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Case Report

Pathology Section

Primary Fallopian Tube Adenocarcinoma

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ABSTRACT

Primary fallopian tube carcinoma is a rare gynaecological malignancy. A post-menopausal woman who was aged 65-years was admitted to the hospital with complaints of severe abdominal pain and fever with chills for 2 days. A laparotomy was done and the final diagnosis was left tubal papillary adenocarcinoma, without any evidence of metastasis in the peritoneal cavity. The diagnosis of fallopian tube carcinoma is seldom made pre-operatively, because its signs and symptoms are not specific and it is often mistaken for an ovarian or a tubo-ovarian mass. We are reporting one such rare case of primary adenocarcinoma of the fallopian tube.

Key Words: Fallopian tube

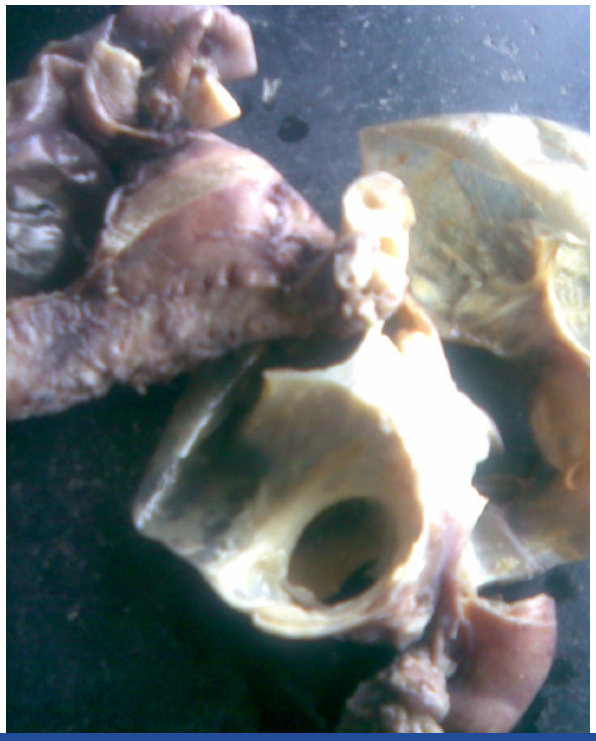
INTRODUCTION

Primary adenocarcinoma represents less than 1% of all the gyna-ecological malignancies which affect women in the fifth and sixth decades of their lives [1]. The incidence of tubal carcinoma is likely to be underestimated, since advanced cases with a spread to the ovaries are often misdiagnosed as ovarian carcinomas in most of the patients with tubal carcinoma, who have a mean age of 57 years. Secondary malignant lesions of the fallopian tube usually arise from the adjacent ovary or the uterus, occasionally from the gastrointestinal tract and rarely from the breast or peritoneal carcinomatosis [2]. An association of the BRCA-1 gene has been found in tubal carcinoma [3].

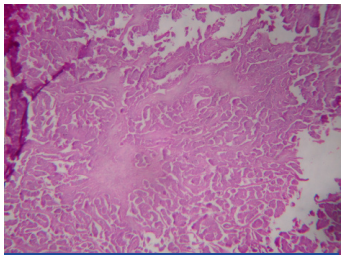
CASE HISTORY

A 65-years old, post-menopausal female presented with complaints of severe abdominal pain and fever with chills of 2 days duration. The patient had four, full term, normal, vaginal deliveries. She had complaints of a foul smelling white discharge for the past 3 months. On examination, the patient showed signs of pallor, along with fever. Her clinical examination revealed a normal-sized, anteverted, mobile uterus. The right adnexae were free and the left adnexae showed tendeness. Her routine examination was normal, except for the total leucocyte count (TLC) which was 12500 cumm, with the presence of neutrophilia. Her CA-125 level was raised. Ultrasonography of her abdomen showed a left adnexal mass without free fluid.

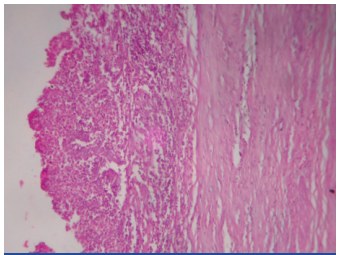
An exploratory laparatomy showed her uterus, bilateral ovaries and her right tubes to be grossly normal. The left tube was swollen and it was adherent to the left ovary. The omentum was normal and the iliac and the para aortic lymph nodes were not increased in size. A total hysterectomy with bilateral salphingo-oopherectomy was performed and the specimen was sent for histopathological examination. The cut section of the left tube showed purulent material and the fimbrial end was closed, which showed a mass which measured 3x2cm and was situated 2 cm away from the cornual end [Table/Fig-1]. Haematoxylin and eosion (H and E) stained sections showed tubal papillary serous adenocarcinoma without any evidence of metastasis [Tables/Figs-2 and 3]. The post-operative period was uneventful and the patient was followed up for 2 years. There was no recurrence of disease.



[Table/Fig-1]:



[Table/Fig-2]:



[Table/Fig-3]:

DISCUSSION

The prevalence of primary fallopian tube carcinoma is estimated to be between 0.15 and 1.8% of all the primary, female genital neoplasms [4,5]. In all the primary female neoplasms, the median age at diagnosis for fallopian tube carcinoma is 56.7 years (range 51 to 63 years). The disease is uncommon in women who are younger than 20 years and more than 65 % of the women are menopausal at diagnosis [6]. The diagnosis is usually unsuspected pre-operatively. In exceptional cases, unusual presentations have been observed, such as torsion, features of the para-neoplatic syndrome like dermatomyositis [7] a sinus in the posterior part of the cervix and a vesico-vaginal fistula. Further, the unusual presentations could include a distinctive presentation of an intermittent, profuse, watery, clear to yellow vaginal discharge which is accompanied by colicky abdominal pain, followed by a decrease in size of an abdominal mass (Hydrops tubae profluens).

The external surface of the tube could give an appearance of a hydrosalpix, a haematosalpinx or a pyosalpinx. The tumour which is located in the infundibulum is associated with a closed end, it is located in the fimbriae and it has a worse prognosis than intra tubal tumours, with a simultaneous depth of invasion. There is a bilateral involvement in 5% to 30% of the cases. The histology of tubal carcinoma is usually the same as that of ovarian carcinomas like serous, endometriod, transitional, undifferentiated, mixed cell, usually clear cell and mucinous carcinomas are rare. CA 125 is a useful marker for monitoring the treatment response and the disease progression. The most important prognostic factor is the stage of the disease. As in our case the stage was $1A_1$ (according to the FIGO staging system) with the tumour being limited to one tube without penetration to the serosal surface, with no ascites, the treatment was total hysterectomy with bilateral salphingo-oopherectomy. For aggressive tumours, chemotherapy is required.

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