GIANT FIBROMYOMA OF THE FALLOPIAN TUBE

by

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Fibromyoma of the fallopian tube is an extremely rare neoplasm. Stringer and Chalmers, in 1948, independently reviewed the literature. Baillie, in 1818, according to Herbut, recorded the first case. Even though embryologically the tube and uterus have a common Mullerian development, yet primary tumours of the tube are rare. Nonreactivity of the tube during menstruation makes it least prone to neoplastic proliferation. Fibromyomata of the tube are usually small and may be multiple. At times, they may be large and weigh two kilogrammes and be either sessile or pedunculated. Commonly, these tumours are seen near the uterine end of the tube and may be submucous, interstitial or subperitoneal. These fibromyomata do not manifest any pathognomonic symptoms and in the 57 cases reported in the literature actual diagnosis has never been made before operation. Most of them were mistaken for tumour of the uterus, broad ligament or of the ovary. These growths were said to be responsible for otherwise unaccountable menorrhagia and dysmenorrhoea.

Recently, we had come across a large fibromyoma; the fallopian tube origin was only revealed at the time of histological study. The detailed clinico-pathological findings of the same are recorded below.

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Case Report

K. A., female aged 60 years, was admitted under Dr. C. Savitri in the gynaecological ward, Government General Hospital, Guntur, for a tumour in the abdomen of 3 years' duration. Her last child is 12 years old. She had experienced no menstrual disorder. Uterine fibromyoma was clinically suspected. At laparotomy, a subperitoneal fibroid, adherent to the posterior aspect of the uterus, was observed. It was suspected to have undergone cystic or malignant change. Total hysterectomy and bilateral salpingo-oophorectomy were done.

Morbid Anatomy and Histology Of Tumour Excised (Biopsy Nos. 3028 A-P/61).

A large tumour weighing 8 kilogrammes was received on 17-10-61. It was pinkish white in colour. Sectioned surface presented whorled appearance with areas of cystic degeneration, the cysts enclosing jelly like material (Fig. 1). Sections studied from multiple blocks showed typical picture of fibromyoma undergoing hyaline change and oedema (Fig. 2). In a couple of sections the neoplastic tissue was seen to be lined with epithelium closely resembling that of fallopian tube (Fig. 3). In none of the sections of the tumour endometrial or other tissues could be made out. On critical naked-eye examination of the tumour, it was not possible to trace the link between the tube and tumour.

Fig. 1
Photograph shows the fibromyoma of the Fallopian Tube.

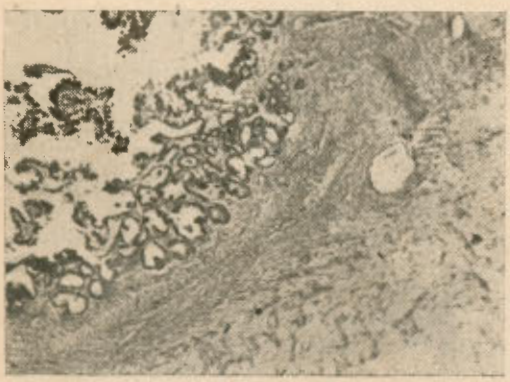

Fig. 2
Photomiiiograph illostrates fibromyoma undergoing hyaline change, bordered by tubal epithelium (H & EX 60).

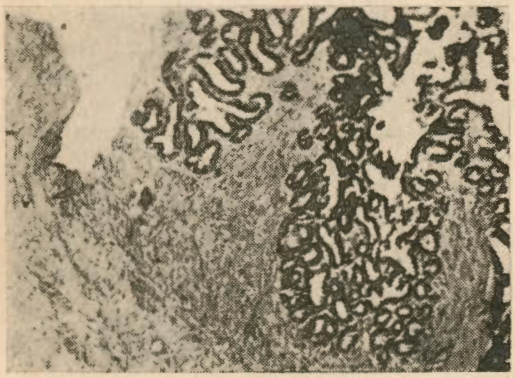

Fig. 3
Photomicrograph illustrates fibromyoma undered by tubal epithelium (H & EX 60).

