

## Case Report

### A Rare Case Of Fallopian Tube Cancer

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**Abstract:**

Fallopian tube carcinoma is a very rare malignancy and we report a case of stage IIC primary fallopian tube cancer.

**Key Words:** Fallopian tube, Primary carcinoma

**Introduction:**

Cancer of the fallopian tube accounts for only 1 to 2 percent of all gynecologic cancers.(1) Primary adenocarcinoma of the fallopian tube is usually unilateral and is extremely rare. About 1,500 to 2,000 cases of fallopian tube cancer have been reported worldwide. Approximately 300 to 400 women are diagnosed with the condition annually in the United States. It is more common for cancer to spread, or metastasize, from other parts of the body, such as the ovaries or endometrial, than for cancer to actually originate in the fallopian tubes.

Fallopian tube cancer typically affects women between the ages of 50 and 60, although it can occur at any age. It is more common in Caucasian women who have had few or no children. Because this cancer is so rare, little is known about what causes it. However, researchers are investigating whether genetics play a role. There is evidence that women who have inherited the gene linked to breast and ovarian cancer, called BRCA1, are also at an increased risk of developing fallopian tube cancer.

The symptoms of fallopian tube cancer also may mimic those of other gynecological problems. Some

of the more common symptoms of the disease are a) abnormal vaginal bleeding, especially after menopause b) abdominal pain or a feeling of pressure in the abdomen c) abnormal vaginal discharge that is white, clear or pinkish d) a pelvic mass at the time of diagnosis, which is present in up to two-thirds of patients.

**Case Report:**

A 48 years old lady, mother of one child, was admitted at NRS Medical College, Kolkata on 13.02.2005 with acute pain and a mass in the lower abdomen for 5 days. She was a resident of Purbasthali, in Burdwan district. Her menstrual history was normal and she was referred by a consultant with a diagnosis of a acute torsion of ovarian tumour. On examination, the patient was haemodynamically stable, pulse rate 86/min, blood pressure 126/84 mmHg, had mild pallor and normal breasts. Abdomen was soft. There was an ill-defined, tender mass in the lower abdomen, partly cystic and partly solid in feel, variegated surface and of the size of 6"X6" with restricted mobility. The pain subsided on conservative treatment with antibiotics, anti-inflammatory drugs, sedation and analgesics. On further investigations, hemoglobin was 8gm%, and other routine blood biochemistry were normal. Ultra sound examination showed a pelvic mass of possible ovarian origin arising from the left side. The other ovary and uterus appeared normal and healthy. Upper abdomen did not reveal any evidence of metastasis.

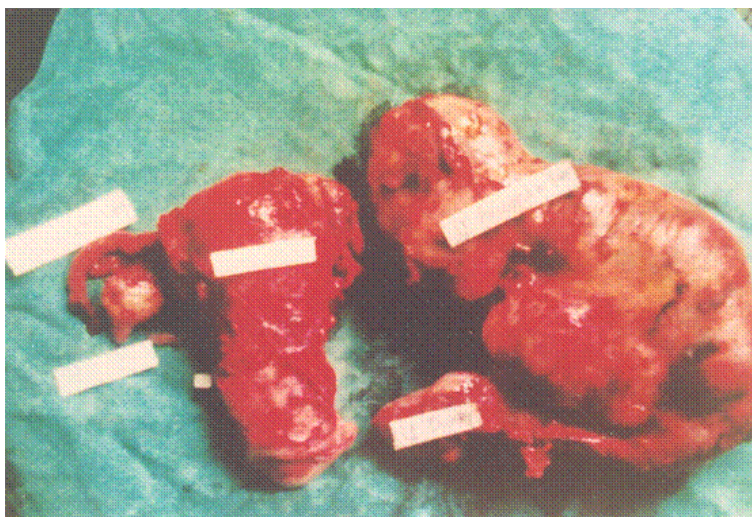


Photo of postoperative specimen of fallopian tubal cancerous mass along with normal uterus and ovaries

