Primary carcinoma of the fallopian tube

Patient Information Series – What you should know, what you should ask.

The Fallopian tubes arises from the uterine corpus posterior and superior to the round ligaments. The lumen of the tubes communicates with the uterine cavity and the intraabdominal cavity. They function as channel for oocyte transport and fertilization as bilateral conduits between the ovaries and the uterus.

What is it?

Primary carcinoma of the Fallopian tube is one of the rarest gynecological malignancies, accounting for 0.18-1.6% of all malignant tumors of the female reproductive tract. It typically presents in the 5th and 6th decades of life (mean age at diagnosis 55-60 years). Most tubal cancers are serous papillary carcinomas; however clear cell carcinoma, endometrioid carcinoma and squamous cell carcinoma have been reported to rarely arise from the Fallopian tubes.
The etiology of Fallopian tube carcinoma is unknown. However, associations with nulliparity and infertility and history of tubercolosis and salpingitis/pelvic inflammatory disease have been described. Also, association with BRCA1 and BRCA2 genes mutations has been reported.

Which are the symptoms?

Clinical presentation of tubal cancer may be acute or subacute. In most cases, it is asymptomatic and it can be found incidentally during examination, imaging or surgery for another indication. The most frequent clinical symptoms at presentation are vaginal discharge or bleeding and lower abdominal pain; the most frequent clinical findings are a palpable pelvic and/or abdominal mass (Latzko's triad) and suspicion of ascites. Other symptoms are abdominal distension, urinary urgency, change in bowel function, low back pain and vulvar or inguinal pain.

How could it be diagnosed?

Evaluation of patients with features suggestive of tubal cancer is typically a multistep process. An initial evaluation including complete physical examination, pelvic ultrasonography and serum CA125 are useful to confirm the presence of an adnexal mass. The definitive diagnosis requires histological examination. Further imaging such as CT scan or PET-CT are necessary to stage the disease. Most tubal cancers present as a unilateral "sausage-shaped" mass with average size of 5 cm. Most tumors are located within the distal two thirds of the tube, a small percentage in the fimbriae.

How can this condition be treated?

The treatment depends on stage. Surgical staging and cytoreduction followed by adjuvant platinum-based chemotherapy is the standard of care. Residual disease after surgery is a poor prognostic factor. The prognosis is similar to primary ovarian carcinoma (5-year survival for all stages varies between 43% and 56%)

Which follow-up will I need?

Patients treated for tubal cancer are at high risk of recurrence. Follow-up consists in general physical and pelvic examination every 3 to 4 months for 2 years, then every 6 months for 3 years, then annually for 5 years. Patients with advanced-stage disease at presentation, who achieve and maintain a complete response, should be followed lifetime. Monitoring should also include assessment of CA 125.

What other questions should I ask?

- Which is the treatment for recurrent disease?

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