Primary Fallopian Tube Carcinoma: A Case Report
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ABSTRACT
Primary fallopian tube carcinoma (PFTC) is an uncommon tumor accounting for approximately 0.14–1.8% of female genital tract malignancies. We report a case of PFTC in a 65-year-old female who presented with abdominal pain and watery vaginal discharge. The peak incidence of PFTC is between the ages of 60 and 64 years. Very often the diagnosis is mistaken for an ovarian carcinoma or a tubo-ovarian mass. The criteria for the diagnosis of primary tubal carcinoma should be very rigid. In primary tubal carcinoma, the uterus and ovaries should appear largely normal on gross examination. The prognosis of tubal carcinoma depends more on staging than histologic grade. Invasion of tubal serosa, of the ovary or corpus uteri, or of other pelvic and abdominal structures indicate poor prognosis.

Key words: Carcinoma, primary fallopian tube, total abdominal hysterectomy, serous papillary adenocarcinoma

INTRODUCTION
Primary fallopian tube malignancy is the least common of all gynecological malignancies. It accounts for approximately 0.14–1.8% of female genital tract malignancies. Primary fallopian tube carcinoma (PFTC) is not routinely suspected preoperatively.

CASE REPORT
A 65-year-old post-menopausal female was admitted for abdominal pain and watery vaginal discharge for 6 months. Per speculum examination showed minimal serosanguinous discharge with healthy cervix and vagina. Per vaginal examination revealed a normal sized antverted uterus with clear fornices. Her hematological and biochemical investigations were within normal limits. Ultrasonography showed bulky uterus along with multilocular cystic mass in the left adnexa measuring 11 cm × 9 cm × 0.2 cm suggestive of hydrosalpinx. The right tube and ovary were normal. Total abdominal hysterectomy was done and specimen was received in the department of pathology. Gross on gross examination, the uterus and the right fallopian tube and ovary were normal. The left fallopian tube was dilated in the distal part forming a mass 11 cm × 8.5 cm × 0.5 cm. On cut section, the tubal mass was multilocular containing serous fluid; the tubal wall showed the presence of grayish white, papillary, polyloid, and friable growth. The left ovary was normal and measuring 3 cm × 2 cm × 1 cm. Microscopy on microscopic examination, the left tubal mass showed features of serous papillary adenocarcinoma [Figures 1-3].

DISCUSSION
PFTC is an uncommon gynecological malignancy and is generally recognized as a disease of menopausal

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women. The earliest description of this entity was given by Reynaud in 1847 and the first microscopic description was recorded by Rokitansky in 1861. The first classic case was reported by Orthmann in 1886.

Nulliparous women are at higher risk for developing PFTC. Most patients of tubal carcinoma are post-menopausal, with a mean age of 57 years. Our patient was a 65-year-old post-menopausal female with two living children. Tubal carcinoma is now being encountered with increased frequency with germline mutations of BRCA1 and BRCA2.

The typical presenting symptoms include abdominal pelvic pain or symptoms of pressure and vaginal bleeding.

Latzko’s triad of symptoms consisting of intermittent, profuse, serosanguinous vaginal discharge, colicky abdominal pain relieved by discharge, and abdominal or pelvic mass have been reported in 15% of cases. Hydrops tubae profluen implies intermittent discharge of clear and blood-tinted fluid spontaneously or on pressure followed by shrinkage of adnexal mass occurs in only 5% of patients. The classic syndrome of crampy lower abdominal pain followed by profuse watery discharge has been found only in 15% of patients with PFTC, while the most common complaint is abnormal vaginal bleeding. Our patient presented with abdominal pain and serosanguinous discharge. Due to its rarity, correct pre-operative diagnosis is rarely made, and it is usually misdiagnosed as ovarian carcinoma. PFTC should be included in the differential diagnosis and especially if the patient has clinical symptoms such as vaginal discharge or abnormal genital bleeding with negative diagnostic curettage.

CA-125 is elevated in 65% of cases. Hence, it should be used in the diagnosis and follow-up. Tubal carcinoma characteristically appears as fusiform swelling that may have external appearance of a hydrosalpinx or hematosalpinx. Some tumors are completely solid and others are predominantly cystic.

Primary adenocarcinoma of fallopian tube with papillary features is the most common histological type of primary tubal cancer (>90%). The pathological diagnostic criteria were first put forth by Hu et al. which were later modified by sidles. PFTC is diagnosed if (a) grossly, the main tumor is in the tube and is seen arising from the endosalpinx, (b) histologically, the pattern reproduces...
the epithelium of the fallopian mucosa and shows a papillary pattern, (c) transition from benign to malignant tubal epithelium should be demonstrated, and (d) the ovaries and endometrium are normal.[9] All the above criteria were exactly fulfilled by the tumor detected in our case, and hence, the diagnosis of PFTC was made. The tumor spreads by local invasion, transluminal migration, through the lymphatics and the bloodstream.[8] In this case, the tumor was confined to the tube only.

Surgery is the treatment of choice for PFTC and the surgical principles are the same as those used for ovarian cancer. The procedure of choice is total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, selective pelvic, and para-aortic lymphadenectomy for any stage of fallopian tube carcinoma.[9] Chemotherapy is advocated for patients with early stage disease.[7] In our case, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done and the patient was referred for chemotherapy.

CONCLUSION

PFTC is a rare tumor accounting for 1% of all female genital tract cancers. The diagnosis of PFTC is rarely considered preoperatively and is usually appreciated at the time of operation or by pathologist. Therefore, PFTC should be considered in the differential diagnosis in case of a post-menopausal female presenting with the above clinical features.

REFERENCES


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