

Fallopian Tube Carcinoma Presenting As Adnexal Cyst.

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Abstract: Historically, carcinoma of the fallopian tube accounted for 0.3% of all cancers of the female genital tract .Very often, the diagnosis is mistaken for an ovarian carcinoma or a tubo-ovarian mass. A correct, preoperative diagnosis is made only in 4% of the patients. This is due to its nonspecific presentation. The Latzko's triad of a watery vaginal discharge, a colicky lower abdominal pain and a pelvic mass is typical of a fallopian tube carcinoma, but this triad is seen only in less than 15% of the patients. Here, we are reporting such a case of 66years old postmenopausal woman with fallopian tube carcinoma with atypical symptoms presenting as adnexal cyst.

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I. Introduction

Primary Fallopian tube carcinoma(PFTC) was first described in 1847 by Rokitansky and in 1861 by Renaud¹.PFTC is a rare malignant tumour of genital tract^{1,2}.Its incidence is 0.3%^{1,3}.Peak incidence occurs between 60 to 64 yrs¹. Most PFTC arises in the distal portion of the fallopian tube^{1,3}.Most common in postmenopausal and nulliparous women. In histologic features and behavior, fallopian tube carcinoma is similar to ovarian cancer^{1,2}; thus, the evaluation and treatment are essentially the same .Almost all cancers are of epithelial origin, frequently of serous histology^{1,2,3}. Rarely, sarcomas are reported¹. The Latzko's triad^{2,3} of a watery vaginal discharge, a colicky lower abdominal pain and a pelvic mass is typical of a fallopian tube carcinoma, but this triad is noted only in less than 15% of the patients.

Very often, the diagnosis is mistaken for an ovarian carcinoma or a tubo-ovarian mass⁴. Fallopian tube cancer may be found incidentally in asymptomatic women at the time of abdominal hysterectomy and bilateral salpingo-oophorectomy⁴.

II. Case Report

A 66y old postmenopausal woman by name chittikondamma came with a c/o breathlessness 15 days,lower abdominal pain from 15days,fever from 15days to medicine OPD then it was referred to Gyn OPD with u/s scan report showing right sided ovarian cyst of 10.4X6.8cm

H/o lower abdominal pain,vague in nature,gradual in onset and gradually progressed,no radiation.No aggravating or relieving factors.Associated with watery loose stools from 3 days 4-6 times a day. H/o breathlessness 15 days during daily physical activities,Associated with palpitations.No h/o chestpain,No h/o dry cough,No h/o orthopnoea/PND. H/o fever from 15days,low grade,continuous,aggravating during night,not associated with chills and rigors .She was a known case of Diabetes and hypertension since 12 years and on treatment.H/o of blood transfusion 2 units 2 years back in view of anaemia

On general examination,Patient is conscious, coherent, well oriented,Morbidly obese;Ht-157cm;Wt-110kg;BMI-44.6.pt was pale. No cyanosis/icterus/clubbing/pedal edema lymphadenopathy.

On,,Per abdominal examination-Thick abdominal wall present Per speculum--Vagina healthy,Cervix flushed with vault.

Per vaginum--Findings could not be made out due to thick abdominal wall ULTRASOUND SCAN –

- Uterus normal in size with midly bulky cervix
- A well defined cystic lesion of 10.4X6.8cm in right adnexal region with internal echos and septations with thickening of cyst wall with minimal nodularity
- Right ovary could not be visualized separately.left ovary normal

Cect Scan Abdomen –

- Uterus normal in size with mildly bulky cervix
- A large well defined hypodense lesion of cystic attenuation in right adnexal lesion – 9.1X7.1X10cm.
- Few enlarged lymphnodes in mesentry 11X12mm PAPSMEAR-

