

# CLINICAL CASE

Adv Clin Exp Med 2005, 14, 1, 179–181  
ISSN 1230-025X

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## Endometrioid Carcinoma of the Hydrosalpinx – Case Report

### Rak endometrioidalny wodniaka jajowodu – opis przypadku

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#### Abstract

The study presented a case of a 53-year-old woman, who had never given birth, nor miscarried, diagnosed with endometrioid carcinoma of the right hydrosalpinx. The patient complained of serous leucorrhagia and hypogastric pain which were present for the past three months. The neoplasm occurred in the patient with uterine body and left oviduct endometriosis, being possibly in relationship to the above-mentioned (*Adv Clin Exp Med* 2005, 14, 1, 179–181).

**Key words:** endometrioid carcinoma, hydrosalpinx.

#### Streszczenie

Prezentowano opis raka endometrioidalnego w wodniaku jajowodu prawego u 53-letniej kobiety, skarżącej się od 3 miesięcy na surowicze upławy i bóle w podbrzuszu. Zasadniczej chorobie towarzyszyła rozległa gruczolistość trzonu macicy i lewego jajowodu. Obie przedstawione zmiany mogły mieć związek patogenetyczny (*Adv Clin Exp Med* 2005, 14, 1, 179–181).

**Słowa kluczowe:** rak endometrioidalny, wodniak jajowodu.

From review it appears that primary fallopian tube carcinoma is an extremely uncommon tumor [1]. The average annual incidence of this tumor in the USA was 3.6 per million women per year [2]. In Austria, during the period between 1980–1990, only 213 cases were registered [3]. In Poland, Rabczyński et al. collected the largest material, considering morphology and immunocyto-genetics of the tumor [4–6]. In cooperation with co-authors [5], he specified five histopathological types of the neoplasm, suggesting that the endometrioid type was the most common. On the other hand, Rorat and Wallach [7] consider the above-mentioned type to be exceptionally rare.

#### Case report

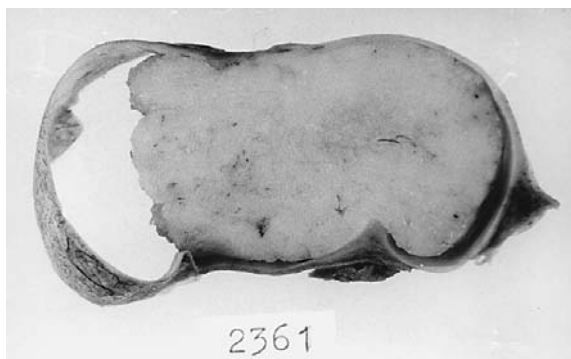
R.W., a 53-year-old female patient with a history of cholelithiasis. The patient had not given birth, nor miscarried. During the past three months

the patient complained of serous leucorrhagia with concomitant hypogastric pain. Investigations demonstrated the presence of a tumor in the right uterine adnexa. The patient underwent surgery which consisted of hysterectomy with adnexa removal. The pathomorphological examination (Nb: 2351-65/2000) was as follows: atrophic uterine body with normal mucous membrane, as well as endometriosis of the muscular membrane. Similar foci were noted in the muscular membrane of the left oviduct. Both ovaries comprised corpora albicantia, being free of endometriosis and neoplastic lesions. The right oviduct was distended, 19 × 6 cm in diameter (Fig. 1). A grey-whitish tumor was localized in the vicinity of the uterine body, penetrating exophytically into the lumen of the distended oviduct (Fig. 1 and 2). Microscopically, the authors noted a solid tumor, composed of cells with an acidophilic cytoplasm and vesicular nuclei with 2–3 nucleoli. The tumor formed solid foci surrounding connective tissue



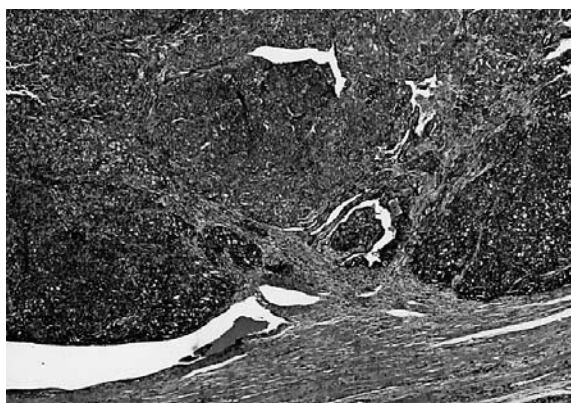
**Fig. 1.** Macroscopic appearance of the hydrosalpinx. On the right side the tumor mass is seen

