Adenocarcinoma of Fallopian Tube Case Coexisting with Tuberculous Salpingitis

Tüberküloz Salpenjit Zemininde Gelişen Tubal Adenokarsinom Olgusu

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ABSTRACT Primay fallopian tube cancers, the least frequently seen among female genital malignancies, are very similar to ovarian cancers in histological properties and behavior. Data on its etiology, risk factors and prognosis is limited probably as a result of its rarity. There are few case reports in literature about tubal cancers coexisting with tuberculous salpingitis. While etiology of the tumor is still unknown, probable relation of it with chronic inflammation, infertility, tuberculous salpingitis and tubal endometriosis was noted. A case of primary tubal adenocarcinoma diagnosed postoperatively in a patient having high levels of Ca 125 and a right adnexal mass that was found during investigations for her menometrorrhagia was presented. In countries where tuberculosis is still an important health problem, the relation of the tubal cancer with tuberculous salpingitis should be remembered and surgical and specific medical treatments of the disease should be made accordingly.

Key Words: Fallopian tube neoplasms; salpingitis; CA-125 antigen

ÖZET Kadın genital kanserleri arasında en az sıklıkla görülen primer fallop tüp kanserleri histolojik özellikler ve davranış bakımından over kanserleriyle çok benzerdir. Nadir görülmesinin bir sonucu olarak bu kanserlerin etiyolojisi, risk faktörleri ve prognozu hakkında bilinenler sınırlıdır. Literatürde tüberküloz salpenjit ile birlikte tubal kanserlerin görüldüğü birkaç olgu sunumu mevcuttur. Tümörün etiyolojisi hala bilinmemekle birlikte, kronik inflamasyon, infertilite, tüberküloz salpenjit ve tubal endometriozisle arasındaki olası bir ilişki dikkat çekmiştir. Menometroraji nedeniyle yapılan tetkiklerde sol adneksiyal alanda kitle tespit edilen ve Ca 125 düzeyleri yüksek olan bir hastada tüberküloz salpenjit ile birlikte bulunan tubal adenokarsinoma olgusu sunuldu. Tüberkülozun hala önemli bir sağlık sorunu olduğu ülkelerde, tubal kanser ile tüberküloz salpenjit arasındaki ilişki akla getirilmeli ve olguların cerrahisi ve medikal tedavileri gerektiği gibi yapılmalıdır.

Anahtar Kelimeler: Fallop tüpü tümörleri; salpenjit; CA-125 antijeni

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Carcinoma of the fallopian tube accounts for 0.1-1.8% of all cancers of the female genital tract and are most frequently seen in the fifth and sixth decades with a mean age of 55-to-60 years.[1-5] The classic triad of sypmtoms and signs associated with fallopian tube cancer is a prominent watery vaginal dyscharge, pelvic pain and pelvic mass.[1] However, this triad is noted in fewer than 15% of patients.[2] In this report, we presented a case of primary fallopian tube cancer occuring in presence of tuberculous salpingitis in both fallopian tubes with the review of literature.

CASE REPORT

A 40-years-old gravida 3, para 2 patient applied to the clinic with complaint of menstrual dysregularity. Endometrial biopsy was compatible with secretory endometrium. Diagnostic laparoscopy performed 7 years ago for tubal occlusion was notable in her history. Ultrasonographic examination and MRI revealed a multicystic mass with thick septae measuring 76 x 66 x 45 mm in right adnexal region (Figure 1) and moderate amount free fluid. Of tumor markers, Ca125 was 476 U/ml. On laparotomic exploration, dense adhesions of fallopian tubes, right ovary and posterior wall of the uterus were noticed. Right fallopian tube was severely hydropic in appearance and there was some purulent material around right adnex. Right salpingooophorectomy was performed and the material was sent for frozen section. Frozen was reported as "adenocarcinoma, gastrointestinal origin is likely". Despite the frozen did not report any genital cancer, considering the appearance of pelvic organs globally and also the probability of a mistake in frozen, operating team decided to carry out tumor surgery in the remaining part of the operation. Then, total abdominal hysterectomy, infracolic omentectomy, appendectomy and pelvic-paraaortic lymphadenectomy were performed. Final pathology report was surprising: "Well differantiated endometrioid type adenocarcinoma in right fallopian tube and metastatic endometrioid type adenocarcinoma in left fallopian tube and ovary (Figure 2). Non-caseifying granulomatous inflammation of left ovary and bilateral fallopian tubes." Caseifying granulomatous lenfadenitis was determined in 12 nodes from common and external iliac lymph chains. Result of PPD test was positive with 16 mm PPD reaction. Antituberculosis treatment was started and patient was discharged with the plan of combined chemotherapy.

FIGURE 1: T2 weighted axial view of pelvic MRI. Lobulated and centrally hyperintense (cystic) mass lesion with nodular projections towards the center.

