

# ADENOMATOID TUMOUR OF FALLOPIAN TUBE

## (A Case Report)

by

SAMAR KUMAR BASU,\* M.D.

and

S. K. DAS,\*\* M.D.

Since the "adenomatoid tumour was described by Golden and Ash (1945), cases had been added to the literature from time to time. Review of literature reveals it as one of the most uncommon benign neoplasm of female genital tract. Controversy regarding its histogenesis, peculiar benign nature of the tumour, and unexplained special predilection for its site of origin prompt us to present this case. The tumour presented in this paper was situated in the fallopian tube, a common site. Recent view about the histogenesis is discussed.

### CASE REPORT

H. A., a 35 years old female was admitted in the hospital with history of continuous vaginal bleeding for 2 months, swelling of abdomen and retention of urine. She attained menarche at the age of 14 years. She had 7 full term normal deliveries. Her last delivery was 3 years back. The patient was found to be anaemic.

### Abdominal Examination

Bladder was full. Approximately 300 ml. of urine was catheterised. Uterus was palpable above the symphysis pubis.

### Vaginal Examination

Uterus was pushed upward and forwards. Cervix was greatly elevated. A hard mass was

\*Registrar, Department of Obstetrics and Gynaecology, Safdarjang Hospital, New Delhi.

\*\*Obstetrician and Gynaecologist, Safdarjang Hospital, New Delhi.

Accepted for publication on 25-4-79.

felt arising from the cervix. Posterior vaginal wall was bulging to certain extent. Anterior fornix was deep. Posterior fornix was flattened. Pouch of Douglas was obliterated. A provisional diagnosis of posterior cervical fibroid was made. Laparotomy was performed after one unit of blood transfusion. Both ovaries were found to be enlarged. Left tube was enlarged at its fimbrial end with a tumour of  $1\frac{1}{2}$ " x  $1\frac{1}{2}$ " size. Right tube was normal. Body of the uterus was situated at the top of a big cervical fibroid about  $3\frac{1}{2}$ " x  $3\frac{1}{2}$ " size. Abdominal total hysterectomy with removal of fallopian tubes and ovaries was done after enucleation of cervical fibroid by bisecting the uterus.

### Histopathology

The bigger mass was diagnosed as fibromyoma with evidence of hyalinization at places. The mass from the fallopian tube showed epithelial cells in solid strands forming acini. At places cells were flattened, at places cuboidal, and other places even columnar. Stroma was having vascular and cellular connective tissue and at some sites papillary growth was seen—adenomatoid tumour of the tube.

### Discussion

A search of literature reveals 80 cases of adenomatoid tumour, 35 of which were in the uterus, 33 in fallopian tube, 6 in ovary and 6 in Broad ligament. The tumour is usually an incidental finding. Regins and Crane (1948) recorded 3 cases encountered in a total of 7485 removed fallopian tube i.e. an incidence of 0.04%. The interesting feature of adenomatoid tumour of fallopian tube is that more than

88% of them were found to be associated with uterine leiomyoma. The tumour is said to be 4 times more commoner in male than in female (Fajers 1949; Jackson 1958).

In the past, there has been considerable debate as to whether the adenomatoid tumour is of endothelial (Morehead 1946), mesonephric (Teel 1958; Teilium 1954) müllerian (Burke and Leslie 1954) or mesothelial (Masson *et al* 1942) origin. In recent years suggestion of Masson *et al* (1942) that these tumours are a form of mesothelioma is accepted. These tumours contain hyaluronic acid, a characteristic of normal or neoplastic mesothelium and the fine structure of this neoplasm is identical to that of extragenital mesothelioma (Mckay *et al*, 1971, Ferenczy *et al* 1972).

No case of malignant transformation of an adenomatoid tumour has been reported so far. However, many a question regarding its peculiar behaviour still remain unexplained. It is still not clear that though being of mesothelial origin it rarely arises

from the ovary as compared to fallopian tube. It is also unknown why the mesothelioma of genital tract should be so benign in nature while those elsewhere behave in a malignant fashion.

#### References

1. Burke, F. J. and Leslie, D. A.: J. Obstet. Gynec. Brit. Emp. 61: 817, 1954.
2. Fajers, C. M.: Acta Path. and Microbiol. Scandivan. 26: 11, 1949.
3. Ferenczy, A., Fenoglis, J. and Richard, R. M.: Cancer (Philad) 30: 244, 1972.
4. Golden, A. and Ash, J. E.: Am. J. Path. 21: 63, 1945.
5. Jackson, J. R.: Cancer. 11: 337, 1958.
6. Masson, P., Riopelle, J. L. and Simand, T. C.: Rev. Comad. biol. 1: 720, 1942.
7. Mckey, B., Binnington, J. L. and Skoglund, R. W.: Cancer. (Philad.). 27: 109, 1971.
8. Morehead, R. P.: Arch. Path. 42: 56, 1946.
9. Regins, A. B. and Crane, R. D.: Am. J. Path. 24: 933, 1948.
10. Teel, P. Am. J. Obstet. Gynec. 75: 1347, 1958.
11. Teilium, G.: Acta Path. et Microbiol. Scandinan. 34: 431, 1954.