A CASE OF PRIMARY CARCINOMA OF FALLOPIAN TUBE

by

COLLEEN SRINIVASAN,* M.S., D.G.O.

Introduction

Primary Carcinoma of the Fallopian Tube is a comparatively rare lesion. Approximately 0.2 to 0.5 per cent of all primary malignancies of the genital tract arise in the tube.

CASE REPORT

Mrs. P., aged 55 years, was admitted to the Govt. RSRM. Lying-in Hospital, Madras, on 8-6-76 for the complaint of pain in the lower abdomen of 2 months duration and swelling in the lower abdomen of 1 month's duration. The patient had attained menopause 5 years ago. She had 2 normal full term deliveries. Her last childbirth was 33 years ago. Twenty years ago the patient had a laparotomy for a tubo-ovarian mass at which a right salpingo-oophorectomy was done. The patient developed vague lower abdominal pain 2 months prior to admission for which she had consulted a gynaecologist. Since, there was no palpable pathology made out, she was treated symptomatically. A month later she again presented herself to the same gynaecologist for swelling of the lower abdomen and lower abdominal pain.

An abdominal examination revealed a firm midline swelling arising from the pelvis about 6" in diameter fairly fixed, with a smooth surface and cystic in consistency. There was no evidence of free fluid in the peritoneal cavity. On doing a bimanual vaginal examination the cervix was pointing downwards, the uterus was bulky; the lower pole of the cystic swelling could be felt through the left fornix. On rectal examination, there was a suggestion of nodularity in the pouch of Douglas. A provisional diagnosis of a malignant ovarian tumour was made. The patient was not a diabetic and except for a mild degree of hypertension, all other investigations were within normal limits. On 30-6-76, the patient had a laparotomy. On opening the abdominal cavity, after releasing some omental odhesions, a large broad ligament cyst about 6" in diameter presented itself. While trying to release adhesions from the cyst wall, it ruptured and about 500 cc. of haemorrhagic fluid was aspirated. The capsule was adherent posteriorly to the small bowel and sigmoid colon; while releasing these adhesions, it was found that the left tube and ovary were adherent to the cyst wall. The tube appeared thickened and enlarged with a bulbous extremity; on cutting the bulbous extremity of the tube, a cauliflower growth about 2" in diameter could be seen protruding, which was friable. Macroscopically the left ovary appeared normal; the right ovary and tube had been removed at a prior operation 20 years ago. The uterus was enlarged to 8 weeks' size. A total hysterectomy with left salpingo-oophorectomy was done with removal of the broad ligament cyst. There was no ascites nor was there any evidence of secondary metastases in the peritoneal cavity.

The pathology report was as follows:

Endometrium atrophic.

Adenomyosis of the uterus.

Ampullary portion of the tube shows a papillary carcinoma.

Ovary was normal.

The Postoperative period was uneventful; she was given 5000 r with tele cobalt therapy. On 28-7-76, patient was discharged. A pelvic examination showed that pelvis was free.

Discussion

Adenocarcinoma of the fallopian tube is the least common of the malignancies found in the pelvic organs. Incidence is between 0.24 and 1.1% of gynaecological malignancies. The diagnosis is seldom made preoperatively. The diagnosis is considered to be among the most difficult

*Professor of Obstetrics and Gynaecology, Stanley Medical College, Madras.

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in gynaecology. In O.V. Jones review, only 10 cases out of 780 collected ones were diagnosed preoperatively. However, it is interesting that in retrospect, many patients with carcinoma of fallopian tube have sometimes exhibited a triad of symptoms namely yellowish discharge, metrorrhagia and pain. The cause of the discharge may be due to the venerable hydrops tubae profluens. According to Sedlis (1961) the mean age was 52 years. Sterility in patients with cancer of the fallopian tube has been known for some time. But, the cause has not been explained. If cytological study shows suspicious cells, while the histopathology of endometrium and cervix produce negative results the suspicion of a malignant lesion in the proximal part of internal genitalia cannot be ruled out.

Chronic inflammation of the tube has been suggested as an important predisposing factor and invariably tubo-ovarian adhesions are uniformly found, and the ovary is often difficult to identify. The tumour always involves the distal 2/3rds of the tube. The external gross findings are similar to those of a pyosalpinx with a friable, papillary tumour mass extending into the lumen. Bilateral involvement is present in one half of the lesion.

The difficulty of gross recognition, has led to less than ideal operations in many instances. Obviously hysterectomy with bilateral salpingo-oophorectomy is the ideal operation of choice, without lymphadenectomy, followed by postoperative external irradiation and chemotheraphy.

Since the fallopian tube is derived from the mullerian duct just as the uterus, some authors wonder whether progestational agents will have a part to play in the management of tubal carcinoma.

References

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