Comment

It was not surprising that the true nature of the tumour was not disclosed until the histological study. It is unusual to encounter 8 kilogramme sized fibromyoma of the tube and this is probably very rare. Cystic, hyaline and myxomatous changes in a fallopian tube fibromyoma have been discribed. LChester and Harold reported a fibromyoma of the tube which was clinically recognised as fibroma of the ovary.

Summary

1. While reviewing the scanty available literature on fibromyoma of the fallopian tube, the rarity of the same is stressed.

2. A giant fibromyoma of the tube with hyaline and cystic change recognised at the time of histological study is described.

Acknowledgment

We are thankful to Dr. Mrs. C. Savitri, M.D., D.G.O., Additional Professor of Obstetrics and Gynaecology, Guntur Medical College, for the case history.

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The left ovary was fairly normal. (Refer to Fig.).

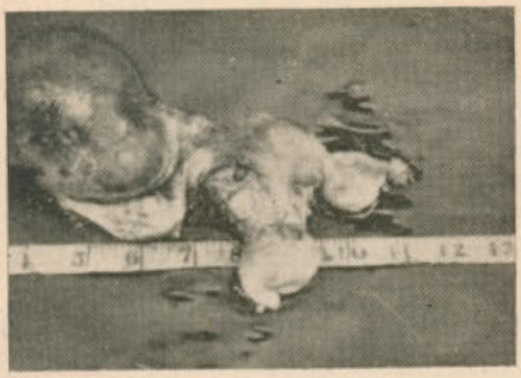

Fig. 1

In view of the history of menorrhagia, unhealthy condition of the whole of the right tube which precluded further conception, and particularly when she already had the desired number of children, a total hysterectomy and bilateral salpingo-oophorectomy was decided upon as the operation of choice.

The patient made an uneventful recovery.

Discussion

The subject presents two items of clinical interest. Firstly, the origin of hydrosalpinx. Secondly, the mechanism of the torsion itself.

The etiological basis of the hydrohalpinx is a matter of speculation only in this case.

Torsion of either hydrosalpinx or pyosalpinx is rare, because of the broad base of the meso-solpinx. That is why in spite of the numerous cases of pelvic inflammatory disease, with formation of hydrosalpinx, the incidence of torsion is very low.

The right tube revealed perisalpingitis and some amount of beading (Refer to Fig.).

The left tube must have had perisalpingitis. Hydrosalpinx occurring after perisalpingitis is rare. It is usually a sequel to gonococcal infection. But this hydrosalpinx appears to be due to pyogenic infection. Firstly, from the history itself, she had all full-term normal deliveries, except for puerperal pyrexia after the last delivery. Therefore there is no plausible reason to suspect that she had contracted gonococcal infection. Secondly, the presence of perisalpingitis in the right tube gives concomitant evidence. The mechanism of formation of hydrosalpinx in this case in perhaps due to fimbrial adhesions and accumulation of tubal secretion.

The torsion itself should have been rare due to adhesions caused by perisalpingitis, but it appears that the adhesions had become cleared due to treatment she had received for puerperal pyrexia.

It is difficult to explain the menorrhagia except that it may be due to concomitant inflammatory disease of the endometrium, and subinvolution of the uterus.

Diagnosis of twisted fallopian tube is always difficult by clinical examination, and is hardly ever made before operation. Most of the symptoms resemble a twisting of an ovarian cyst except for the difference that usually twist in an ovarian cyst, because of the long pedicle, occurs rapidly and therefore the symptoms of shock is a predominant feature. Due to the broad mesosalpinx the twist in this case was a slow procedure and therefore was not accompanied by shock.

The relatively mild nature of the symptoms and absence of shock in a case resembling a twisted ovarian

cyst should lead one to a diagnosis of twisted hydro- or pyosalpinx, if there is reason to believe from the past history that she had either pyogenic or gonococcal infection.

Acknowledgment

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