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Case report

Primary fallopian tube carcinoma discovered by mistake – A case report

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ABSTRACT

Introduction: Fallopian tube carcinoma is a rare neoplasm derived from mucous tissue located inside fallopian tubes. The disease is most prevalent in women in 4th to 6th decade. The early stages are asymptomatic, advanced stages can be diagnosed based on Latzko's triad: serous, amber-colored discharges, pathological resistance during abdominal physical examination, colic abdominal pain alleviating when the discharge is released.
Aim: To present a case of an uncommon neoplasm found by mistake.
Case study: We present a case of a 60-year-old asymptomatic woman admitted to gynecological–oncological department with a suspicion of a neoplasm in the left ovarian cyst. The surgery performed excluded the possibility of malignancy of the ovary, but the histopathological examination afterwards revealed the presence of a high-grade serous carcinoma in the right fallopian tube. In CT imaging enlarged, paraaortic lymph nodes were revealed. The patient underwent a surgery and received postoperative adjuvant chemotherapy.
Results and discussion: The fallopian tube cancer may be related to ovarian cancer. It can be found on one side or bilaterally. There is a need for further diagnostic proceedings in order to confirm diagnosis and to select optimal treatment. Main negative prognostic factors are stage and the lack of optimal cytoreduction. Depending on the staging appropriate treatment is chosen with surgery being the basic procedure. Adjuvant chemotherapy is used. Radiotherapy is only justified as a palliative procedure.
Conclusions: The fallopian tube carcinoma if often found either during or after the surgery. The optimal treatment is the excision of the reproductive organs with lymphadenectomy.

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1. Introduction

Fallopian tube carcinoma (FTC) is a rare neoplasm derived from mucous tissue located inside fallopian tubes.[1–3] Only 20% of FTCs origin in fallopian tubes (primary fallopian tube carcinoma – PFTC), the rest is caused by ovarian, endometrial, digestive tract and breast metastases.[4,5] The disease is most prevalent in women in 4th to 6th decade with a median age of 55.[3] Genetic, hormonal and reproductive factors are believed to play a significant role in pathogenesis of PFTC and they are similar to ovarian carcinoma factors. There is also a documented connection to germ-line BRCA1 and BRCA2 mutations.[6,7] The disease is most often found during a gynecological operation or an abdominal surgery.[1,3] The lesions containing this tumor are visible to eyes and are the initiators of the following diagnostic process.

2. Aim

The aim of this study is to present an unusual clinical case of a FTC. There is not much literature concerning FTC. Cases presented most often describe common moment of diagnosis, which is intraoperational diagnosis. The one presented in this study differs from the rest and stresses the importance of oncological vigilance and the fact that one disease does not exclude the existence of another.

3. Case study

We present a case of a 60-year-old woman admitted to gynecological–oncological department due to a neoplasm suspicion. Patient had no earlier signs or symptoms. Menarche at the age of 12, periods were regular every 30 days, lasting 3–4 days, of mediocre intensification and painfulness. Last period was at the age of 54. Patient has denies additional bleedings. Patient was pregnant 3 times, had 3 parturitions, 1 via the vaginal route, 2 with a caesarean section, all parturitions were premature. Last birth was 35 years before. Patient also suffered from osteoarthritis of lumbar part of the spine. Patient chronically takes valsartan, amlodipine. She has also an oncological family history: first sister had a breast neoplasm at the age of 63 and second sister had a thyroid neoplasm at the age of 40. In present patient has a deskwork, is of secondary education.

In March of 2014 the patient was diagnosed a cyst of the left ovary leading to a resection of the ovaries and uterus. Intraoperational examination excluded the possibility of malignancy in the left ovary (including the existence of a metastatic tumor[8]). After the operation, samples of the excised organs were taken and were examined histopathologically. The tests revealed a presence of a high-grade serous carcinoma of the right fallopian tube, there were also carcinomatic vessel embolisms as well as a creamy infiltration nearby fallopian tube hyphae (1.5 × 1.0 × 0.8 cm) found. Because that latter neoplasm was diagnosed by accident, there was a need of further examination of a patient in search of metastases. In the computer tomography (CT) scan (Fig. 1) of the abdomen there was an enlargement (4.0 × 1.7 cm) of paraaortic lymph nodes revealed beneath right renal vessels – stage FIGO III. Biochemical tests results were correct with Ca-125 on the verge of normality.

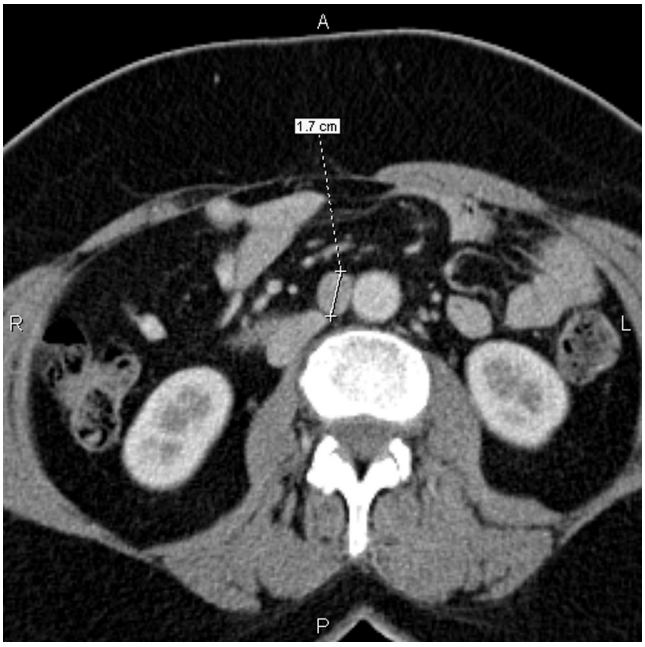

Fig. 1 – Enlarged paraaortic lymph node at computed tomography scan.

There has been a surgery performed (Fig. 2). Greater omentum, cervix of the uterus, and metastatic paraaortic lymph nodes (4 cm in diameter) were excised (Fig. 3). During the surgery samples from the omentum and swabs from the diaphragm were taken, iliac lymph nodes biopsy was performed. As a side effect a bladder damage occurred. A catheter has been set up in the urinary bladder for 14 days.

Patient was released in good overall condition after 17 days of hospitalization with recommendation to take dalteparine injections, furasidine orally and estriol vaginally. Histopathological examination of the paraaortic lymph nodes showed metastases: *adenocarcinoma serosum lymphonoduli* (Figs. 4 and 5). The rest of the excised organs showed no neoplasmatic abnormalities. According to WHO standards III stage was diagnosed.

After leaving the hospital, patient underwent six courses of chemotherapy at an interval of 21 days. The chemotherapy consisted of platine derivatives and taxane.

4. Results and discussion

PFTC is a rare disease occurring commonly to women in 4th to 6th decade.[1,3] However, if there is a germ-line BRCA1 and BRCA2 mutation linkage, the disease may occur 10 years earlier and the occurrence in such a group is 120 times greater with BRCA1 mutation being more common. As mentioned before, there are genetic, hormonal and reproductive factors that are important in pathogenesis of both PFTC and ovarian carcinoma.[3] Moreover it is believed, that those two carcinomas share similar genetic,