PRIMARY CARCINOMA OF THE FALLOPIAN TUBE

(A Case Report)

by

KAMALA TIWARI,* M.S.

and

SHAHNAZ BEGUM NIAZI,** M.B.B.S.

Introduction

Primary carcinoma of the fallopian tube, is the least common malignancy of the Mullerian system. Only about 725 cases have been reported in the literature, so far, hence a gynaecologist comes across primary carcinoma of fallopian tube, only occasionally in her or his life time.

The first case of primary carcinoma of fallopian tube was described by Renaud (1847). The first authentic description has, however, been given by Orthmann in 1888 (Horten *et al*, 1966).

It occurs usually in women over 40 years, most often postmenopausally, the average age being 48 years, although Ross, Ward, and Lenbay reported 2 cases, in which the patients were below 18 years of age. 50% to 59% of cases are nulliparous. Hue *et al* (1950) recorded greater incidence in multiparous patients.

The commonest complaint is the appearance of a thin watery discharge between periods, or more frequently occurring postmenopausally. Occasionally, the initial complaint may be abdominal pain and distension, but these symptoms usually signify advanced disease. Sometimes relatively early cases have presented with pain, apparently due to tubal distension. Often there may be no symptoms, and the adenexal enlargement is discovered on routine pelvic examination.

From India, 2 cases each have been reported by Masani (1960) and Banerjee and Majumdar (1964), one case each by Choudhari *et al* (1954), Reddy (1957) Kehar and Saxena (1960), and Fonseca (1966).

Case Report

G. B. Hindu, 42 years old married woman was admitted for continous bleeding per vaginam and lower abdominal pain. of 2 months' duration following an amenorrhoea of 7 months. Her previous menstrual cycles were normal. She was sterile. Her marital life was 30 years. The bleeding was rather scanty, though continous. The pain was vague in nature.

Patient was of average built, there was no oedema of feet, no anaemia or lymphadenopathy. Her blood pressure was 110/70 mm of Hg., pulse 82/mt. regular and systemic examination did not reveal any abnormality.

Abdominal examination also did not reveal any palpable lump.

Vaginal examination, however, revealed a cystic mass about 8 cm. x 7 cm. in the right and posterior fornix. The mass was tender and behind the uterus which was normal sized and anteverted. The left ovary was palpable.

Speculum examination showed a healthy cervix and blood stained watery discharge was seen coming from the os.

Rectal examination confirmed the above findings. Provisional diagnosis of an ovarian tumour, probably malignant, was made.

**Reader.*

***Demonstrator, Obst. & Gynec., Pt. J. N. Medical College & Associated Hospital, Raipur.*

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Investigations: Hb. 13.6%. R.B.C. Count 4.9 million/cm. Blood urea. 20 mg.%. Blood Sugar. 100 mg.%. Urine normal.

A diagnostic curettage was done and histopathological report showed endometrial glands in proliferative phase with marked stromal congestion. There was no evidence of malignancy.

Exploratory laparotomy was performed. The findings were, a large hydrosalpinx measurng about 8 cm. x 6 cm. x 3 cm. of the right tube, which was adherent to the omentum. The adhesions could be separated easily. Right ovary was normal. Left ovary and tube were normal, uterus was normal sized, but contained a small fibroid 1 cm. x 1 cm. on the anterior surface near the left cornu. No secondaries on the omentum, intestines, or in the liver. Lymph glands not enlarged.

A total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. The post operative period was uneventful.

PATHOLOGY REPORT OF THE SPECIMEN:

Microscopic: (Fig. 1)

Uterus normal sized. Cervix hypertrophied. Myometrium—Intramural fibroid. Right ovary normal size. A cystic mass in the right tube, 12 cm. x 7 cm. wall papery thin. Cut section shows papillary projections (Fig. 2). Left ovary and tube normal.

Histopathology: (Fig. 3)

Uterus—multiple leiomyoma of uterus. Right tube-papillary adenocarcinoma. Right ovary—endometriosis and haemorrhages, along with lumen emboli in some blood vessels. Left ovary—endometriosis, left tube—chronic salpingitis.

Follow-Up:

Patient was sent for radiotherapy after discharge from hospital, but did not turn up after that.

Discussion

Though, metrorrhagia, pain and leucorrhoea are frequent symptoms this patient had continuous bleeding per vaginam after an ameonorrhoea of 7 months (? Menopause). Preoperative diagnosis was? Malignant ovarian tumour. The diagnostic curettage did not give any clue. Sadlis (1961) and Wharton (1947), however, have noted, that a positive smear combined with a negative curettage and biopsy was almost pathognomic of tubal malignancy, but in this case, we were more or less certain about our diagnosis and hence cytology was not done.

Distension of the tube with blood stained fluid, and invasion of the uterine cornu by cancer (or other disease) may result in sudden passage of a thin serosanguineous fluid associated with relief of the abdominal pain. However, this was not present in our patient.

According to Hu *et al* (1950) carcinoma of the fallopian tube is only accepted as being a primary carcinoma when the main bulk of the tumour arises from the mucosa of the tube and the uterus and ovaries are normal or are involved by lesions which are either benign or of sufficiently smaller size to be considered metastatic or of independent origin. Histologically, the malignancy is an adenocarcinoma, arising from the mucosa.

Although the left tube, showed chronic salpingitis in this case, chronic inflammation of the fallopian tube is probably not an etiological factor, because of the disparity of the incidence between tubal cancer and tubal infection.

The presence of fibroids in the uterus and endometriosis in the ovaries can be explained by the nulliparity of the patient. As mentioned previously tubal cancer is more common in nulliparous and so also, fibroids and endometriosis.

Preoperative diagnosis of tubal cancer is made only in 5% of the cases. In early cases the condition has been diagnosed, when exploratory laparotomy was performed for uterine bleeding of undetermined origin, or for some adenexal mass

or as an accidental discovey during an operation performed for some other condition like an ovarian tumour, fibromyoma, etc.

An exploratory laparotomy is always indicated for an adenexal mass specially in women of more than 35 years of age. If adenexal masses are treated conservatively in this age group, we may perhaps miss an increasing number of tubal cancers.

The treatment of carcinoma of fallopian tube is a total hysterectomy and a double salpingo-oophorectomy with as wide an excision of the involved tube as possible. If the lesion is adherent to a broad ligament, the latter structure, along with the parametrium should be excised, as widely as possible If the tube is found, adherent to the bowel, the adherent segment should be resected along with the pelvic organs.

Surgery alone gives poor results and hence it should be followed by routine pelvic irradiation post-operatively, Omentectomy is useful in the treatment of tubal carcinoma in eliminating the most common site of spread of the tumour to the upper abdomen, as well as a diagnostic aid in identifying microscopic spread of the tumour. Chemotherapy has not given encouraging results.

Prognosis is usually poor because of the late diagnosis, Hayman and Potter (1960) reported a 27% five year survival rate which Horton *et al*, (1966) gave a survival of 44%.

Summary

A case of primary carcinoma (papillary adenocarcinoma) of the fallopian tube in a women aged 42 years has been reported. Clinical features, pathology, and treatment of the primary malignancy has been discussed.

A plea for routine exploration of an adenexal mass, specially in a woman above 35 years of age has been made.

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See Figs. on Art Paper III