An Unusual Cause of Post Menopausal Bleeding

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A 67 year old post-menopausal woman came to our OPD with complaints of bleeding PV for 15 days.

Menopause 20 years back. Her previous menstrual history was a regular 5/30 – day cycle. P4A2L4 – She had all FTNVD at home. She had 2 induced abortions. Her last child birth was 30 years back. A right-sided simple mastectomy with axillary clearance was done 4 years back which revealed an infiltrating ductal carcinoma. The nipple, aerola, overlying skin, and the margin of resection were free of the tumor. The biopsy report of the lymph nodes was negative & she had post operative radiotherapy. She was not a known diabetic, hypertensive, asthmatic, or tubercular patient. There was no family history of breast cancer or any other malignancy.

On examination, she was not anaemic. There was no lymphadenopathy or pedal oedema. B.P.: 120/70 mmHg. Mastectomy scar present on right side of chest. RS: Clear. P/A: soft abdomen, no mass palpable. P/S: Cx healthy. P/V: Uterus AV, exact size was not made out. A firm mobile mass, 5 cm in diameter was felt through the right, fornix-adjacent to the uterus. A preliminary diagnosis of adnexal mass was made.

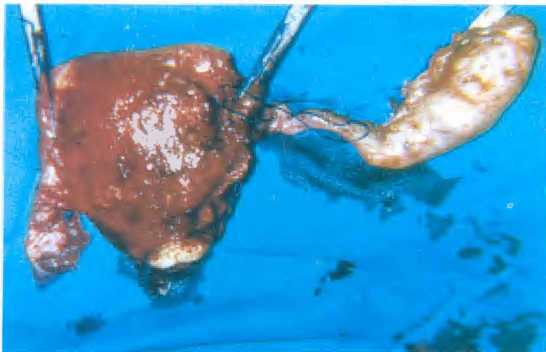

Fig. 1 Uterus with enlarged (L) fallopian tube

Routine investigations were within normal limits. Ultrasound showed a posterior wall fibroid with multiple calcifications present in the periphery of the uterine wall. Endometrial thickness 4.6mm. Pap Smear: no evidence of dysplasia or malignancy. Fractional currettage showed an atropic endometrium with a strip of normal looking squamous epithelium. As bleeding persisted she was posted for laparotomy.

At laparotomy it was found that the uterus, superior surface of the bladder and left tube showed a shaggy, appearance with tubercles. The uterus was 10 wks size. The right tube and ovary were normal. The left tube was enlarged to approximately 10x5 cm and adherent to the posterior peritoneum. The bladder could not be pushed down, hence a supra cervical hysterectomy was proceeded with (Fig. 1). The enlarged left tube could not be completely released en-mass from the adhesions, so a 2x2 cm distal portion was left in situ. On cut section uterus appeared normal. The left tube revealed necrotic material with hypertrophid wall. The biopsy report revealed a poorly differenciated adenocarcinoma of the fallopian tube with massive necrosis and infilteration of the uterus. Serum CA-125 was 93.3 u/ml. (N 0.0 – 35.0 u/ml).

Primary adenocarcinoma of the fallopian tube is the most infrequent of gynaec malignancies forming 0.3% of all gynaec cancers. In this patient this was the second malignancy, earlier being ductal carcinoma of the breast, so there was a controversy as to whether this was primary or secondary. The histopathology was however strongly suggestive of a primary adenocarcinoma of the tube, however differenciation is possible only by immunohistochemical studies. But whether primary or secondary once serosal penetration has occurred, the prognosis is poor.