# A case with primary carcinoma of the fallopian tube

## Primer tuba uterina kanserli bir vaka sunumu

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**Abstract**
Carcinoma of the fallopian tube is the most infrequent gynecologic cancer and usually impossible to diagnose preoperatively. We report a case of fallopian tube cancer at 55-year-old with gravidity 1 and parity 1. The patient admitted to hospital with lumbal and inguinal pain. In another medical center, patient had undergone a surgery due to a pelvic mass and a myomectomy with left salpingectomy had been performed. Postoperative pathologic examination had revealed out tubal serous papillary adenocarcinoma and patient had been referred to our hospital. We performed total abdominal hysterectomy, bilateral oophorectomy, right salpingectomy, infracolic omentectomy and pelvic lymph node sampling. She had a history of appendectomy. According to histopathologic evaluation, tumor was grade II serous papillary carcinoma. Patient was in stage IIa and first line chemotherapy (cisplatin and paclitaxel) was administered for 6 times. Due to a relapse in the 20th month, patient underwent a second look laparotomy and a second line chemotherapy (Topotecan HCL) was given for 3 times. She refused to visit outpatient clinics regularly and survived for 35 months.
**Key words:** Fallopian tube cancer, treatment, prognosis

**Özet**
Tuba uterina kanseri, en az görülen jinekolojik kanserdir ve preoperatif tanısı genellikle konulamamaktadır. Elli beş yaşında gravidite 1, parite 1 olan bir primer tuba uterina karsinomu olgusu sunulmuştur. Hasta, bel ve kasık ağrısı şikâyeti ile doktora başvurmuş. Hariçte pelvik kitle ön tanısı ile operasyona alınan hastaya myomektomi ve sol salpenjektomi yapılmış. Postoperatif patoloji raporu tubal seröz papiller adenokarsinom gelen hasta, kliniğimize refere edildi. Hastaya kliniğimizde total abdominal histerektomi (TAH), bilateral ooforektomi, sağ salpenjektomi, infrakolik omentektomi, pelvik lenf nodu örneklemesi yapıldı. Hasta daha önceden appendektomi geçirmişti. Histopatolojik rapor; grade II seröz papiller adenokarsinom infiltrasyonu olarak geldi. Evre IIA olan hastaya birinci sıra kemoterapi (Cisplatin ve Paclitaxel) 6 kür verildi. 20 ay sonra nüks saptanan hastaya second look laparotomi sonrası ikinci sıra kemoterapi (Topotecan HCL) 3 kür verildi. Kontrollere düzenli gelmeyen olgu, tanı konulduktan sonraki 35. aya kadar yaşayabildi.
**Anahtar kelimeler:** Tuba uterina kanseri, tedavi, prognoz

## Introduction

Fallopian tube cancer is the least frequent gynecologic cancer. Etiology is not exactly known, however it seems to be related with nulliparity and same as in endometrium and ovarian cancers and 20% of tubal cancers are seen in nulliparous women (1). Fallopian tube cancer is rarely diagnosed preoperatively and usually observed accidentally during surgeries performed for other purposes (2). Most common symptoms are vaginal bleeding or discharge, lower abdominal pain and pelvic masses. Clinical staging and therapeutic approaches are similar to that of epithelial ovarian cancer (3, 4). We present a case of fallopian tube cancer since it is rarely seen.

## Case report

A 55-year-old patient with gravidity 1 and parity 1 was suffering from lumbal-inguinal pain and operated for pelvic mass in another medical center. Histopathologic examination revealed out tubal serous papillary adenocarcinoma subsequent to myomectomy and left salpingectomy and then the patient was referred to our clinic. Recovering Phannenstiel incision scar was observed in physical examination. Vulva-vagina were hyperemic, mixed discharge was evident and collum was specific to multiparity however due to early postoperative period, uterus and adnexes were not examined sufficiently. Simple cystic mass in 3x3 cm size was observed in ultrasonographic examination of left ovary. No pathologic finding was observed in uterus and right ovary. Tumor markers were in normal range and no abnormal finding was present in rectoscopic and mammographic examinations. Fecal occult blood test was negative and she had chronic hepatitis C infection.

