PRIMARY CARCINOMA OF THE FALLOPIAN TUBE

(A Case Report)

by

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Introduction

Primary carcinoma of the Fallopian tube is an uncommon neoplasm of the female generative tract. The reported incidence varies from 0.16% (Lafgren and Dockerty 1946) to 1.6% (Hayden and Potter 1960). Orthmann (1888) described the first authentic case of primary carcinoma of the Fallopian tube. Only very few cases have been reported in Indian literature (Chaudhary *et al*, 1954; Reddy 1967; Kehar and Saxena 1960; Masani 1960; Jhaveri and Shah 1961; Banerjee *et al*, 1964; Parmar and Fonseca 1966; Daruvala 1970 and Monga and Bhagwat 1971). Bhaskara Reddy *et al* (1965) reported seven cases from Guntur.

Case Report

A Mohammedan female, 44 years old, attended the Gynaecology out-patient with the complaints of lower abdominal pain and irregular bleeding for the last 1½ years and yellowish discharge per vaginam.

Menstrual history: Attained menarche at the age of 14, Cycles were regular, 3-4/28, flow normal, no dysmenorrhoea.

Obstetric History: Married for 25 years, sterile.

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The present illness started as pain in the lower abdomen 1½ years back with irregular bleeding occurring once in 2-3 months. Since five months there has been no bleeding. When seen she had only yellowish non-offensive discharge. No pruritus. Past history, nothing relevant.

On examination the patient looked somewhat ill-nourished, not anaemic. Cardiovascular and respiratory systems were normal. The abdomen was soft, moved freely with respiration, not tender and there was no palpable mass.

Per speculum, cervix appeared normal. Vulva and vagina were healthy.

Per vaginam, cervix was pointing forwards, uterus was retroverted and pushed to the left. A tubo-ovarian mass was felt in the right fornix about 8 x 5 cms. in size, not tender, firm in consistency with restricted mobility. Left fornix was free.

Hb 10.5 gms% TLC—6600/cm. DLC, poly 60%, lympho 30%, eosino 10%. ESR—12 mm/hr. Urine. Nil abnormal. BP 130/80 mm of Hg.

A provisional diagnosis of non-specific pelvic infection? Tuberculosis, or Malignancy of ovary was made.

A dilatation and curettage was done following preliminary course of strepto-penicillin. The histopathologic appearance was one of hyperplastic endometrium. She was given a course of chloromycetin and prednisolone. The mass persisted without any difference in the clinical findings. A laparotomy was done 1½ months after admission. On opening the abdomen, the uterus was found to be normal in size. There was a small fibroid in the anterior wall. Right tube was enlarged and thickened, fimbrial

end was adherent to the right ovary and the whole mass was adherent to the back of the uterus. The left tube was normal and the left ovary was cystic. The adhesions were separated and a panhysterectomy was done.

Gross Appearance: Panhystrectomy specimen, uterus measuring 7 x 4 x 2½ cms. Right tube and ovary form a solid retort shaped mass measuring 6 cm. in dia. at the tip. The Fallopain tube for about 2 cm. from the uterus was normal and the rest dilated. The left ovary was enlarged, 3 x 3 x 3 cms. Left tube, normal. Section of uterus showed normal appearance. Section of the right tube and ovary showed the Fallopian tube to be markedly dilated and filled with a yellowish-white granular mass (Fig. 1). The wall was thin. The fimbrial end was adherent to the ovary. The ovary was compressed. Left tube on section showed a normal appearance. Left ovary showed two small cystic spaces.

Histology: Section from the cervix showed acanthosis and hyperkeratosis of the squamous epithelial lining. The cervical glands showed epidermisation. The endocervical glands showed hyperplasia. Some of the cervical glands were dilated. There was subepithelial and periglandular round cell infiltration. The myometrium showed a few hyalinised blood vessels. Moderate hyperplasia of the endometrial glands Left ovary showed follicular cysts. The left tube showed moderate blunting of the endosalpinx. Sections from tubo-ovarian mass on the right side showed a malignant neoplasm arising from the endosalpinx and projecting into the lumen which was markedly distended (Fig. 2). The cells were large, round or oval with hypochromatic nuclei. They were arranged in a papillary as well as alveolar pattern (Fig. 3). The serous coat of the Fallopian tube showed groups of tumour cells. The ovary was adherent to the wall of the tube and showed infiltration by a few groups of tumour cells showing an adenomatous pattern. Follicular cyst and cystic spaces lined by flattened out cells were also seen. An area of calcification was seen in the cortical area. A histological diagnosis of carcinoma of the Fallopian tube (Papillary alveolar) was made.

The post operative period was uneventful.

Discussion

Primary malignancy of the Fallopian tube is rare. This is the first case the authors have seen in their experience, in this part of the country. It is often difficult to diagnose the case preoperatively. The present case was diagnosed as a pyosalpinx pre-operatively and on the operation table. Only after the histopathological study the true nature of the condition was obvious.

As in this case, the common age group in which the cases are seen is between 40-55 years. Coexistence of tuberculosis and carcinoma has been reported (Willis 1952). A possibility of a previous salpingitis has been suggested (Ewing 1940). In this case no clinical evidence of any anticedent disease could be identified.

Characteristic symptoms described are metrorrhagia, vaginal discharge, colicky type of abdominal pain and a lump in the pelvis. A positive vaginal smear with a negative currettage are pathognomonic of carcinoma of the tube (Sedlis 1961). No vaginal smear examination was done in this case.

As in the present case most often the involvement is unilateral. Bilateral involvement has been emphasised by Bland Sutton (Quoted by Jhaveri and Shah). Infiltration of the ovary is not uncommon and it is sometimes difficult to differentiate a secondary involvement of th tube from a primary carcinoma of the ovary or the uterus. The close attachment of the ovary to the tube in this case gave a doubt at first as to whether it was a secondary involvement of the tube. However, the intact compressed ovary with a few groups of malignant cells suggesting secondary infiltration and the demonstration of the origin of the tumour

from endosalpinx proved beyond doubt the primary nature of the condition. According to Hu *et al* (1950) the diagnosis of primary carcinoma of the Fallopian tube is accepted when the main bulk of the tumour arises from the mucosa of the tube and the uterus and ovary are normal or are involved lesion which are either of sufficiently small size to be considered metastatic or of independent origin.

The gross appearance varies from nodular enlargement of the involved area to an enlargement of the whole tube which presents a retort shaped appearance reminiscent of pyosalpinx or hydrosalpinx. However, adhesions are minimal.

Cut sections present a characteristic granular greyish white appearance of the mass occupying the distended tube. The tubal wall is markedly thinned out. Histologically it is an adenocarcinoma, either a papillary form or papillary alveolar form (Sanger and Barth). The papillary form is more common. Hu *et al* grade papillary as Grade I, papillary-alveolar, Grade II and alveolar-medullary as Grade III. According to the latter classification the histological appearance in this case is—that of a Grade II carcinoma.

The usually accepted line of treatment is a panhysterectomy Post operative irridiation is advocated. The five year survival in case of primary carcinoma of the Fallopian tube is surprisingly high (Sedlis 1961, Horten *et al* 1966).

Summary

A case of primary carcinoma of the Fallopian tube in a 44 year old nullipara is described. The diagnosis was made only after a histological study. The pathology of the condition is briefly discussed.

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See Figs. on Art Paper VI