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Primary adenocarcinoma of the fallopian tube -A case report

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Summary

Adenocarcinoma of the fallopian tube is a rare clinical entity. The incidence of primary tubal carcinoma has been reported as varying from 0.1 to 1.0 percent of all gynaecological malignancies. In Malaysia the incidence is unknown. A case of primary adenocarcinoma of the fallopian tube is reported.

Key words: Primary adenocarcinoma, Fallopian tube.

Case Report

The 51 year old Indian, para three, was seen with complaints of blood stained per vaginal discharge of eight months duration. She had seen a couple of doctors for this problem and was subjected to numerous high vaginal swabs for culture and sensitivity tests and two pap smears. She was given antibiotics and vaginal pessaries. All investigations were normal. She did not respond to the above therapy. She was referred to the Gynaecology Clinic when she started to have abdominal pains along with her vaginal discharge, which was becoming more profuse.

On examination, her general condition was fair. All systems were normal. On abdominal examination, there was slight tenderness on deep palpation, in the right iliac fossa. Vaginal examination revealed a 3cm x 2cm right adnexal mass. It was fixed to the right border of the uterus and was tender on rocking the uterus. There was watery blood-stained discharge from the os. A diagnosis of carcinoma of fallopian tube was made. She was listed for laparoscopy and diagnostic endometrial currettage. Laparoscopy confirmed the diagnosis of right fallopian tube tumour. The endometrial currettage and pap smear were normal.

At operation, the right fallopian tube had a cystic, firm mass, at its fimbrial end measuring 3cm x 2cm. The left fallopian tube, uterus, cervix both ovaries, liver, spleen and omentum appeared normal. There were no ascites. Para aortic nodes were normal. She was staged as carcinoma fallopian tube stage 1 a (FIGO Type). A total abdominal hysterectomy with bilateral salpingo-oopherectomy was done.

Histological examination of the operative specimen showed that the sections of the right tube had neoplastic cells arranged in alveolar and medullary patterns (Figures 1A and 1B). There was infiltration of the muscle layer of the fallopian tube. The cervix, endometrium and myometrium were normal. The left ovary showed an endometrial cyst. Features were of an invasive primary tubal adenocarcinoma.

Further treatment was instituted in the form of intermittent infusion of cyclophosphamide at

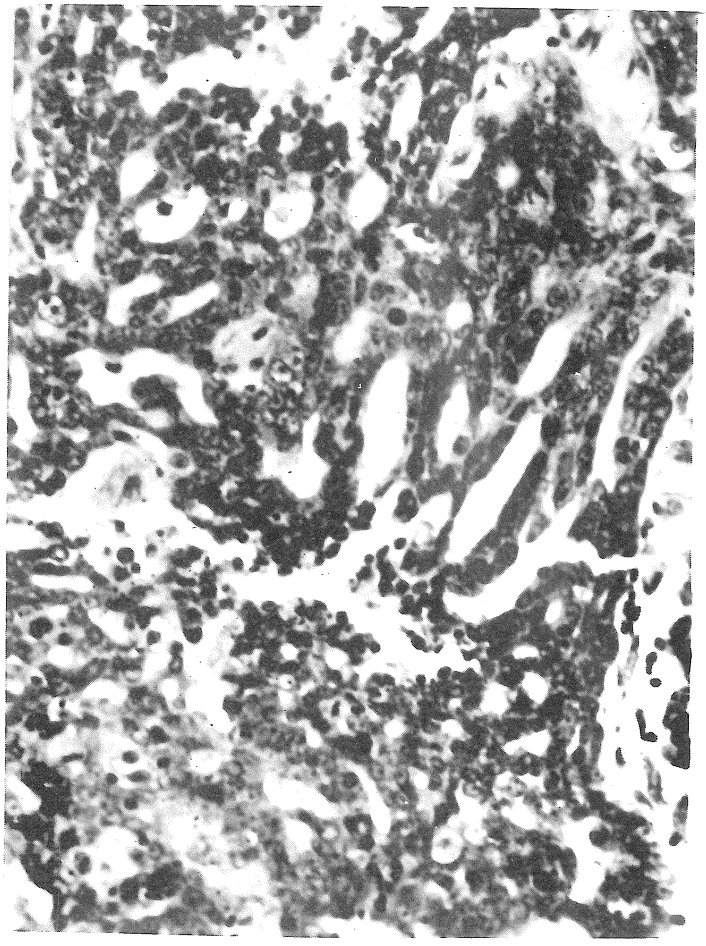

Figure 1A: Fallopian tube adenocarcinoma (Low level magnification)

