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Case Report

Primary Choriocarcinoma Fallopian Tube - A Rare Case Report

Sarandeep Singh Puri[1], Krishn Sudha[2]

[1]Associate Professor, Department of Pathology, School of Medical Sciences and Research, Sharda University, Greater Noida, Uttar Pradesh, India.
[2]Senior Consultant & Head, Department of Pathology, ESI Hospital, Okhla, New Delhi, India.
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I N F O

Corresponding Author:
Sarandeep Singh Puri, Department of Pathology, School of Medical Sciences and Research, Sharda University, Greater Noida, Uttar Pradesh India.
E-mail Id:
drsarandeep147@gmail.com
Orcid Id:
https://orcid.org/0000-0002-6523-3070
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A B S T R A C T

Primary Choriocarcinoma of fallopian tube is a very rare entity, its incidence being 0.8% of Gestational Trophoblastic Disease (GTD). We report a case of primary choriocarcinoma of fallopian tube. The histologic diagnosis of Choriocarcinoma of the Left fallopian tube was made This case of gestational choriocarcinoma of the Fallopian tube was confirmed by p57 immunostaining. The patient was given 2 courses of chemotherapy (EMA-CO regimen). The interval between two courses was 3 weeks.

Keywords: Choriocarcinoma, Fallopian Tube

Introduction

Primary choriocarcinoma of fallopian tube is a very rare entity, its incidence being 0.8% of gestational Trophoblastic disease (GTD). Patients with tubal GTD are not clinically distinguishable from tubal ectopic pregnancies. We report a case of primary choriocarcinoma of fallopian tube.[1]

Case Report

A 29 years old female, gravida 2, para 2, was admitted to hospital with complaints of amenorrhoea since 2 months, irregular vaginal bleeding for 25 days and painful abdominal mass . On examination, she was conscious, moderately pale with tachycardia, and normotensive. Respiratory system was clear .The mass was tender, fixed about 22 week size gestation and was arising from pelvis. A transabdominal ultrasound showed no evidence of pregnancy, a normal uterus and a hypoechoeic mass of 9 x 7 cm with multiple bright internal echoes in the left adnexal region Provisional diagnosis of ectopic tubal pregnancy was made. Exploratory laparotomy revealed a large haemorrhagic friable mass in the pelvis which was obliterating the left adnexal area. It was closely adherent to the rectum and the left lateral pelvic wall. This was identified as left tubal chronic ectopic. The mass was separate from the uterus but was adherent to the left ovary and parts of small intestine. On manipulation heavy bleeding started from the growth area.

The tumour along with the affected tube and left ovary, removed at operation, were sent for histopathological examination. The histologic diagnosis of Choriocarcinoma of the Left fallopian tube was made. Section of the tubal growth showed tumour made up of cytotrophoblast and syncitiotrophoblast. The cytotrophoblast consisted of large round to polyhedral shaped cells with distinct cell borders. The cells were having pale cytoplasm and large round vesicular nuclei with prominent nucleoli. The syncitiotro-

phoblast consisted of columns of large pleomorphic cells having basophiic cytoplasm and large multiple nuclei.