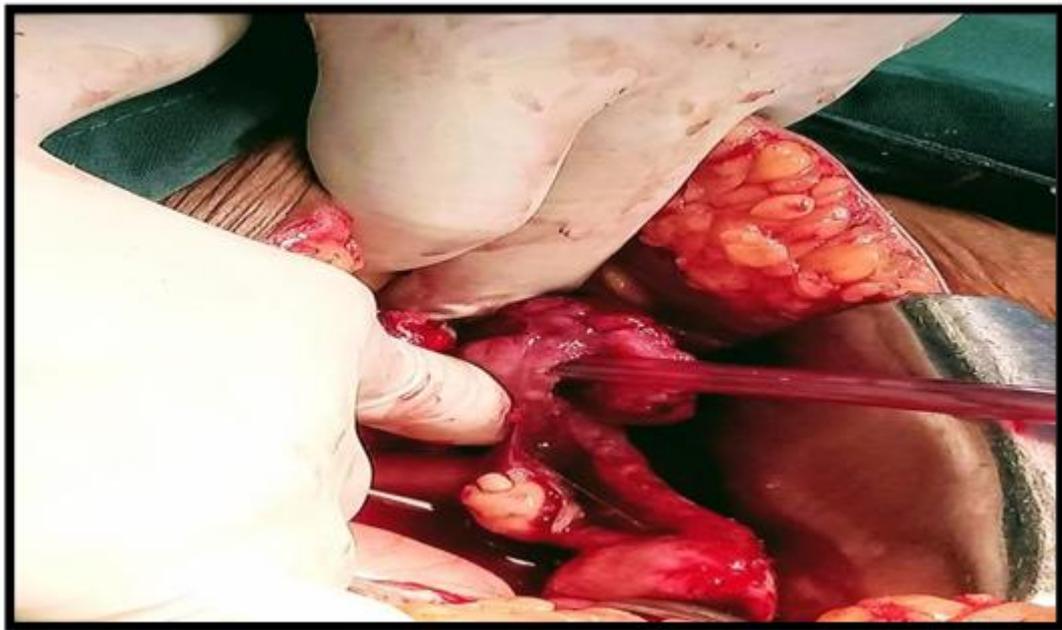
Conventional and adequate smears show few intermediate squamous cells plenty of parabasal cells, squamous metaplastic cells & endocervical cells in streets and clusters along with neutrophils in the background

Negative for dysplasia/malignancy

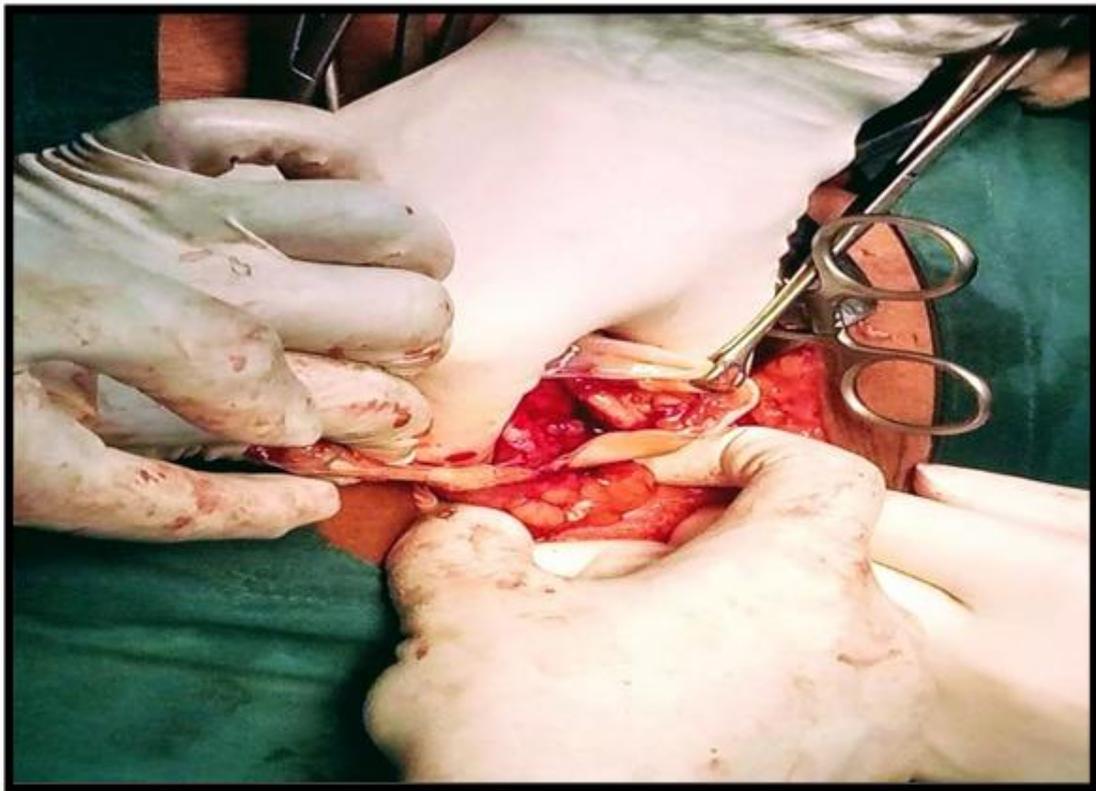
After treating loose stools, controlling blood sugar levels and fever case posted for exploratory laparotomy & total abdominal hysterectomy with bilateral salpingoophorectomy with cystectomy done under General anaesthesia

Peroperative Findings -

- Immediately after opening abdomen haemorrhagic ascitic fluid was seen. The same was aspirated and sent for cytology
- uterus atrophic , right fallopian tube and ovary are healthy
- left fallopian tube has fungating mass at distal portion of tube with seedling over the tube (left ovary unhealthy) the same tube and ovary sent for HPC

