Case Report:
Primary Papillary Adenocarcinoma of Bilateral Fallopian Tubes.

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Abstract: Primary carcinoma of fallopian tube is one of the rarest malignancy of female genital tract accounting for about 1% of primary genital tract malignancies. Primary fallopian tube carcinoma clinically and histologically resemble primary ovarian cancers. The preoperative diagnosis of tubal carcinoma is rarely correct as the classical clinical triad is present in less than half of the cases and the usual ultrasound findings only suggest hydrosalpinx so, in most of the cases it is the pathologist who appreciates the tumor histologically. Because of the rarity of this tumor, a primary bilateral papillary adenocarcinoma of fallopian tubes in a perimenopausal female is presented highlighting its clinical, morphological and radiological features.

Key Words: Carcinoma, Bilateral, Fallopian tubes.

Introduction:
Fallopian tube carcinoma was first described in 1847. Since then over 2000 cases have been reported in literature. Primary fallopian tube carcinoma (PFTC) is rare, uncommon tumor of female genital tract with annual incidence of about 3.6 per million women per year.(1) Most patients are menopausal and present with atypical irregular vaginal bleeding.(2,3) The cervicovaginal smears are positive in only minority of cases but endometrial smears will may reveal malignant cells in high percentage of cases.(3) The tumor may be bilateral but more often the contralateral tube is either normal or the site of hydrosalpinx.(3,4) The criteria for the diagnosis of PFTC is very rigid because frequency of this tumor is only a tenth of that of direct tubal extension by uterine or ovarian extension.(3) PFTC is similar to epithelial ovarian cancers histologically, and in surgical staging/management. The prognosis of tubal carcinoma depends more on staging and residual tumor mass rather than on the histologic grade.(5-7)

Case Report:
A 40 years old multigravida presented with irregular bleeding per vaginum, for 4 to 5 months along with dysmenorrhea and yellowish white discharge. Her general physical condition was satisfactory. Vaginal examination showed antverted normal sized uterus with tender, palpable adnexal masses in both the fornices. Cervicovaginal cytology was not done in the patient. Ultrasonography showed massive bilateral hydrosalpinx with normal appearing uterus. Ovaries were not visualized. Special investigations like CT / MRI were not done in the patient. Routine haematological investigations with complete urine examination were within normal range except for mild anemia. Chest X- ray was normal. Patient underwent panhysterectomy and biopsy was sent for histopathological examination. Grossly, the specimen measured 10.0cm x 7.5cm x 5.5 cm in size. Both the tubes were markedly dilated. Cut surface of uterus, cervix and ovaries were unremarkable. The cut section of both the tubes showed firm to friable greyish white papillary growth present in the distal half of the tubes and partially filling the lumen of the tubes. Necrosis was also seen grossly. Microscopically, tumor composed of solid sheets, acinar formations and papillary structures of highly malignant looking epithelial cells showing features of papillary serous adenocarcinoma. High mitotic count with large areas of tumor necrosis was seen . Tumor cells extended up to serosa. Vascular invasion was also seen. Patient was followed up for eight months after which contact with the patient was lost. Patient was symptomatic during the follow up period.
Primary carcinoma of fallopian tube is rare, uncommon tumor of female genital tract and accounts for 0.14% - 1.8% of all gynaecologic cancers that clinically and histologically resemble epithelial ovarian cancer.(1,8) Most patients are menopausal with a mean age of 57 years. The patient usually presents with atypical irregular vaginal bleeding with or without clear to yellowish discharge.(1,2) Patients with PFTC appear to have shorter history of presentation as compared to epithelial ovarian cancers.(9) Latzko’s triad, including intermittent profuse serosanguinous vaginal discharge, colicky pain relieved by discharge and abdominal / pelvic mass is present only in minority of patients and therefore preoperative clinical diagnosis of PFTC is seldom made and in most cases the diagnosis is usually made on the operating table or by a pathologist in the lab.(4,6,7)

The etiology of this tumor is unknown. High parity has been reported to be protective and use of oral contraceptives decreases the risk of PFTC.(8) The tumor usually involves the ampullary part of fallopian tube. Bilaterality has been reported in 10% - 20% cases but more often the contralateral tube is either normal or the site of hydrosalpinx.(3,4)

PFTC is rarely asymptomatic as compared to epithelial ovarian cancers. Compared with ovarian carcinoma, primary fallopian tube carcinoma more often presents at early stages, due to abdominal pain secondary to tubal distention but it has a worse prognosis.(4) It should be suspected in cases of postmenopausal bleeding or spotting with negative diagnostic curettage. The cervicovaginal smears are positive in only 10% to 36% of cases.(3,9)

The criteria for the diagnosis of PFTC is very rigid because frequency of this tumor is only a tenth of that of direct tubal extension by uterine or ovarian extension. In PFTC, the uterus and ovaries should appear largely normal on gross examination; the foci of malignancy in these organs, when present, should have the appearance of metastases or independent primaries by virtue of their size and distribution.(3) Histologically, about half of the tubal carcinoma are serous, roughly a fourth are endometrioid, a fifth are transitional or undifferentiated and remainder are of other epithelial cell type.(3)

Prognosis of tubal carcinoma depends more on clinical staging and residual tumor mass rather than on histological grading. Involvement of tubal serosa, of the ovary or corpus uteri or of other pelvic and abdominal structure indicates a poor prognosis.(3,5) Stage 0 is in situ carcinoma limited to tubal mucosa, grade I is tumor limited to fallopian tube, grade II and III are tumor extending outside the tube and spreading into pelvic and abdominal organs respectively.(3) PFTC carries a 5 year survival rates of about 68 – 76% for stage I disease, 27 – 42% for stage II disease and 0 – 6% for stage III & IV disease, so it is very important to diagnose these neoplasm at very early stages.(7) In our case it was a Stage II Serous papillary adenocarcinoma.

Lymphatic spread is less common and depends on tumor grade. Patients of PFTC have higher chances of retroperitoneal and distant metastases.(5) Tumor marker such as CA 125 is a useful marker for diagnosing, assessing response to treatment and detecting tumor recurrence during follow up.(10)

References