**Ryc. 1.** Obraz makroskopowy wodniaka jajowodu. Po prawej stronie widoczna masa guza



**Fig. 2.** Tumor masses growing widely into the lumen of transverse sectioned distended fallopian tube are seen

**Ryc. 2.** Masy nowotworowe wzrastające do rozdętego światła jajowodu widoczne w przekroju poprzecznym



**Fig. 3.** Microglandular pattern of the tumor structure (HE,  $\times 110$ )

**Ryc. 3.** Mikrocewkowa struktura utkania guza (HE, 110 $\times$ )

septa. Under magnification, numerous, small glandular patterns were observed (Fig. 3). Positive staining was obtained using mucicarmine and alcian blue. Under 360 $\times$  magnification, 3–5 patho-

logical mitoses per field were noted. The tendency towards papilla or psammomatous body formation was not observed. The neoplasm was separated from the wall of the oviduct which comprised a chronic inflammatory infiltration without specific character (Fig. 3). Only in two areas did authors note macrofocal infiltration of the muscular membrane of the oviduct. The patient was diagnosed with endometrioid carcinoma (G3) of the right oviduct, stage Ia according to FIGO. The patient was directed to the Lower-Silesian Oncological Center in good general condition.

## Discussion

Clinical diagnosis of primary oviduct carcinoma is difficult. Baekelandt et al. diagnosed the above-mentioned in one (0.66%) of 151 cases. Intraoperative diagnosis was established in 11.3% of patients [8]. Abnormal bleeding and excessive vaginal discharge as well as hypogastric pain in postmenopausal women are considered the most common, although non-specific neoplastic symptoms [8, 9]. Intraoperatively, the operating surgeon noted the presence of hydrosalpinx or oviduct hematoma in 21% of cases [9]. The presented case confirmed the above-mentioned. In case of endometrioid carcinoma, diagnosed in a 48-year-old patient by Rorat and Wallach [7], the oviduct hematoma was 11  $\times$  1.5  $\times$  0.9 cm in diameter, the neoplasm being localized in the distal part of the oviduct. In the presented case, the lesion was localized near the body, with greater oviduct distention. The cited authors [7] maintain that the neoplasm was derived from endometriosis foci. Alvarado-Cabrero et al. [9] observed endometriosis foci in 23% of patients with primary oviduct carcinoma, and Rabczyński and Ziółkowski in 30%, although without significance with regard to cancer development [6]. In the presented case, the authors noted numerous endometriosis foci in the body of the uterus as well as the wall of the left oviduct. Thus, it seems possible that the presented neoplasm derived from right oviduct endometriosis foci, since Zarzycki [10] described bilateral oviduct endometriosis in a 44-year-old woman that also had not given birth, nor miscarried.

As of today, there are no markers which could significantly influence prognosis of the above-mentioned disease [4, 6]. The only feature influencing the time of survival is the clinical stage of the neoplasm [6, 9].

Closure of the ostium of the uterine tube can protect from neoplastic dissemination to the peritoneal cavity [6, 9]. Unfortunately, the authors do not know the mechanism of the above-mentioned

closure, inflammatory infiltrations having no influence [9]. In the presented case, the lesion was localized in the vicinity of the uterine ostium, the oviduct wall presenting insignificant, non-specific inflammatory changes.

Endometrioid oviduct carcinoma can be diagnosed in its early developmental stage, being characterized by non-invasive or superficial proliferation which was the case here. Thus, prognosis seems promising.

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Received: 15.04.2004

Revised: 19.05.2004

Accepted: 2.06.2004

Praca wpłynęła do Redakcji: 15.04.2004 r.

Po recenzji: 19.05.2004 r.

Zaakceptowano do druku: 2.06.2004 r.