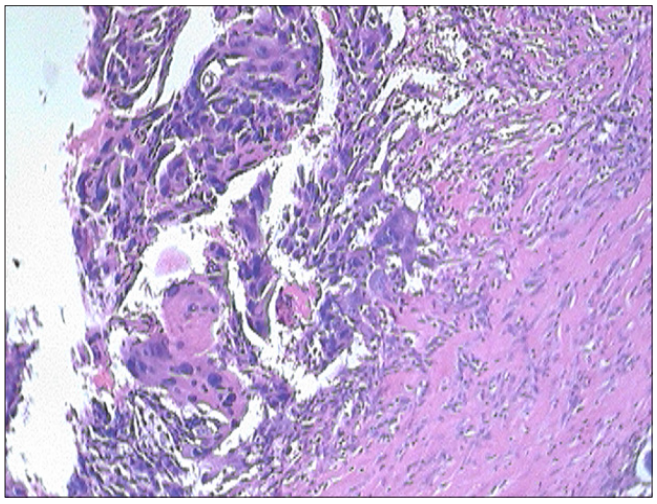

Figure 1

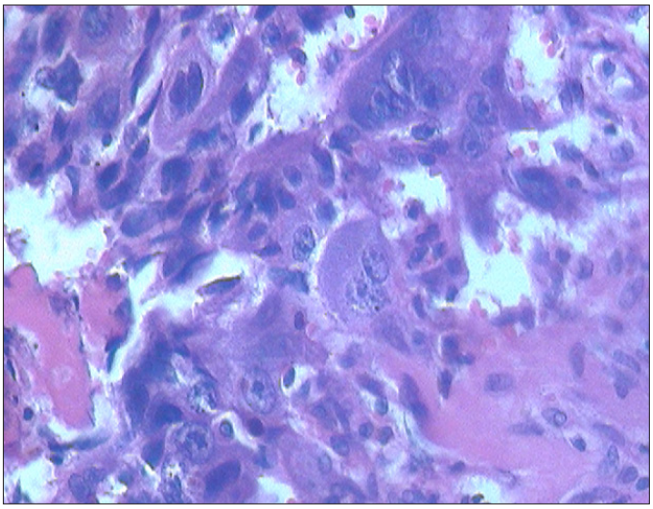

Figure 2

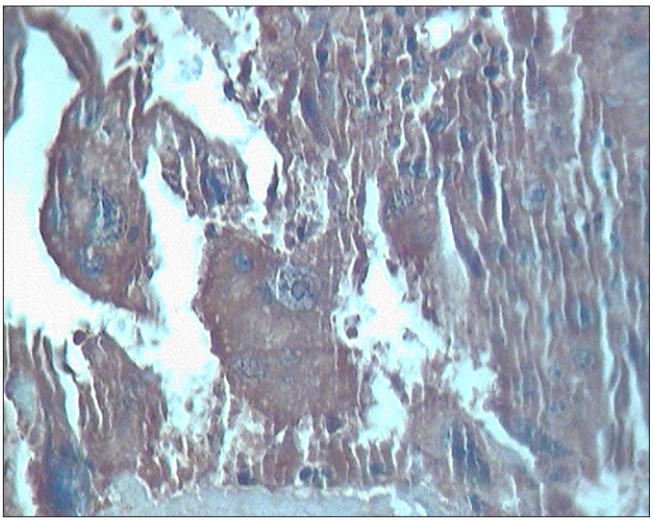

Figure 3

(Figure 1 and 2). This case of gestational choriocarcinoma of the Fallopian tube was confirmed by p57 immunostaining (Figure 3).

Urinary hCG done on 10th postoperative day was negative. X-ray chest showed multiple bilateral well-defined opacities in lower and mid- zones. She was given 2 courses of chemotherapy (EMA-CO regimen). The interval between two courses was 3 weeks. Before starting the second course complete hemogram, and liver and renal function tests were done and found to be within normal limits.

Discussion

Choriocarcinoma of the fallopian tube is a rare tumor. The preoperative diagnosis of choriocarcinoma of the fallopian tube is difficult, challenging and is rarely suspected on gross examination.[2] The histogonesis of tubal choriocarcinoma is not clear. Choriocarcinoma of the fallopian tube can develop by two principal mechanisms, the first one being a malignant transformation of a tubal pregnancy and the second one arising denovo without an ectopic pregnancy.[3] Fallopian tube carcinoma is rarely suspected preoperatively. The treatment approach includes total abdominal hysterectomy, bilateral salpingo-oophorectomy and staging followed by chemotherapy.[4] The prognosis of patients depends on the depth of invasion of the tubal wall and the presence of carcinoma in the fimbriated end even without invasion are important prognostic indicators. The modified International Federation of Obstetrics and Gynecology staging system should be used on a routine basis in all carcinomas of the Fallopian tube.[5] Although there are few data on the management of patients with choriocarcinoma and viable early pregnancy, the choice of conservative management demands strict follow up of the maternal and fetal health condition. The delivery should be performed as soon as the gestational age provides safe survival outcomes of the fetus, so between 30th-33rd gestational weeks. Close post chemotherapy follow-up is necessary in agreement with general guidelines on gestational trophoblastic disease.[6]

Conclusion

Primary Fallopian tube cancer constitutes 1% of gynecological malignancies. Early clinical manifestation and prompt investigations lead to diagnosis in the early stage of disease accounting for a better survival.

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Conflict of Interest: None

References

1. Parijatham BO, Gupta M. Primary Fallopian tube adenocarcinoma, J Clin Diagn Res, 2012;6(4):723–724.
2. Ajithkumar TV, Minimole AL, John MM, Ashokkumar

OS. Primary Fallopian tube carcinoma. Obstet Gynecol Surv, 2005;60(4):247–252.
3. Goldstein DP, Berkowitz RS. Gestational trophoblastic disease. In Abeloff MD, Armitage JO, Niederhuber JE, Kastan MB, McKenna WG (eds). Abeloff's clinical oncology. 4th edition, Elsevier-Churchill Livingstone, Philadelphia, 2008;Chapter 94.
4. Vimala N, Kumar S, Dadhwal V. Primary choriocarcinoma of the Fallopian tube. Int J Gynaecol Obstet, 2002; 79(1):37– 38.
5. Cabrero AI, Stolnicu S, Kiyokawa T, Yamada K, Nikaido T, Santiago-Payán H. Carcinoma of the Fallopian tube results of a multi-institutional retrospective analysis of 127 patients with evaluation of staging and prognostic factors. Ann Diagn Pathol, 2013;17(2):159–164.
6. Lee SM, Kang HJ, Young SO, Hong JS, Kim JW. A successfully trated case of primary tubal choriocarcinoma coexistent with viable intrauterine pregnancy. Gynecol Oncol. 2005;97(2):671-673.

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