

Incidental finding of Advanced Primary Fallopian Tube Carcinoma (PFTC) by Miss E. Ande/Miss B. Subba

OBJECTIVE

To highlight the incidental finding of advanced PFTC in a patient with slightly elevated CA-125 who had laparoscopy for chronic pelvic pain. Emphasising the fact that even slightly elevated CA 125 should be assessed and investigated fully for suspected cancer.

CASE REPORT

A 46-year-old nullipara with chronic pelvic pain (CPP), dyspareunia, history of infertility, normal cervical smears with normal examination and USS findings.

Laparoscopy: peritoneal seedlings in the lower anterior abdominal wall, inflammatory mass (left adnexa, fallopian tube, ovary and sigmoid colon), thickening of the peritoneum involving the diaphragm, no ascites. Postoperatively she developed dyspnoea.

Chest CT: right lung pleural effusion and collapse, mediastinal shift, 9mm nodule in the mediastinal fat. Pleural fluid was negative for Acid Fast Bacilli and malignant cells.

CT Abdomen/Pelvis: liver cysts, para aortic lymph nodes.

CA 125- 180kIU/L, BRCA genes negative and histopathology-metastatic serous adenocarcinoma of fallopian tube origin.

She was counselled on diagnosis of stage 4 PFTC and managed by the Oncology team.

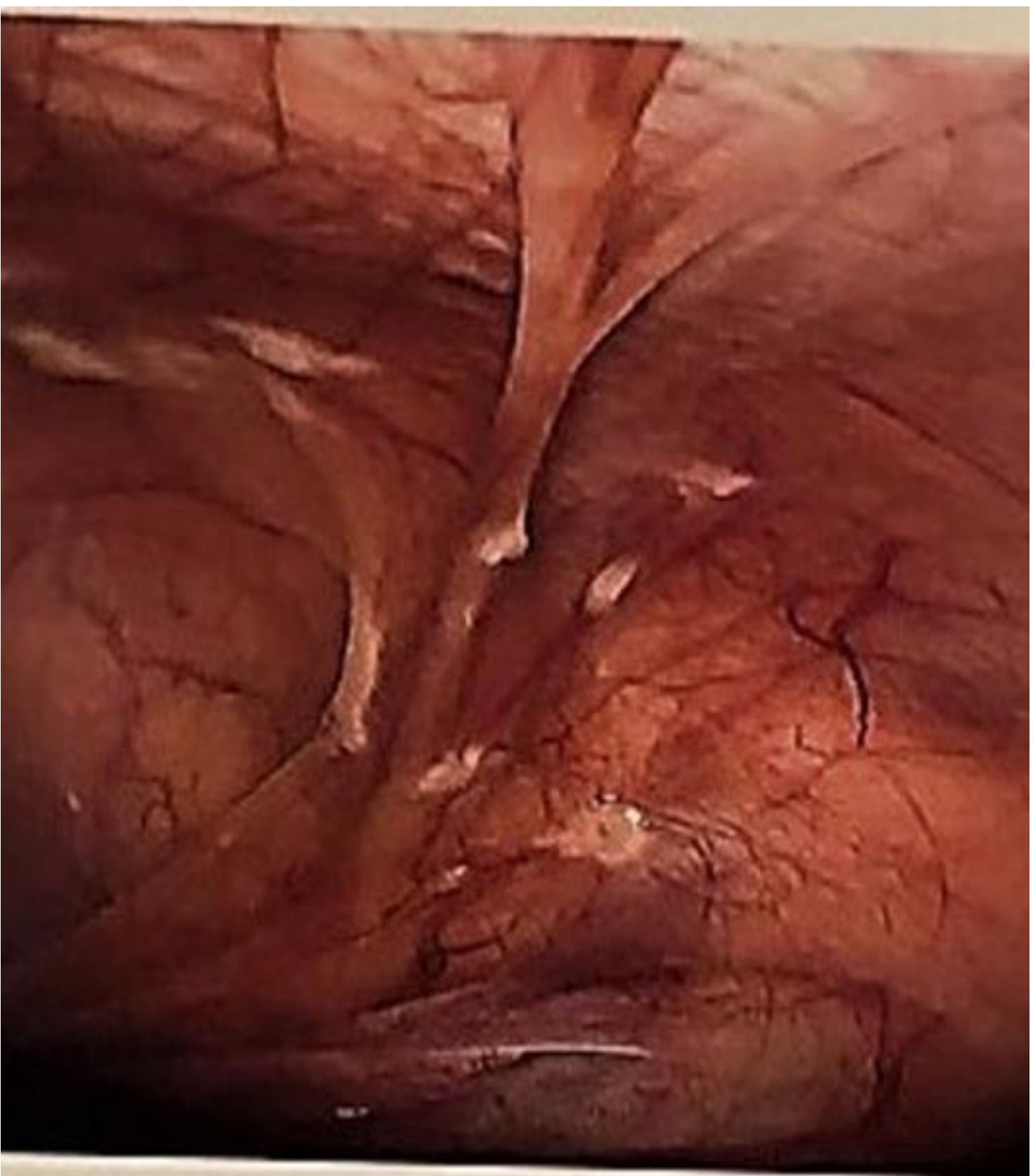


Figure 1 : Peritoneal seedlings on the lower anterior abdominal wall



Figure 2 : Peritoneal seedlings on the lower anterior abdominal wall



Figure 3 : Inflammatory mass involving the left adnexa, fallopian tube, ovary and sigmoid colon

