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CASE REPORT

Primary Fallopian Tube Carcinoma (PFTC) - A Rare Genital Malignancy with Unusual Presentation

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Abstract: A 33 yrs. multiparous lady attended GOPD with insidious dull abdominal pain with sudden onset of abdominal distension. On examination, along with positive shifting dullness, an intra-abdominal firm mass was palpable in left iliac fossa which corroborates USG findings. After proper preoperative investigations, patient was admitted and planned for laparotomy.On laparatomy about 1.5 litres of ascitic fluid was drained, uterus was found bulky & inspite of normal right fallopian tube, left tube had been replaced by firm growth. After adhesiolysis, total abdominal hysterectomy with bilateral shaphingo-oophorectomy was performed and specimen sent for HP study. HP examination revealed – poorly differentiated papillary adenocrcinoma of left fallopian tube with metastasis in both ovaries and other fallopian tube. Body of uterus & cervix were not invaded. Thus the patient was diagnosed to be a case of PFTC. Patient received six courses post-operative chemotherapy at 3 weeks interval consisting of – Inj. Paclitaxel & Carboplatin. Patient is reasonably well upto seven months of follow up.

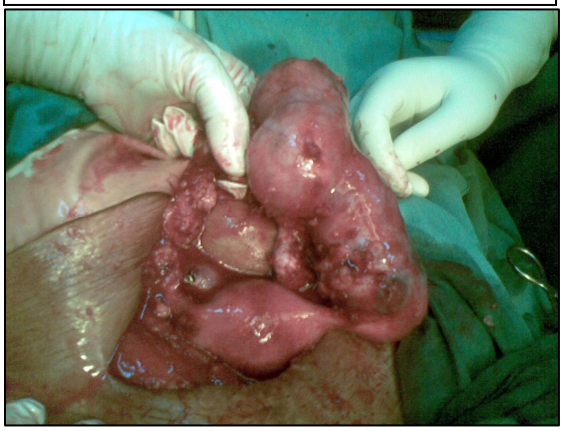
Introduction

Primary fallopian tube carcinoma (PFTC) is a rare malignancy accounting for <1% of all female genital cancers [1]. Clinically and histologically it resembles epithelial ovarian carcinoma. The diagnosis of PFTC is rarely considered preoperatively and is usually first appreciated at the time of operation or by a pathologist [2].

Case History

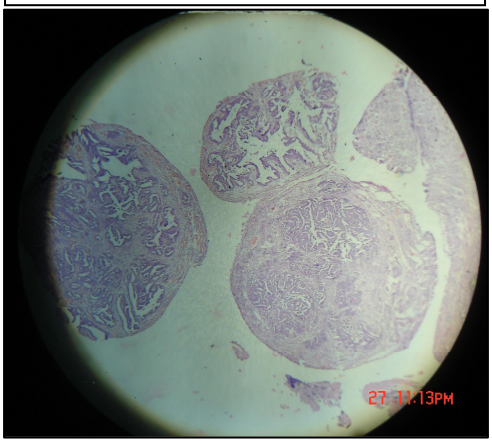
A 33 years old woman admitted through GOPD with compliants of insidious onset lower abdominal dull aching pain for six months and generalised abdominal distension since 15 days along with loss of appetite. Patient had no history of weight loss, jaundice, abnormalities in bladder and bowel habit or abnormal bleeding P/V. Her menstrual cycles were irregular with normal flow. She is $P_{2+1;}$ both vaginal deliveries having last child birth nine years back. She had no history of taking hormonal contraception or tubal sterilization. On examination, abdomen was distended with positive shifting dullness. On deep palpation an intra-abdominal firm mass of 6cm x 5cm size was palpable in left iliac fossa. USG showed a hypoechoic heterogenous SOL measuring 102 x 70 x 46mm present in left side of pelvis behind urinary bladder along with huge ascites. Ovaries were not visualised separately.

Figure-1: Replacement of left fallopian tube by firm growth



Pre-operative investigations including liver & renal function tests were within normal limits. She was planned for exploratory laparotomy. Laparatomy was done on 9/6/2010 under general anesthesia through low transeverse incision. About 1.5 litres of ascitic fluid was drained and sent for biochemical & cytological studies. Uterus was bulky, right fallopian tube was normal, left fallopian tube had been replaced by firm growth of approx. 10cm x 4 cm size, adhered to bowel loops posteriorly and anteriorly to bladder (Figure-1).

Figure-2: Poorly differentiated papillary adenocarcinoma of fallopian tube



After adhesiolysis, total abdominal hysterectomy with bilateral shaphingo-oophorectomy was performed and specimen sent for histopathological study. Histopathological examination of specimen revealed – Poorly differentiated papillary adenocrcinoma of left fallopian tube (Fig-2) with metastasis in both ovaries and other fallopian tube. Body of uterus & cervix were not invaded. Thus the patient was diagnosed to be a case of Primary Fallopian Tube Carcinoma (PFTC). Ascitic fluid was negative for ZN stain but positive for PAP stain. Patient received six courses post-operative chemotherapy from our Oncology department consisting of–Inj. Paclitaxel (260 mg) & Inj. Carboplatin (450 mg) IV infusion with prehydration and antiemetics. Such courses were given at 3 weeks interval. Patient is reasonably well upto seven months of follow up.

Discussion

According to various series frequency of primary adenocarcinoma of fallopian tube is 0.3 to 0.5% with unknown etiology [2]. Fallopian tube carcinoma is known to be insidious & asymptomatic for prolonged & variable periods of time which concords with our case. Most common presenting symptoms are perimenopausal or postmenopausal bleeding per vagina seen in about 50% of the patients followed by amber coloured vaginal discharge & abdominal pain [2] whereas pain was only presenting symptom in our patient.

The most common finding on physical examination is usually palpable abdomino-pelvic mass without ascites [2]. But our case had predominant evidence of ascites. Pre-operative diagnosis of fallopian tube carcinoma is seldom made prior to surgery. It is suspected in fewer than 5% of cases preoperatively [2]. Such patients are mistakenly diagnosed as primary ovarian neoplasm.

The FIGO staging system assigns nearly two-thirds of patients to stage I or II and is based on surgical staging criteria similar to ovarian cancer [3]. Total abdominal hysterectomy with bilateral salphingo–oophorectomy is clearly the mainstay of treatment and probably the first approach to diagnosis [2]. Patients with advanced disease (> stage IIA) should be treated with post-operative combined chemotherapy with carboplatin plus paclitaxel [1] as done in our patient. Stage of the disease during primary surgery and residual tumor are the most important prognostic factor for outcome [1]. In conclusion, PFTC is rare genital malignancy and diagnosis can only be made with prior suspicion and intensive anatomic delineation during laparotomy to improve the outcome of treatment.

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