BILATERAL PRIMARY CARCINOMA OF FALLOPIAN TUBE

(A Case Report)

by

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Introduction

Carcinoma of the tube is rarest of all the malignant tumours of genital tract. The incidence has been diversely estimated as 0.16 to 1.6% of all cancers of female genital tract and gonads (Emge, 1948; Finn and Javert, 1949; Hayden and Poller, 1960; Logfren and DockKerty, 1946; Robinson, 1936) and in all rather 600 cases have been recorded (Glenn, 1974).

Very few cases have been reported from India. Jhaveri and Shah, 1961; Banerjee and Majumdar, 1964; Parmar and Fonseca, 1966; Daruvala, 1970; Monga and Bhagwat, 1971; Harilal and Sharda, 1972; Tiwari and Niazi, 1973; Srinivasan, 1978.

But in none of the above cases the condition was bilateral. It has been reported in over 25% of cases (Sedlis, 1961; Wechsler, 1926).

CASE REPORT

Patient B. D. aged 40 years was admitted to Lady Reading Hospital on 21-4-1979 with history of pain in the abdomen difficulty in passing urine and irregular bleeding for the last 6 months. The pain was at times, acute.

She gave past history of having menorrhagia during her menstrual periods and bleeding lasted for 8-10 days. She had been married for last 27 years but was sterile.

On examination she was an average built middle aged anaemic woman. Heart and lungs were normal.

On abdominal examination a middline suprapubic firm, irregular, hard, mass was left reaching upto 2″ above the umblicus. No free fluid was made out.

On vaginal examination cervix was flush with the vagina. Size of the uterus was not made out. A tense cystic mass in the left and posterior fornices could be felt in continuation with the abdominal mass. There was another hard and modular mass in the right anterior fornix about 14 weeks pregnant uterus.

On speculum examination cervix appeared congested and there was dirty brownish discharge.

Most of the investigations were normal Intravenous pyelography showed both kidneys to be functioning normally. Both ureters, were dilated however, upto the level of the mass. Bladder was normal. Plain X-ray abdomen showed ill-defined soft tissue shadow.

Clinical diagnosis of bilateral malignant ovarian tumours was made.

Abdomen was opened by right paramedian incision. There was minimal haemorrhagic ascites. The distal portion of the right tube was cystic of 2″ x 3″ size. It appeared to be filled with haemorrhagic fluid and omentum

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and pelvic colon were adherent to this. Ovary on this side appeared normal. The distal portion of the left tube was also enlarged to form a partially cystic solid mass, 4" x 4" in size. Left ovary was very small and fibrotic and could not be identified clearly.

On both sides the cystic masses were adherent to the pouch of Douglas and outer surface of uterus. Utero vesical pouch, pouch of Douglas and omentum showed multiple nodular deposits. Panhysterectomy with partial omentectomy was done.

Pathological findings

Uterus, cervix with bilateral adenexa and a portion of omentum. On opening the cyst, lot of haemorrhagic fluid came out. The wall of the cyst showed multiple nodular papillary projections and the lumen of these cysts could be traced continuous with that of fallopian tubes. The isthmal end of fallopian tube on both sides appeared normal. On cutting open the uterus the uterine cavity and cervical canal and myometrium appeared normal, but the serosa on the posterior surface of uterus showed a small ill-defined nodular deposit. The omental pieces on examination showed multiple well circumscribed firm nodular masses.

On microscopic examination, microsections from dilated ampullary end on both sides showed evidence of papillary carcinoma. In few sections the malignant change was confined to the mucosa only, while other sections showed evidence of invasion in the wall of the tube. However, the isthmal end revealed chronic salpingitis and was free from tumour. Right overy showed normal appearance while the left ovary was fibrotic. Sections from uterus showed proliferative endometrium, myometrium was normal but the serosal surface of uterus showed carcinomatous deposits on the posterior surface. Omentum revealed metastatic papillary carcinoma.

Discussion

Though cases as young as 18 years or as old as 80 years have been reported, carcinoma of the fallopian tube, usually develops in women between 40-60 years of age (Sedlis, 1961) and this case also falls in this age group. 50-60% cases are nulliparous (Hanton *et al*, 1966). However, Hu *et al* (1950) recorded greater incidence in multiparous patients. Present case too happened to be a nulliparous woman.

Patients usually present with menstrual irregularities as menorrhagia, metrorrhagia, post menopausal bleeding, pain in lower abdomen and thin watery discharge in between the periods. In addition our patient had dysuria indicating that the tumour was producing pressure symptoms which was confirmed by intravenous pyelography which showed hydroureters.

Finn and Javert (1949) Logfren and Dockerty (1946) have postulated association of chronic inflammation with the carcinoma, especially in tubercular lesions in pelvis. Pelvic tuberculosis is very common in India but tubal carcinoma is very rare (Sharma and Bhuyan, 1973). However, tubo-ovarian adhesions are uniformly found and ovary is often difficult to identify as happened in the present case too on left side.

The diagnosis is seldom made, preoperatively (Srinivasan, 1978; Bontselis and Thompson, 1971). The present case was diagnosed as malignant ovarian tumour preoperatively while at the operation table it was thought to be? Haematosalpinx. One should differentiate between the primary carcinoma or metastatic growth of tube by the criteria mentioned by Sharma and Bhuyan, 1973.

All the criteria mentioned by them have been fulfilled in the present case to establish the diagnosis of primary carcinoma.

The tumour metastasizes to a neighbouring structures by direct spread through tubal ostium. Commonest sites being peritoneum ovary and endometrium. There was marked involvement of peritoneum with heavy omental metasta-

sis in the present case. The ovary and the endometrium being free.

Prognosis of tubal carcinoma is unfavourable because this carcinoma is usually overlooked in its early stage. The difficulty of gross recognitions had led to less than ideal operation in many instances. Obviously, hysterectomy with bilateral salpingo-ophorectomy is the ideal operation of choice followed by post operative irradiation and chemotherapy.

Summary

A case of Bilateral primary carcinoma of fallopian tube is reported and discussed.

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