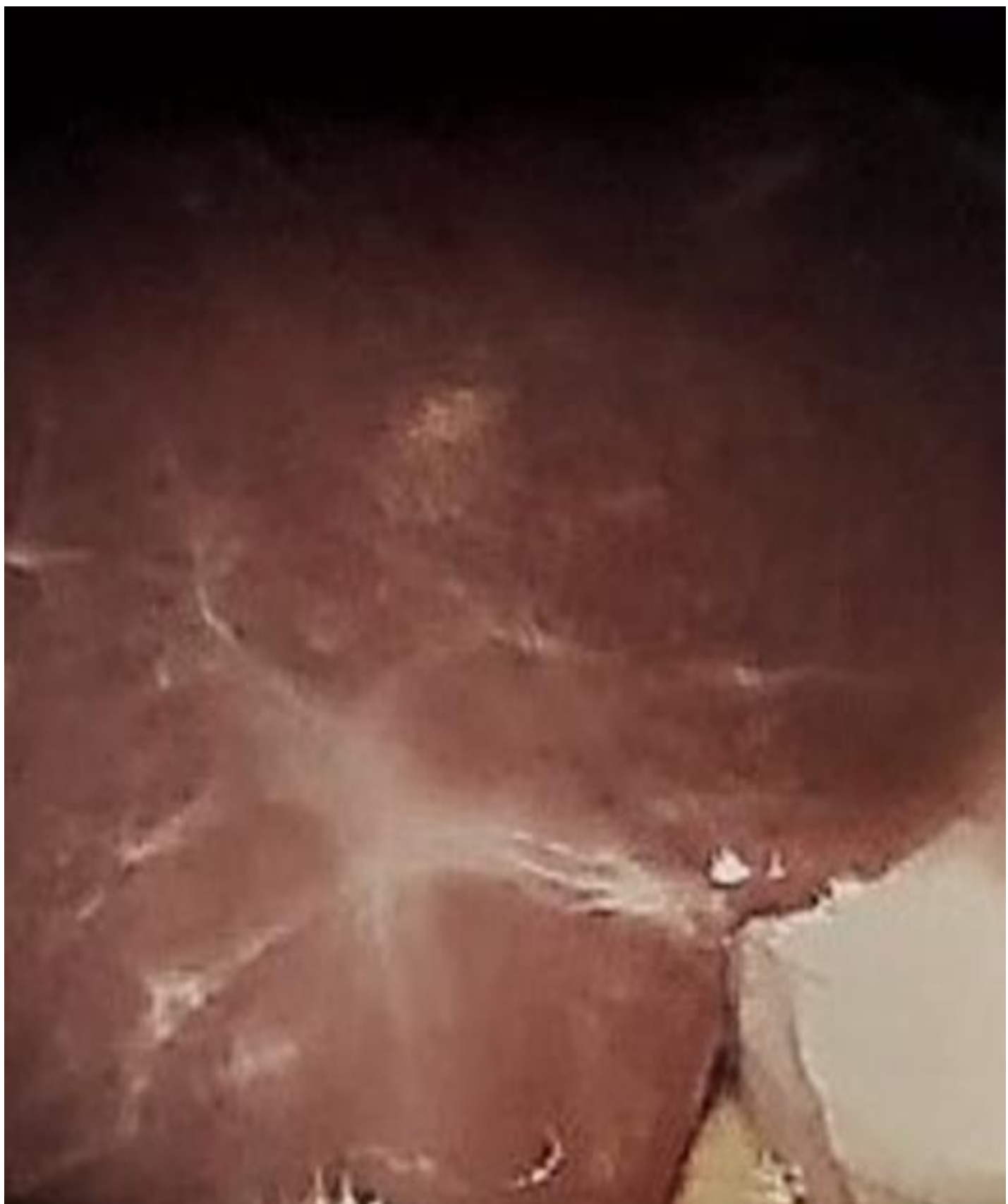


Figure 4 : Normal liver and gall bladder

DISCUSSION AND LEARNING POINTS

Risk factors in her were age, nulliparity and infertility. She was negative for mutations of P53 and BRCA 1&2 genes and did not have the other risk factors.

PFTC originates distally and are usually Serous in origin or high grade Endometroid adenocarcinoma. Serous tubal intraepithelial carcinoma is presumed to be the precursor for ovarian carcinoma. This has been found in fallopian tubes specimens of women with BRCA mutations who had prophylactic salpingo-oophorectomy and also in 60% of sporadic cases of ovarian cancer.

Presentation- asymptomatic/nonspecific, Latzko’s triad (abdominal pain relieved by vaginal discharge, abdominal or pelvic mass, sero sanguineous vaginal bleeding), ‘Hydrops tubae profluens’(abdominal pain relieved by watery vaginal discharge), elevated CA-125, atypical glandular cells on cervical smears without primary source. CT, MRI and USS can detect solid and lobulated components of the tube but are usually nonspecific.

Treatment-surgery, chemotherapy, radiotherapy and hormone therapy. Prognosis depends on the stage, histological type, depth of infiltration and residual disease after surgery.

Effective screening modalities are unavailable; women with high risk genes should be advised to have prophylactic bilateral salpingo-oophorectomy. Salpingectomy during sterilization and at hysterectomy will reduce the risk.

CONCLUSION

Diagnosis and management of PFTC is challenging with similarities to epithelial ovarian cancer and similar management of ovarian cancer. Development of effective screening tools and novel biomarkers would aid diagnosis and improve management.

References

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