RARE CASE OF SARCOMA FALLOPIAN TUBE

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Primary sarcoma of the fallopian tube is one of the rarest malignancy of the genital tract. It is an unusual coincidence that Sanger reported the first case in 1886, in the same year that Orthomann called attention to the first authenticated primary carcinoma of the tube. Dodd in 1924 collected 12 cases and added two of his own. In 1946, Scheffey *et al.*, found 21 cases reported in the literature and added the 22nd case. Abraham and Kazal (1958) reported 9 cases of sarcoma of the fallopian tube. Till 1967 only 31 cases have been reported (Novak, 1967). In view of the rarity of this lesion, this case report has been presented.

CASE REPORT

Mrs. M. D., 45 years, postmenopausal for 5 years, married for 20 years, nulliparous, was admitted to the Gynaecological service of Nehru Hospital, Postgraduate Institute of Medical Education & Research, Chandigarh, on 20th September, 1973, with complaints off:

(1) Progressive swelling of the lower abdomen and colicky pain for 5 months.
(2) Intermittent watery discharge per vaginam for 4 months.
(3) Frequency of micturition for 4 months.

The present history started 5 months back when she noticed a swelling in the lower abdomen which had progressively increased to the present size. There was intermittent cramp like pain located on the left side of the lower abdomen which occasionally radiated to the left thigh. A month later she started having intermittent vaginal watery discharge along with frequency of micturition. There was no h/o retention of urine. She did not have any checkup before admission. She attained menopause 5 years back. Her past, personal and family history were non-contributory except that she had a history of pelvic inflammation at 20 years of age and has been taking various treatments without any relief.

Abdominal examination revealed a swelling in the suprapelvic region arising out of the pelvis, more to the left side of midline and extending 4" above symphysis pubis. The mass was irregular, variable in consistency, slightly tender and was fixed. There was no hepatosplenomegaly or ascites.

Bimanual pelvic examination revealed a healthy cervix pointing forwards and the uterus was retroverted, small and atrophied, not easily defined separate from the mass felt par abdomen. This mass was felt through all the fornices and was fixed.

A clinical diagnosis of bilateral malignant ovarian umour was made but in view of her age and parity sarcoma of uterus was also kept in mind.

Investigations

Hb = 10.4 gm%, PVC 30%, TLC =5000/chh, DLC = P65%, L30%, E5%. Blood urea = 27 mg% Urine = N. A. D.Bloodsugar fasting 87%, Random 140 mg%.

Pap. cercival smear—Type I. Post, vaginal pool smear—No malignant cells. I. V. P.:—N.A.D.

The patient had an exploratory laparotomy on 26-9-1973.

Abdomen was opened by a right paramedian skin incision. There was a small amount of

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haemorrhagic fluid in the peritoneal cavity. The tumour tissue was soft, friable, haemorrhagic and perforating through the capsule. The swelling was markedly adherent to uterovesical pouch of peritoneum, omentum and parietal peritoneum. Intestines were free from any adhesions. The stomach and liver were free from secondary metastases. There were no palpable paraortic glands. The uterus was atrophied. Right ovary and tube were healthy. Tumour was definitely arising from the left tube even though one failed to identify the left ovary separate from the mass. Adhesions were separated and attempts were made to remove the tube en mass alongwith the ovary but due to extensive adhesions and friability the mass was removed piecemeal.

Histopathological Report—"Multiple sections of the tumour showed a mixture of elongated spindle shaped cells, multinucleated giant cells Tumour shows highly ill-differentiated pleomorphic character showing mixture of different type of cells". There were no definite cell arrangement seen all through. At places it gave suggestion of whorling and intrafasciculate arrangement. There were extensive area of necrosis and haemorrhages. The morphological appearance and the reticuler staining of the section suggests that this tumour was more of a sarcomatous origin rather than a carcinoma".

Final pathological report:—

Lieomyosarcoma arising from tube.

Her postoperative period was uneventful and the patient was discharged on the 12th Post operative day with advice to have radiotherapy. She had two exposures of Telecobalt therapy (400 rads) and then failed to turn up for follow up.

Discussion

This type of malignancy of the fallopian tube usually occur in the premenopausal or postmenopausal epochs Anspach (1950). Only 2 cases were reported where the patients age was less than 24 years.

In nearly all cases, pain was a prominent symptom. Abdominal enlargement was sequentral to a late advancing lesion in 1/3rd of the patients Scheffey *et al.*, (1946).

Vaginal bleeding is not merely as well marked as in uterine carcinoma. This symptom is much more likely to be in the nature of watery blood stained discharge. The present case also gives a similar history Scheffey *et al.*, (1946). The physical signs may be regarded as early and late. In the former the presence of an adnexal mass is all that one can expect to find.

With progressive lesion, abdominal distension and ascites, knowing the clinical manifestations, early diagnosis as in malignancy elsewhere is the goal to be aimed at. Vaginal and cervical cytological smears for malignant cells should be taken and a diagnostic curettage performed. If the latter investigation fails to explain the postmenopausal discharge the possibility still remains of an ovarian or a tubal malignancy. In no case was the diagnosis of tubal malignancy entertained preoperatively. The preoperative diagnosis is generally that of ovarian malignancy, ovarian cyst, or pelvic inflammation. It is only on laparotomy that a diagnosis of tubal malignancy is made after histopathological examination of the specimen. Pathologically these lesions are usually leiomyosarcoma arising either secondarly in a pre-existing leiomyoma or primarily from the vasculature of the tube Roscher, (1956).

The treatment of such lesions is surgical as one might expect the diagnosis is usually made in the pathology laboratory. The procedure should be total abdominal hysterectomy with bilateral salpingo-oophorectomy. This is not always possible as has been learned from the cases reviewed.

Postoperative irradiation therapy is given when operation has been incomplete, or when metastasis has been observed. The question of irradiation when operation has been complete is debatable Scheffey, (1946). It should be apparent

too that the gross difference between sarcoma and carcinoma is impossible. Chemotherapy has very little role in such cases.

Prognosis

Whatever may be the line of treatment, the prognosis is extremely poor and similar to that recorded in sarcoma elsewhere. Curability can only be enhanced by early diagnosis and prompt treatment. The majority of the cases reviewed lived for less than 2 years and others failed to turn up for follow up.

Summary

A rare case of Primary Leiomyosarcoma in a Nulliparous woman has been presented. The problems in diagnosis and treatment have been discussed.

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