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PRIMARY FALLOPIAN TUBE CARCINOSARCOMA: REPORT OF TWO CASES

Case Report

PRİMER FALLOP TÜP KARSİNOSARKOMU: İKİ OLGU SUNUMU

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ABSTRACT

Primary carcinomas of the fallopian tube are one of the exceptional malignancies of the female genital tract and it is very difficult to diagnose preoperatively or intraoperatively due to nonspecific presentation. Primary fallopian tube carcinosarcomas are extremely rare and make up only 4% of all gynecological carcinosarcomas. Few cases of have been reported in the literature. In this study we presented two cases of Primary carcinomas of the fallopian tube. Our aim was to provide additional information about the clinico-pathologic features of this rare disease.

Key words: Follopian tube; carcinosarcoma

ÖZET

Follop tüplerinin primer karsinomları kadın genital sistem kanserleri içerisinde oldukça ender görülen olgulardır. Spesifik bir belirti vermediğinden dolayı operasyon öncesi veya operasyon esnasında tanı alması oldukça güçtür. Primer tubal karsinosarkomlar; tubal sarkomlar içerisinde en sık görüleni olmakla birlikte, literatürdeki olgu sayısı son derece sınırlıdır ve tüm jinekolojik karsinosarkomların % 4' ünü oluşturmaktadır. Çalışmamızda kliniğimizde son 4 yıl içerisinde tanı alan iki tubal karsinosarkom olgusunu sunarak bu nadir hastalığın kliniko-patolojik özelliklerini ortaya koymayı ve hastalıkla ilgili bilgi birikimine katkıda bulunmayı amaçladık.

Anahtar kelimeler: Fallop tüpleri; karsinosarkom

INTRODUCTION

Primary carcinomas of the fallopian tube (PFTC) are one of the rare malignancies of the female genital tract and accounts for 0.14-1.8 % of all genital malignancies (1). They usuallly seen in many cases as an unexpected operative finding at the time of laparotomy for a pelvic mass because of

its low incidence and difficulty in distinguishing preoperatively fallopian tube masses from ovarian or uterine pathology. Carcinosarcomas contains both malignant epithelial and mesenchymal elements. Although, carsinosarcomas (malignant mixed müllerian tumors) represent the largest number of sarcomas, few cases have been reported in the literature. Those that develop in the fallopian tube are extremely rare and make up only 4% of all gynecological carcinosarcomas and 2.4% of all malignant fallopian tube neoplasms (2). This report describes two PFTCS cases diagnosed during the last 4 years in our gynecologic oncology clinic.

CASE REPORT

Case 1

A 56 years old woman admitted to gynecologic oncology unit with a palpable large-fixed pelvic mass at July 2011. Computed tomography (CT) scan showed a large bilateral solid-cystic tumor originating from the both adnexia, diffuse ascites and omental thickening. Neither hepatic nor pulmonary metastasis were detected and there were no enlarged lymph nodes. Pre-operative serum CA125 level was 2582 U/mL and other tumor markers were within the normal range. The patient underwent explorative laparotomy. During the surgery hysterectomy, bilateral salpingo-oophorectomy, total omentectomy, appendectomy and partial gastrectomy were performed. Optimal debulking was not achieved due to tumoral implants around the porta hepatis. The postoperative period was uneventful. Final pathology revealed bilateral PFTCS, 34 reactive lymph nodes, metastatic implants on the omentum, appendix and gastric serosa. Both ovaries and uterus were normal with the metastatic implants on the surface. FIGO (International Federation of Gynecology and Obstetrics) stage of tumor was stage 3c. After 3 cycles of paclitaxel and carboplatin, interval debulking was done. Then, patient received four cycles of adjuvant paclitaxel and carboplatin. Four months after completion of chemotherapy abdominal CT revealed tumoral mass around the vaginal cuff and a third operation including tumoral debulking and low anterior resection carried out. Postoperatively, weekly paclitaxel and carboplatin was started and patient was accepted to have stable disease. During the follow up period; disease progression was tried to be controlled by weekly paclitaxel, gemcitabine, topotecan plus bevacizumab and docetaxel, respectively, but we could not able to accomplish a complete response. At the last fallow up visit she was alive with disease, so chemotherapy was stopped and palliative pain control was started.

