CASE REPORT

Primary Bilateral Fallopian Tube Adenocarcinoma - A Case Report

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Abstract:

Cancer of the fallopian tube accounts for <0.1% of all gynaecologic cancers. Primary adenocarcinoma of the fallopian tube is usually unilateral , extremely rare that clinically and histologically resembles epithelial ovarian cancer(EOC).It is more common for cancer to spread or metastasize from ovaries or endometrium, than for cancer to actually originate in the fallopian tubes. Some of the common symptoms are abnormal vaginal bleeding, abdominal pain, abnormal vaginal discharge and pelvic mass which are present in up to two-thirds of patients and may mimic those of other gynecological problems. So we are presenting a rare case of stage IB primary fallopian tube cancer which is difficult to diagnose early.

Keywords: Fallopian tube, Primary adenocarcinoma

Introduction:

Primary fallopian tube carcinoma (PFTC) is a rare malignancy accounting for <1% of all female genital cancers [1]. Cancer of the fallopian tube may be either primary or secondary. Approximately 80% of the malignancies of fallopian tube are from other sites, most commonly from ovary, endometrium and gastrointestinal tract [2].

Primary adenocarcinoma of the fallopian tube is usually unilateral and is extremely rare. About 1,500 to 2,000 cases of fallopian tube cancer have been reported worldwide [2]. Because of the rarity of this cancer, little is known about what causes it. There is evidence that women who have inherited the gene linked to breast and ovarian cancer, called BRCA1, are also at an increased risk of developing fallopian tube cancer. Primary carcinoma of fallopian tube usually presents with various non-specific symptoms. The most common presentation is vaginal bleeding and discharge [3] followed by abdominal pain and abdominal mass [4]. Latzko's triad of symptoms namely intermittent serosanguinous vaginal discharge,colicky abdominal pain and abdominal or pelvic mass is seen in 11% of patients [5]. Another sign of fallopian tube carcinoma, hydrops tubae profluens (intermittent discharge of clear or blood tinged fluid spontaneously or on pressure followed by shrinkage of adnexal mass), is seen in about 9% of cases.

Most of the tubal carcinomas are diagnosed only at the time of surgery and some after histological examination. Pre operative diagnosis is made only in 4-6% of cases [6] clinically and histologically it resembles epithelial ovarian carcinoma. The diagnosis of PFTC is rarely considered preoperatively and is usually first appreciated at the time of operation or by a pathologist [7].

Case Report:

A 35 year old female presented with lower abdominal pain and vaginal bleeding since one month. Her menstrual history was normal. She had no history of taking hormonal contraception or tubal sterilisation. Ultrasonography revealed hypoechoic mass measuring 2x1cm in the uterus suggestive of leiomyoma. Hysterectomy with bilateral salpingo-oophorectomy was done. Specimen of uterocervix with bilateral adnexa was received. Uterocervix measure 6x4x2.5cm

both fallopian tubes measured 6cm (Fig. 1). Cut section of the uterus showed a well circumscribed nodule with a whorled appearance measuring 2x1cm and cut section of both tubes showed obliteration of the lumen by a mass measuring 2x2cm (Fig. 2)which was an incidental finding. Cut section of bilateral ovaries was unremarkable.

