspected, it is safer to operate, rather than to wait for radiological investigation. It is very rare to find fallopian tube cancer presenting as inguinal lymphadenopathy.

References

1. Courville, Xan F, Cortés, Zenia, Katzman, Philip J, Rosier, Randy N. Bone metastasis from fallopian tube carcinoma. Clinical orthopaedics and related research. 2005;434:278-281
2. Ajithkumar, Minimole, John, Mary M, Ashokkumar. Primary fallopian tube carcinoma. Obstretrics and Gyenecological survey. 2005;60(4):247-252
3. Winter-Roach BA, Tjalma WA, Nordin AJ, Naik R, de Barros Lopes A, Monaghan JM. Inguinal lymph node metastasis: an unusual presentation of fallopian tube carcinoma. Gynecol Oncol. 2001;81(2):324-325.

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