Case 2

A 60 years old woman admitted to our clinic with abdominal pain. transvaginal ultrasonography revealed a solid- cystic mass with 9 cm in diameter which was located around right adnexia. No ascites were present. Her Ca-125 level was 32.7 U/mL while CA19-9 and CEA were within the normal range. The patient underwent exploratory laparotomy that revealed a mobile, 8 cm mass originated from the right fallopian tube. Right ovary, left ovary and fallopian tube, uterus and abdomino- pelvic peritoneal surfaces and viscera were all normal. Frozen section of the mass was reported as malignant. Total abdominal hysterectomy, bilateral salpingo-oophorectomy, pelvic and para-aortic lymphadenectomy and omentectomy were performed. The postoperative period was uneventful. Final pathology revealed PFTCS, 1 metastatic and 71 reactive lymph nodes. Omentum and the other specimens were free of disease. The FIGO stage of the disease was stage 3c. Six cycles of adjuvant chemotherapy consisting of paclitaxel and carboplatin have started to be given to the patient. She is still receiving chemotherapy without any problem.

DISCUSSION

Fallopian tube carcinosarcomas have a similar histology compared to its ovarian

counterparts. Carcinosarcoma of the fallopian tube is regarded as a very rare and highly malignant tumor with poor prognosis that is relatively chemo-resistant (3). There is no enough data relating to survival of PFTCS based on all stages. Recent study related to ovarian carcinosarcoma involving 33 patients revealed that most of the patients (84 %) belong to advanced stage (III –IV) and overall survival was only 21 months (4). A standard therapeutic approach to fallopian tube carcinosarcoma has not yet been established. Postoperative adjuvant therapy to reduce recurrence and relapses, as well as the resection of foci by surgery, is regarded as the principal therapy for uterine carcinosarcoma, the most frequently occurring carcinosarcomas in the gynecological field. The role of radiotherapy is less clear (5). Optimal cytoreductive surgery is the best strategy to improve patient survival in epithelial ovarian cancer, and the same seems to be true for carcinosarcoma of the fallopian tumors (6).

Usually, surgeons perform an additional staging surgery after the initial incomplete surgery, which seems to increase the morbidity of the patients. Therefore, PFTC's should be considered in patients complaining of lower abdominal pain in association with vaginal bleedings/watery discharge; a hydrosalpinx or adnexal mass of unknown location is shown on imaging, especially in postmenopausal women (8). Imaging studies such as ultrasound, computed tomography, or magnetic resonance imaging may aid in diagnosing PFTC. Although the imaging findings of tubal carcinoma are nonspecific, and mimic other pelvic diseases such as tubo-ovarian abscess or ovarian tumor, several findings may provide a diagnostic clue preoperatively. A sausage-shaped mass or a multi-lobular mass with a cog-and-wheel appearance on ultrasound, or low-impedance vascular flow within the solid components on ultrasound with color Doppler might lead to a suspicion of tubal malignancy (9). Magnetic resonance imaging is considered a better method than computed tomography or ultrasound for detecting tumor infiltration of extra-tubal organs (10).

It is reasonable to postulate that platinum combined with paclitaxel may have a greater benefit than other chemotherapy regimens in the management of this disease (11). Although we are using the most reported adjuvant chemotherapy regimen (carboplatin plus paclitaxel) in our patients, the number of reports is still limited and they have all been retrospective studies (6,11). In the literature there is also case report of PFTCS treated wit neo-adjuvant chemotherapy that consisting carboplatin and paclitaxel and surgery (12). To overcome the problems related to various clinical variables during the treatment of PFTCS, we must enroll more patients in future studies to determine the most favorable medical management protocols to be applied, which can be achieved by close cooperation among gynecologic oncology centers.

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