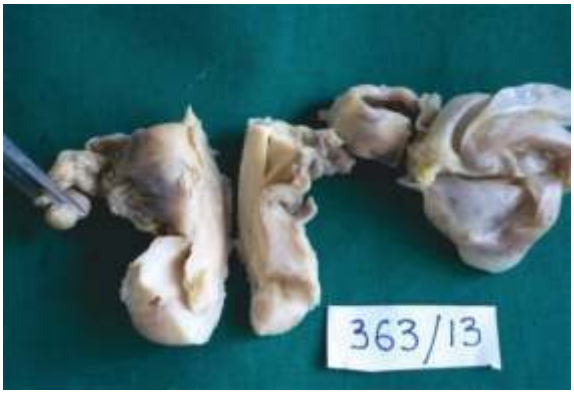

Fig.1: Specimen of Uterocervix with Fallopian Tube Adenocarcinoma

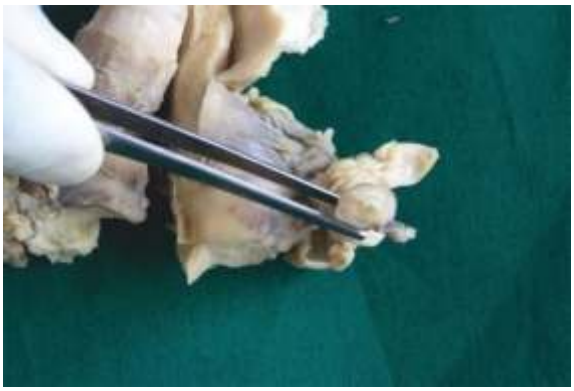

Fig. 2: Gross Photograph Showing Obliteration of Lumen of Fallopian Tube by a White, Firm Mass

Microscopy revealed normal histology of cervix, right and left ovary.

Bilateral tubes showed tumour tissue arranged in glandular pattern (Fig. 3) and at places in solid irregular sheets.

Tumour tissue comprised of multiple enlarged irregular glands formed by cuboidal to columnar epithelial cells containing enlarged, pleomorphic and hyperchromatic nuclei and eosinophilic cytoplasm (Fig. 3 and 4).

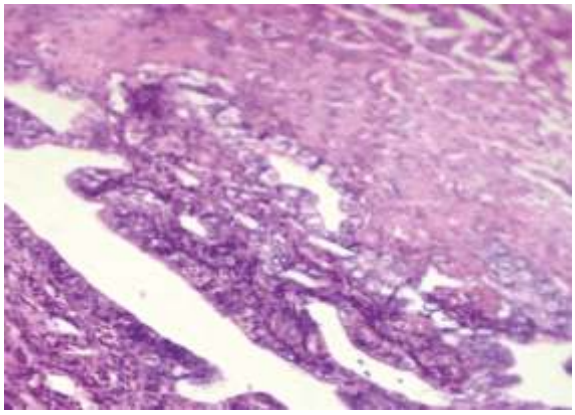

Fig. 3: Microphotograph (10x) Showing Primary Fallopian Tube Adenocarcinoma

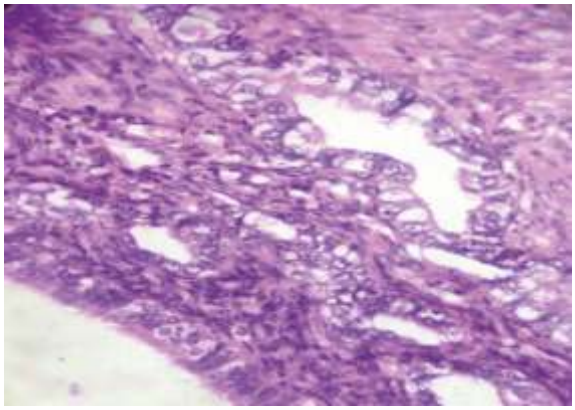

Fig. 4: Microphotograph (40x) Showing Tumor Tissue Arranged in Glandular Pattern with Pleomorphic Cells having Prominent Nucleoli

Discussion:

The aetiolgy of the disease remains unknown. The triad of pain, menorrhagia and leucorrhoea with an adnexal mass are considered pathognomonic of tubal cancer. Preoperative diagnosis of fallopian tube carcinoma is suspected in less than 5% of cases. Primary ovarian neoplasm is the most

common preoperative diagnosis made in these patients. Fallopian tube carcinoma is known to be insidious & asymptomatic for prolonged & variable periods of time [8].

The International Federation of Gynaecology and Obstetrics (FIGO) have formulated a surgico-pathological staging system and are essentially based on tumour penetration through the layers of tube. The FIGO staging system assigns nearly two-thirds of patients to stage I or II and is based on surgical staging criteria similar to ovarian cancer [9].

The definitive treatment is exploratory laparotomy to confirm the diagnosis and staging the disease & to remove the primary tumour along with total abdominal hysterectomy and resection of pelvic metastases

Conclusion:

This case was a stage IB primary fallopian tube adenocarcinoma. It is a very rare type of gynaecological malignancy which is difficult to diagnose early and carries a poor prognosis.

References:

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