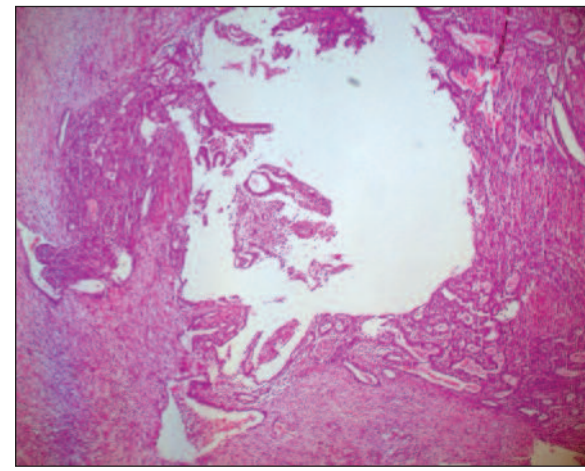

FIGURE 2: Primary adenocarcinoma focus in fallopian tube (HE, x50).
(See for colored form http://jinekoloji.turkiyeklinikleri.com/)

COMMENT

Like most of the cases that have been reported so far, preoperative diagnosis of fallopian tube cancer was not possible in this patient, too. Reasons for difficulty of preoperative suspicion of diagnosis may be rarity of tumor, absence of specific clinical symptoms and physical findings. Presumed diagnosis was ovarian cancer in this case, a prediagnosis that was almost inevitable at first look when combined a solid mass, free peritoneal fluid and elevated Ca-125 levels are taken into account.

Prevalence reported in literature changes between 0.3-1.8%[3-5] and incidence was said to raise during last decades.[6] In their review on determinants of incidence of primary fallopian tube carcinoma, Riska and Leminen said that while city life

and high social class are predisposing the tumor, high parity and previous sterilization procedure are protective against it.[6] In our case, the parity was two and the patient was coming from city life and from middle social class. Although etiology of the tumor is unknown, it is suggested to be associated with chronic tubal inflammation, infertility, tuberculous salpingitis and tubal endometriosis.[3] Relatively younger age of the patient for a tubal carcinoma makes us think that chronic granulomatous inflammation might be responsible for the development of this malignancy within tubal mucosa. Despite fallopian tube carcinoma is asymptomatic in many patients[3], the main symptoms in this case were menometrorrhagia and pelvic pain. We think that laparoscopy in medical history of our patient is notable. Coexisting tuberculous salpingitis was the most likely cause of tubal occlusion and consequent secondary infertility of her.

Ca 125 levels are higher-up in more than 80% of patients and this marker is useful in follow-up.[3] In this case, too, Ca125 level was haute. In fallopian tube cancers coexisting with tuberculosis infection which are clinically latent in most cases, antituberculosis therapy should initially be applied and then combination chemotherapy consisted of paclitaxel and cisplatin should be started regarding the probability of reactivation of tuberculosis infection because of immunosuppression due to chemotherapy.[7,8] In our case combined anti-tuberculosis therapy was started immediately after pathology report and chemotherapy was planned.

In conclusion, although rare, primary fallopian tube cancer may coexist with tuberculous salpingitis. So, in countries where tuberculous salpingitis is still a significant problem, this coexistence should be kept in mind and surgical and medical treatments of the disease should be made meticulously.

REFERENCES

1. Büyükkurt S, Güzel AB, Altıntaş A, Vardar MA, Küçükgöz Güleç Ü, Kadayıfcı O. [Extraperitoneal metastasis of the fallopian tube cancer: a review of the literature]. Turkiye Klinikleri J Gynecol Obst 2010;20(1):35-43.
2. Berek JS, Natarajan S. Ovarian and fallopian tube cancer. In: Berek JS, ed. Berek&Novak's Gynecology. 14th ed. Philadelphia: Lippincott Williams&Wilkins; 2007. p.1527-31.
3. Mladenović-Segedi L. [Primary fallopian tube carcinoma]. Med Pregl 2009;62(1-2):31-6.
4. Monge AH, Pineda RP, del Rocio Estrada Hernandez M, Juárez EG, García JC. [Fallopian tube primary invasive adenocarcinoma associated with acute inflammatory pelvic disease. Case report and literature review]. Ginecol Obstet Mex 2008;76(2):118-24.
5. Friedrich M, Villena-Heinsen C, Bonkhoff H, Schmidt W. [Primary fallopian tube carcinoma. Report of a single case with review of the literature]. Gynakol Geburtshilfliche Rundsch 1997;37(4):216-20.
6. Riska A, Leminen A. Determinants of incidence of primary fallopian tube carcinoma (PFTC). In: Verma M, ed. Methods of Molecular Biology, Cancer Epidemiology. 3rd ed. New Jersey: Humana Press; 2009. p.387-96.
7. Ingec M, Erdogan F, Kumtepe Y, Isaoglu U, Gundogdu C, Kadanali S. Management of bilateral fallopian tube carcinoma coexistent with tuberculous salpingitis. J Obstet Gynaecol Res 2005;31(1):65-7.
8. Scanga CA, Mohan VP, Joseph H, Yu K, Chan J, Flynn JL. Reactivation of latent tuberculosis: variations on the Cornell murine model. Infect Immun 1999;67(9):4531-8.