Patient was referred to our clinics for establishing diagnosis and performing staging procedure. Patient was undergone to total abdominal hysterectomy, bilateral oophorectomy, right salpingectomy (she had an appendectomy, already), infracolic omentectomy

and also pelvic lymph node sampling was performed and peritoneal cytology was obtained. Injured area on serosa of sigmoid colon during adhesiolysis was sutured. Postoperative histopathologic examination revealed out grade II infiltrated left periovarian papillary adenocarcinoma. No complication was developed and patient was discharged at the 11th day. First line chemotherapy (cisplatin and paclitaxel) was administered for 6 times. She refused to carry on regular visits and at the 20th month subsequent to adjuvant chemotherapy, CA-125 level was 118 u/ml. Tomographic examination pointed out metastatic lesions on liver, omentum and mesentary, solid masses on pelvic area and multiple pelvic and paraaortic lymphadenopathies. Consequently, second look laparotomy was performed. Widespread metastatic tumoral lesions were detected on peritoneum, omentum and pelvic area in surgical exploration. Due to the diffused adhesiolysis, liver and spleen were not clearly evaluated. Biopsies from tumoral lesions and samples from ascitic fluid were obtained. Histopathologic examination confirmed the diagnosis of metastatic serous papillary adenocarcinoma and malignant cells were observed in the cytologic examination of ascitic fluid. Second line chemotherapy consisting of topotecan hydrochloride was administered for 3 times. Pancytopenia; predominantly severe neutropenia was observed at the end of 3rd chemotherapy seance. Patient was consultated with Hematology Clinics and filgrastim (Granulocyte colony-stimulating factor) therapy was initiated. She was also consultated with Infectional Disease Clinics for diarrhea and oral candidiasis and antifungal therapy was administered. She had delirium tremens and medical therapy was initiated subsequent to psychiatric consultation. Patient was discharged with a relatively good condition. She carried out visits irregularly and died at the 35th month.

## Discussion

Primary cancer of the fallopian tube occupies 0.14-1.8% of all gynecologic cancers (5) and usually seen in fifth or sixth decade of life (6). Our patient was 55-year-old. Most common symptom of tubal cancer is postmenopausal vaginal bleeding however less frequently patients may suffer from vaginal discharge, lower abdominal pain, distention and fullness. Although pelvic mass is palpable in the half of patients, some may have no symptom (7). Our patient was suffering from lumbar and inguinal pain and pelvic mass was palpable in physical examination. Early diagnosis of tubal cancer is difficult and usually it is diagnosed accidentally during operations performed for pelvic or abdominal masses. Taner et al. reported 3 cases of tubal cancer and 2 of 3 patients underwent to operations for pelvic mass (8).

Although ultrasonography, computerized tomography and magnetic resonance imaging are diagnostic methods, sensitivity of these methods has not been exactly confirmed. Measurements of CA-125 levels are recommended for both diagnosis and follow-up; same as in ovary cancer (9). Although a pelvic mass was detectable in ultrasonography, CA-125 levels were in normal range in our patient. Biological and histological features of fallopian tube cancer are similar to ovarian cancer (1). Pathologic diagnosis of tubal cancer is more complicated in advanced stages and has some confusion in the differential diagnosis with ovarian cancer. Diagnosis depends on the presence of following criteria; main tumor on tuba, mucosal involvement with papillary pattern, benign-malignant transitional zone if the tumor expands deeper than mucosa (10). We established the diagnosis in the presence of these criteria.

Therapeutic approaches similar to ovarian cancer are recommended (3). However adjuvant therapy would lead no significant improvement in the surveillance rate due to rapid expansion and aggressive nature of the tumor. Rarity of the disease results in the lack of controlled trials comparing the affectivity of therapeutic approaches. Second look laparotomy is recommended for patiens in stage IIb-V or in stage I-IIa with inadequate surgery. We performed second look laparotomy due to recurrence of the disease. Tubal cancers have poorer prognoses and usually diagnosed at the advanced stage. Five years survivals according to stages are; 95% in stage I, 75% in stage II, 69% in stage III, and 45% in stage IV (3). Our patient survived for 35 months.

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