J Obstet Gynecol India Vol. 56, No. 2 : March/April 2006 Pg 169-170

CASE REPORT

The Journal of Obstetrics and Gynecology of India

Primary fallopian tube carcinoma associated with procidentia

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Key words : fallopian tube carcinoma, procidentia

Although fallopian tubes are frequently involved in benign gynecological conditions and are a common site for metastasis, their primary malignant involvement is rare. Primary fallopian tube carcinoma is not routinely suspected preoperatively. A woman presented to us with procidentia and was accidently found to have fallopian tube growth during surgery.

Case report

Sixty-two year old, para 1 live 0 was admitted on 7th August, 2002 complaining of a mass coming out from the vagina for the last 5 years. There was no history of vaginal bleeding or discharge. She was menopausal for 12 years. She was not a known diabetic or hypertensive. Her general physical examination including abdominal examination was unremarkable. On local examination, cervix was healthy looking and was lying 10 cm outside the introitus. Cystocele, rectocele and entrocele were present. Stress incontinence was demonstrated. On vaginal examination, uterus was atrophic and a hard, mobile, nontender mass of 4x4 cm was palpable through the left fornix. Rest of the fornices were free. There was no nodule in the pouch of Douglas. On rectal examination, the same mass could be felt. A clinical diagnosis of procidentia with stress incontinence and ovarian tumor was made. Hemoglobin was 11g/dL, blood urea 27 mg/dL and blood sugar 84 mg/dL. Urine examination revealed no abnormality; x-ray chest and ECG were normal. On transvaginal sonography, uterus was atrophic with a solid mass of 4x3x4.5 cms on left side Left ovary could not be appreciated separately; but right ovary was normal looking. Keeping the diagnosis of ovarian tumor in mind, a decision for laparotomy and concurrent repair by vaginal route was taken. On laparotomy, there was no free fluid, uterus was atrophic, and right fallopian tube and both the ovaries were normal looking. There was a solid tumor involving the distal end of the left fallopian tube (Figure 1). There were adhesions between the tumor and the sigmoid colon. Peritoneal washings were collected. Adhesions were released and the tumor was freed. Staging was done. Total hysterectomy along with bilateral salpingo-oophorectomy was performed employing both abdominal and vaginal routes. Infracolic omentectomy was done. Finally, pelvic floor repair and Kelly's repair were done. The tumor measured 4x3x3 cm. Its outer surface was irregular and nodular. The cut section showed grey white solid areas with hemorrhage, necrosis, and papillar excrescences. Histopathology of the specimen showed chronic cervicitis, atrophic endometrium, and myometrial invasion by the tumor cells with presence of psammoma bodies. The tumor at the distal end of left fallopian tube showed adenocarcinoma (Figures 2,3 and 4). Peritoneal washings were negative for malignant cells. A final diagnosis

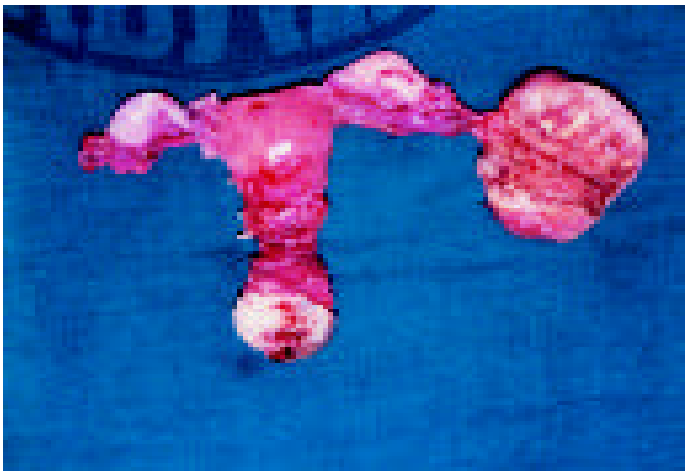

Figure 1. Uterus and growth involving the distal end of left fallopian tube.

Paper received on 06/01/2004 ; accepted on 07/12/2005

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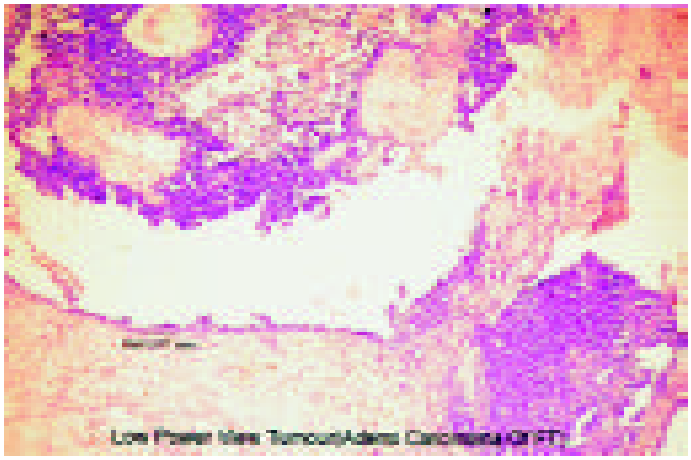

Figure 2. Photomicrograph of adenocarcinoma of fallopina tube. Low power view of the tumor. Wall of the fallopian tube is seen in the lower part.

