



Fallopian tube carcinoma - A case report

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Introduction

Primary carcinoma of the fallopian tube is rare and accounts for about 0.3% of all gynecologic cancers. The first classic case was reported in 1886 by Orthmann ¹. Less than 1500 cases have been reported in the literature ². Etiology is unknown. It arises in postmenopausal women with a wide age range having a mean of 52 years. Correct diagnosis is rarely made preoperatively. Clinically tubal carcinoma closely resembles ovarian carcinoma. Bilateral involvement occurs in about 20% of cases.

For diagnosing primary tubal carcinoma, both the ovaries and the uterus should appear normal on gross examination. The tubes, at least in the distal portion should be grossly abnormal. The fimbriated ends, may be dilated and occluded resembling chronic salpingitis.

Case report

A 56 year old female was admitted for postmenopausal bleeding for 2 months. She had menopause 5 years back. She had four deliveries which were normal. She was hypertensive. Her blood pressure was 220/120 mm Hg. Speculum examination showed a small cervical erosion. On vaginal examination the uterus was anteverted and bulky, and through the left fornix, a orange sized mass with restricted mobility was palpable. Right fornix was normal.

Investigations

Her hemogram, and hepatic and renal functions were normal. Serum Australia antigen, VDRL, and HIV I and II were negative. Blood sugar and urine examination were reported to be normal. Blood group was 'O' positive, x-ray chest was normal. Sonography showed no abnormality in upper abdomen and revealed a uterus with normal echotexture, measuring 8.8 x 3.3 x 3.8 cm. Endometrial thickness was 4 mm. Right ovary measured 1.2 x 1.0 cm and had normal echotexture. Left ovary was enlarged, had solid and cystic component and measured 5.6 x 5.4 cm. There was no free fluid in the abdomen and pelvis. Serum CA - 125 was 164 U/mL (Normal upto 35 U/mL). Pap smear showed inflammatory picture.

With a provisional diagnosis of ovarian malignancy, total abdominal hysterectomy with bilateral salpingo-oophorectomy and omentectomy was done. The left sided adnexal mass was having flimsy adhesions to surrounding viscera and left ovary could not be identified separately from the mass.

Pathological examination of the specimen: On gross examination, the uterus and right fallopian tube were normal. Left fallopian tube was dilated in the distal part forming a mass measuring 8 x 5 x 4 cm, and involving left ovary which measured 3 x 1 cm. On cut surface the tubal mass showed granular yellowish and grey areas. The omentum measured 20 x 5 x 0.8 cm and appeared grossly normal. On microscopic examination the left tubal mass showed features of high grade papillary adenocarcinoma with areas of necrosis. Other findings were unremarkable.

Postoperatively six cycles of adjuvant combination chemotherapy including paclitaxel 175 mg / m² and carboplatin 300 mg/M² were given at 3 weeks intervals. Seven months after surgery, the patient is free of disease on sonography (USG) and is receiving radiation therapy.

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Figure 1. Total abdominal hysterectomy specimen with right sided tumor of fallopian tube distending tubal lumen with soft gray tissue.

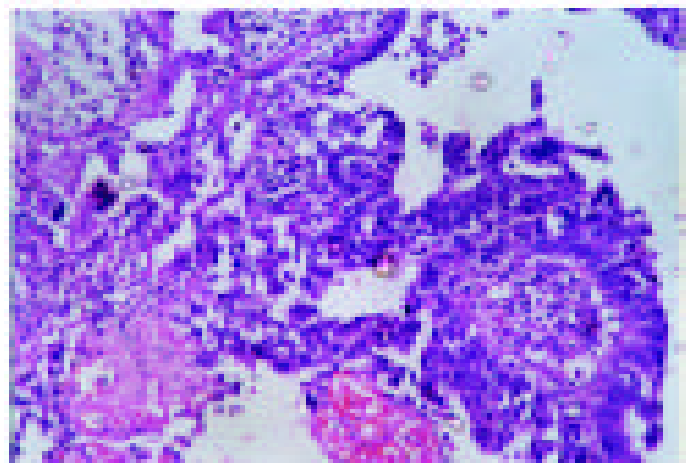


Figure 2. Microphotograph of adenocarcinoma of fallopian tube. Transition from normal epithelium to typical papillary pattern with invasion.

Discussion

The rarity of fallopian tube carcinoma has inhibited the definition of its natural history and of optimal treatment. Fallopian tube carcinoma has been reported to be diagnosed at an early stage¹. The stage of the disease and complete removal of gross disease are important predictors of overall survival^{3,4}. Peters et al³ reported that the malignant peritoneal cytology is the strongest predictor of overall survival and the only one to be significant in the multivariate analysis. Rosen et al¹ found that bleeding as a presenting symptom is associated with a significantly longer overall survival regardless of the stage of the disease¹. The rationale that bleeding is associated with

prolonged survival does not relate to early detection. Perhaps these tumors were more angiogenically active and more sensitive to anticancerous chemotherapy even in the advanced stage of the disease.

Negative second look laparotomy in fallopian tube carcinoma was associated with a greatly increased overall median survival⁵. Treatment of rare malignancies is always problematic as there is usually no standard therapy based on randomized studies and this holds true of fallopian tube carcinoma.

Since fallopian tube carcinomas resemble ovarian carcinoma, they have been treated in a similar fashion^{7,8}. It is difficult to comment on the optimal chemotherapy regimen for early stage disease. The use of paclitaxel has not been studied in these patients but should be considered because of its efficiency in the current management of advanced ovarian cancer.

Dasari and Vivekanandam⁹ report two cases of primary fallopian tube carcinoma of grade III treated with postoperative chemotherapy, one with cisplatin and cyclophosphamide and the other with the addition of vincristine.

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