Bilateral Fallopian Tube Cancer In A Postmenopausal Woman

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ABSTRACT: Primary fallopian tube carcinomas (PFTC) are rare adnexal tumors with non-specific presentations. A 74 year old post-menopausal woman complained of vaginal discharge and treated for vaginitis. TVS showed a right adnexal mass with IOTA adnex 75.5% risk for malignancy. Frozen section was done - High Grade Serous Tumor. Fallopian tube cancers behave the same as ovarian cancers and usually have the same management. Limited data is still known, and in-depth studies are essential for these cases to provide better survival outcomes.

CASE
A 74 year old, Gravida 4 Para 3 (3013), Filipino, menopause, consulted for vaginal discharge, diagnosed and treated as vaginitis. Transvaginal Ultrasound revealed (See Figures 1, 2, 3 and 4): Normal sized retroverted uterus, thin endometrium with atrophic left and right ovary, no free fluid in the cul de sac.

Right adnexal mass measuring 2.2 x 2.4 x 2.0 cm (vol=4.7 cc), globular, heterogeneous, color score =3, moderate. Adherent to the fundus is another heterogeneous solid-cystic structure measuring 3.0 x 2.6 x 2.7 cm (vol=10.6 cc), color score =3, moderate. Malignant by IOTA-ADNEX: consider tubal malignancy. Risk Prediction: Total risk of malignancy - 75.5%, Risk for stage II-IV ovarian cancer of – 51.8%. (See Figure 5).

Referred to a Gyne-Oncologist, serum markers were CA-125 107.53 Ul/ml and HE-4 83.20 pmol/L. Surgery done - Diagnostic cystoscopy, Exploratory laparotomy, PFC, TAHBSO, BLND, omentectomy, and PALS with frozen section. The right fallopian tube was dilated to 8.0 x 0.5 x 0.5 cm, with 2 soft masses. Mass 1 - 4.0 x 2.5 x 2.5 cm; Mass 2 - 4.0 x 2.5 x 2.5 cm, Frozen section resulted to a High grade serous carcinoma, with lymphovascular invasion (See Figure 6).

DISCUSSION: Fallopian tube cancer (FTCA) is very rare and accounts for 1-2% of gynecologic cancers, about less than 0.2% of cancer among women annually with an incidence of 0.41 per 100,000. Sedlis and colleagues modified these criteria in 1978: (1) tumor arises from the endosalpinx; (2) histologic pattern reproduces the epithelium of tubal mucosa; (3) demonstrable transition from the benign to malignant tubal epithelium, and (4) ovaries or adnexum are either normal or contain a tumor that is smaller than the tumor in the tube. Pelvic ultrasound, is reported to be accurate in the diagnosis, adnexal size, its morphology and other parameters, strengthen with doppler ultrasound and scoring systems in assessing the risk of malignancy. All tumor subtypes in the ovaries are also known in the fallopian tube, with serous 50%, 25% endometrioid, 20% transitional cell and 5% were of other subtypes (Alvarado-Cabrero et al., 1999).

Treatment is the same as those for ovarian carcinoma and post operative therapy is most often needed. Patients with stage la have 100% 5-year survival and need not be treated. In contrast, patients with invasion as well as with lymph node involvement, has a 5-year survival of 71% to 72% and should receive additional therapy.

CONCLUSION: Primary FTCA is a rare gynecologic malignancy. Diagnosis of FTCA is difficult due to the silent course. Accurate mode of diagnostics, such as ultrasound and tumor markers are helpful. The treatment approach is similar to that of ovarian carcinoma. Since limited data is still known in such cases, it will be better to have in depth studies regarding these cases for further diagnostics, surgical management and chemotherapeutic strategies to provide better survival outcomes.