Laparotomy was done on 18.02.05 after stabilizing the patient with 2 units of pre-operative blood transfusion. On opening the abdomen, a hugely distended growth was seen to arise from left fallopian tube. The growth appeared haemorrhagic, adherent to the gut, omentum and the posterior surface of the uterus. The peritoneal fluid after saline wash was collected for cytology. Liver, undersurface of the diaphragm, paracolic gutters, peritoneum, gut, omentum and para-aortic space were explored and found free of any metastasis. The pouch-of-douglas (POD) when approached was found to have metastatic deposits. Total abdominal hysterectomy with bilateral salpingo-oophorectomy and infra-colic omentectomy was done after releasing all adhesions. The metastatic deposits in the POD was removed partially with as much debulking as possible because of its friable nature and gross adhesions. The patient had an uneventful postoperative period. The histopathology report of the mass confirmed papillary adenocarcinoma of the left fallopian tube, the nodule in POD revealed metastases and peritoneal wash had malignant cells. The patient was referred for chemotherapy but did not turn up. She returned after 7 months with bleeding per vagina from a metastatic growth at vaginal vault. The mass regressed with 6 cycles of chemotherapy with cisplatin and cyclophosphamide. The patient remains asymptomatic and is still under follow-up.

#### Discussion:

Cancer of the fallopian tube may be either primary or secondary. Most tumours involving the fallopian tube are metastatic (80%), mainly from ovarian cancer as well as from endometrial and gastrointestinal tumours.<sup>(2)</sup> Primary adenocarcinoma of fallopian tube is usually unilateral. The fallopian tube cancer is extremely rare and comprises only 0.3-0.5% of all gynaecological malignancies. The aetiology of the disease remains unknown. Many of the patients are nulliparous and infertile. Fallopian tube carcinoma may remain asymptomatic in early stage of the disease. The usual presenting symptom is perimenopausal or postmenopausal bleeding per vagina seen in about 50% of the patients. The patient may also complain of continuous watery or amber coloured vaginal discharge and lower abdominal pain.

The most common finding on physical examination is a palpable pelvic or abdominal mass that occasionally has a characteristic sausage shape. The triad of pain, menorrhagia and leucorrhoea with an adnexal mass are considered pathognomonic of tubal cancer. Ascites is rarely present. Preoperative diagnosis of fallopian tube carcinoma is seldom made prior to surgery. It is suspected in fewer than 5% of cases preoperatively. Primary ovarian neoplasm is the most common preoperative diagnosis made in these patients.

Ultrasound, both abdominal and vaginal, is accurate to diagnose fallopian tube pathology when it demonstrates a cystic and solid mass in the adnexal region in the presence of an identifiable separate ipsilateral ovary. Computed tomography may be helpful for localising distant spread to other intra abdominal or retro peritoneal structures. The International Federation of Gynaecology and Obstetrics (FIGO) has formulated a surgico-pathological staging system and is essentially based on tumour penetration through the layers of tube.

The definitive treatment is exploratory laparotomy to confirm the diagnosis, and staging the disease, to remove the primary tumour along with total abdominal hysterectomy and bilateral salpingo-oophorectomy and resection of pelvic metastases. It appears that cisplatin based chemotherapy improve long term survival in patients with advanced disease as in this case. Its benefit as adjuvant therapy for early stage disease has not been defined. The role of second look surgery is controversial. The prognostic factor that directly correlates with survival is stage of the disease at the time of surgery.

#### Conclusion:

Fallopian tube cancer is a very rare type of virulent genital cancer which is difficult to diagnose early and carries a poor prognosis. Thus pre-operative diagnosis of fallopian tube carcinoma is seldom made and most of the time the diagnosis is made on the operating table. This case was a stage IIC primary fallopian tube cancer. The 5-year survival of stage II disease reported in one report of FIGO published in 1983 were 52%. Chemotherapy with cisplatin containing regime improve the long-term survival.

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