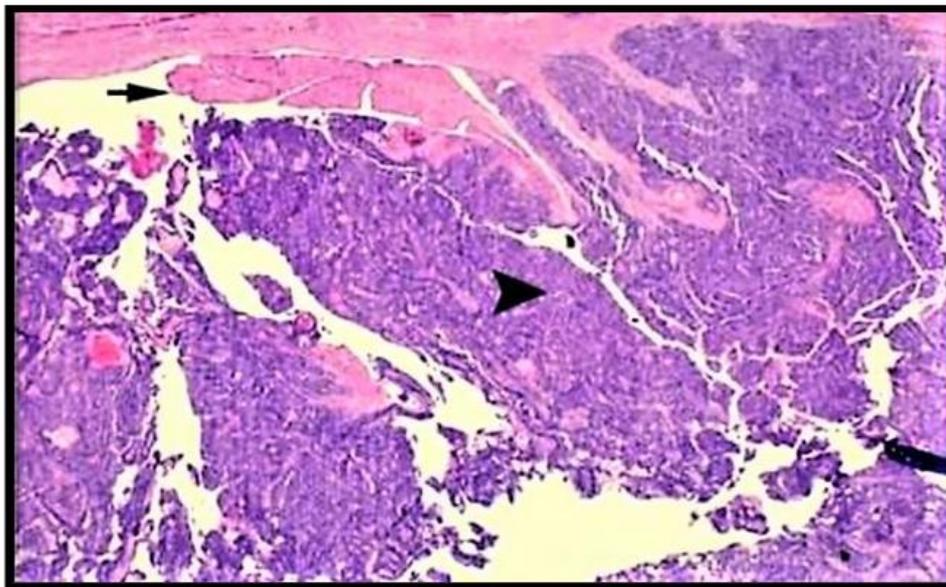


- A cyst of 6*6cm size seen attached 4cm proximal to the caecum- same ruptured during separation
- Bloodstained serous fluid aspirated and sent for cytology walls of cyst are excised and sent for HPE.
- Within the cyst, friable tissue obtained (peritoneal secondary deposits over caecum?) the same sent for HPE. Dead space within cyst obliterated by continuous suture with catgut no 1-0



Histopathology Report

- Section studied shows tubal growth showing infiltrating glandular and branching papillary structures consisting of pleomorphic and hyperchromatic atypical cells. Similar tumour deposits are noted in peritoneal tissues
- Endometrium shows features of cystic atrophied endometrium. Both ovaries show multiple corpus albicantes
- Cervix shows chronic non specific cervicitis
- Cervix and endometrium and both ovaries are free of tumour deposits



Impression – features are suggestive of **Papillary Serous Adenocarcinoma** of left fallopian tube with papillary tumour deposits in peritoneal tissue

Ascitic Fluid For Cytology

- 5ml haemorrhagic fluid
 - sediment smears are highly cellular show plenty of reactive mesothelial cells in sheets clusters of single along with few lymphocytes and occasional neutrophils
 - Negative for malignant cells
- #### **Cystic Fluid For Cytology**
- Smears show few lymphocytes in hemorrhagic background
 - Negative for malignant cells

Postoperative Period-Diabetes controlled with insulin.

Suture removal done on POD-8. on POD-9, pt presented with burst abdomen for which resuturing of abdomen done on emergency basis.pt was then given for chemotherapy

III. Discussion

Most primary fallopian tube cancers arise from ampulla with endoluminal growth that leads to obstruction and distension of the fallopian tube (hydrosalpinx), which explains why the majority of these patients are rarely asymptomatic. Benign or malignant neoplasms of the fallopian tubes are uncommon. If they develop, they may be located in the wall or within the lumen as a growth attached to the wall by a stalk. Sedlis criteria to diagnose primary fallopian tube carcinoma.⁴

1. Grossly _the main tumour is in the tube and arises from endosalpinx.
2. Histologically _the pattern reproduces the tubal mucosa (papillary pattern)
3. Transition from benign to malignant tubal epithelium should be demonstrated.
4. The ovaries and endometrium are normal or have a much smaller tumour volume than that of tube.

IV. Conclusion

Any postmenopausal women presenting with adnexal mass ,PFTC should be suspected. PFTC is rare and its preoperative diagnosis is frequently misses or delays because of lack of specific symptoms and signs.

References

- [1]. Berek &Novak’s Text Book Of Gynaecology, 15 th Edition section vii Gynaecologic oncology ,1350-1427.
- [2]. CN Purandare’s Text Book Of Gynaecological cancer ,first edition,267-76.
- [3]. Howkins & Bourne Shaw’s Textbook of Gynaecology, 17th edition 507-30.
- [4]. Szklaruk J ,Tamm EP,choi H,Varavithya v,MR Imaging of common and uncommon large pelvic masses, 23;403-24.

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