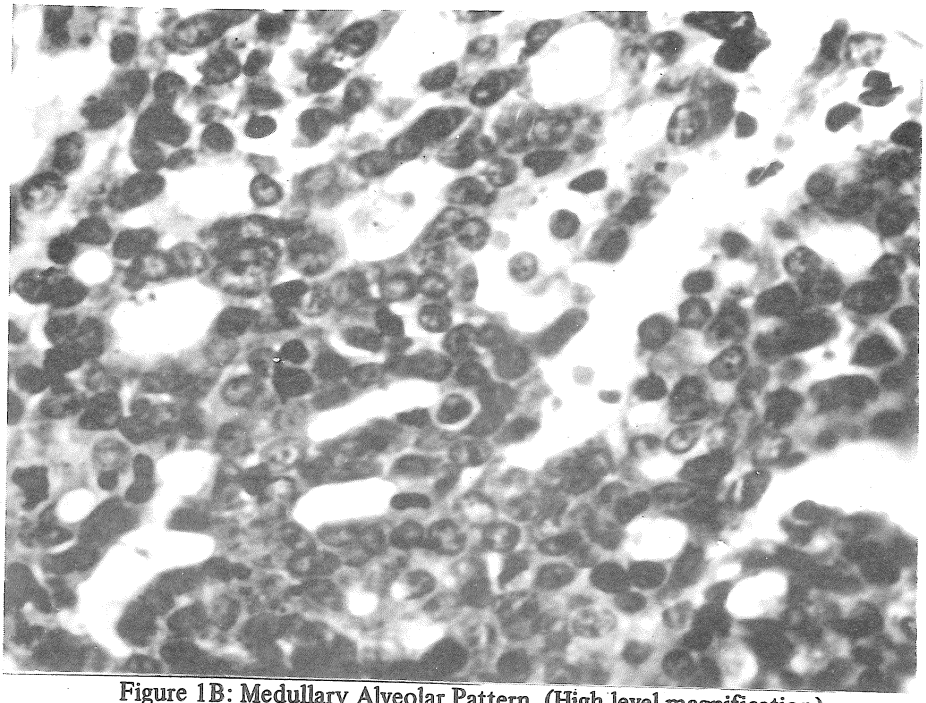

Figure 1B: Medullary Alveolar Pattern. (High level magnification)

monthly intervals. She was given six courses. On follow up she was normal with no evidence of secondaries for two years. Subsequently she was lost to follow up.

Discussion

Primary adenocarcinoma is such a rarity that it merits reporting every case. A high degree of clinical suspicion is required to diagnose fallopian tube malignancies. Latzko's triad of symptoms – profuse vaginal discharge, colicky pain and adnexal mass, are usually present. The pain is due to the intermittent discharge of bloody or watery mucoid secretions containing tumour debris from a partially obstructed distended tube.

The tumour involves the distal or fimbrial end twice as frequent as the proximal isthmic area. The tumour in this case was unilateral and at the fimbrial end. Histologically most tumours are papillary whereas in this case the tumour was alveolar-medullary, which is more solid and lacks differentiation.

Persaud and Burkett[2], Starr et al[1] observe that clinical diagnosis is extremely difficult and is almost never made preoperatively. The diagnosis was nevertheless made, as this patient who was in the perimenopausal age presented with profuse, watery, blood-stained discharge, collicky abdominal pain and an adnexal mass.

For treatment most authors advocate total abdominal hysterectomy and bilateral salphino-oopherectomy supplmeneted by radiotherapy,[3,4,5] and sometimes with adjuvant chemotherapy-alkylating agents[6,7] whereas Johnson[8] says that treatment of Fallopian tube cancer is highly individualised. He chose either radiotherapy or chemotherapy preferring the latter with initial surgery in his series of 13 cases. This patient received supplementary cyclophosphamide therapy and survived up to two years.

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