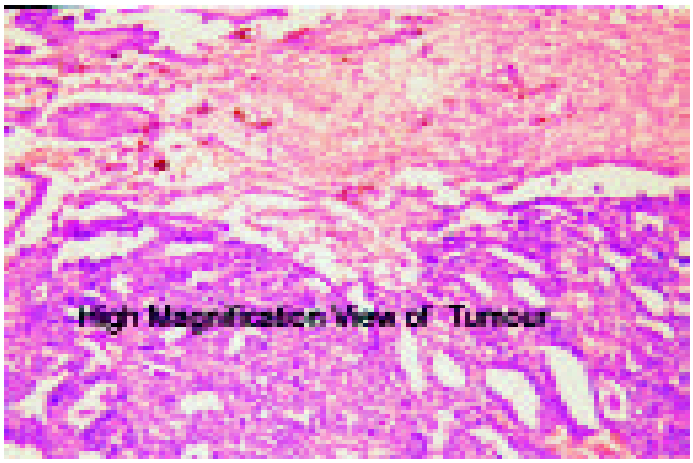

Figure 3. High power photomicrograph of the tumor

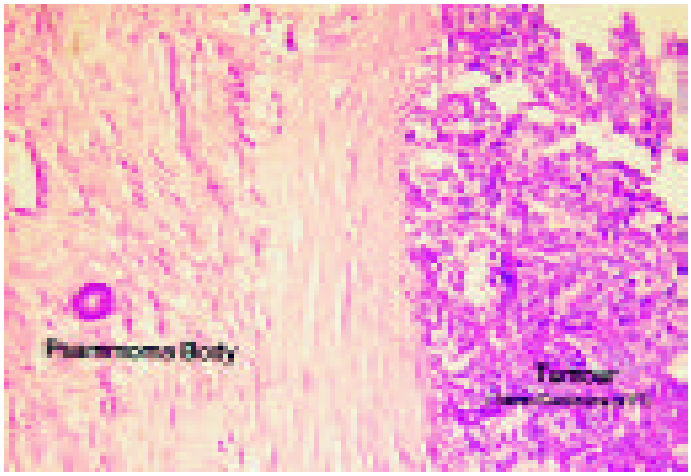

Figure 4. Psammoma body.

of primary fallopian tube carcinoma FIGO stage II A, was made. Her postoperative period was uneventful. She was discharged on 29th August, 2002 after giving one course of cisplatinum and cyclophosphamide. She has received six courses of chemotherapy. She is being followed up and has no trace of malignancy till December 2003.

Discussion

Primary fallopian tube carcinoma is very rare. Its incidence is about 1% of all female genital malignant tumors [1]. Its etiology is poorly known but high parity is considered to be protective. Low parity, late menopause, and chronic salpingitis have often been found to be associated with this malignancy. Peak incidence is between 60 and 64 years of age [1]. The case reported here was of low parity and 62 years age. The common symptoms reported are postmenopausal bleeding, abdominal /pelvic pain and vaginal discharge [2]. The most common physical sign is a pelvic mass. Our case presented as procidentia with no other symptoms and a pelvic mass was detected on examination. Staging system and management of fallopian tube carcinoma is same as that of ovarian carcinoma. Unlike ovarian carcinoma FIGO system assigns nearly two-thirds of patients to stage I or II [3]. Because of rarity and insidious onset of primary adenocarcinoma of the fallopian tube it is rarely suspected preoperatively. In many series diagnosis of fallopian tube carcinoma was missed in all cases. Distinction between ovarian and tubal pathology by transvaginal color and pulsed doppler depends on the stage and spread of the tumor [4]. Surgery remains the cornerstone of treatment and exploratory laparotomy with total abdominal hysterectomy, bilateral salpingo-oopherectomy, staging biopsies, and cytoreductive surgery is recommended. Sampling of para-aortic and pelvic lymphglands is also considered mandatory [5]. The basic management of fallopian tube carcinoma mirrors that of ovarian cancer with similar chemotherapeutic agents used. The 5 year survival for stage I and II is 60% on an average and for stage III and IV it varies from 10 to 19% [6].

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