

## Huge Fallopian Tube Cystadenofibroma-A Rare Case

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**Received:** January 07, 2015; **Published:** February 12, 2015

### Abstract

A 30 year old P2L2 woman admitted with a slowly growing abdominal mass. A huge ill-defined abdominal mass arising from the pelvis reaching upto xiphisternum firm to hard consistency was palpable. On per vaginum examination uterus could not be felt separate from the mass and both the fornices were full and non-tender. All routine investigations were within normal limits. USG showed a large 17\*14 cm lower abdomino-pelvic complex cystic lesion. Tumour markers: - CA 125-52.95; LDH 651; CEA: 1.03; CA 19-9-4.84 and AFP 0.69. CT scan showed an ill-defined cystic lesion of 16\*14\*17.8 cm arising from the pelvis and extending into abdomen up to sub-hepatic region with no internal fat or calcification with minimal free fluid.

Patient posted for exploratory laparotomy with frozen section on 16/10/2014. A huge ovarian cystic mass occupying the entire abdomen was seen with no free fluid in the abdomen and pelvis. The cyst was aspirated and drained of 1.5 liters of straw colored fluid. Cyst exteriorized and found to be arising from the left tubal area and the entire ovarian tissue could be found separate from the lesion. Right ovary, tube and uterus were found to be normal. Left tubal cystectomy was done. On cut section, a focal area of hard papillary excrescences was seen, rest entire cyst lining appeared normal. Fluid was negative for malignancy and the cyst revealed a borderline serous cystdenoma. Decision to conserve the opposite ovary and uterus was made.

Final histopathology report was benign tubal cystadenofibroma and patient did not require any treatment post-operatively and has been advised regular follow-up.

**Keywords:** Fallopian tube; Adenexal mass; Lump in abdomen; Fallopian tube tumours; Cystadenofibroma

### Introduction

Neoplasms of the fallopian tubes are the rarest tumours of the female genital tract. Cystadenofibroma are rare benign tumours of fallopian tube with around 15 cases reported worldwide [1]. They are usually asymptomatic and are found incidentally during investigations for infertility and embryo transfer [2]. They are confined to the fimbrial end and considered to be mullerian in origin [3,4].

### Case Study

A 30 year old multiparous woman (P2L2) came to our OPD with complaints of a slowly growing abdominal swelling with abdominal pain over the past one year. There were no other complaints. Patient was stable clinically with no anorexic features. On examination a huge ill-defined abdominal mass arising from the pelvis reaching upto xiphisternum was felt with firm to hard in consistency and restricted mobility. On per speculum examination cervix was pulled up and on per vaginum examination uterus could not be felt separate from the mass and both the fornices were full and non-tender.

Patient was admitted and all her routine investigations were within normal limits. Ultrasonography revealed a large 17\*14 cm lower abdominal pelvic cystic lesion with mildly lobulated solid lesion and soft tissue in its lower part with vascular flow with both ovaries not visualized. Tumour markers: -CA 125-52.95 (0-35 U/ml); LDH 651 (313-618 U/L); CEA: 1.03; CA 19-9-4.84 and AFP 0.69.



**Figure 1:** Pre operative picture of the mass occupying the entire abdomen.

CT scan was suggestive of large ill-defined cystic lesion of 16\*14\*17.8 cm arising from the pelvis and extending into abdomen up to sub-hepatic region with no internal fat or calcifications. A few regular nodular enhancing soft tissue components along the inferior margin with minimal free fluid were seen. No lymphadenopathy was detected. Impression of left ovarian cystic neoplasm was made.

Pre-anaesthetic fitness was made and patient was posted for exploratory laparotomy with frozen section facility available on 16/10/2014. Abdomen was opened by paramedian vertical incision. In situ a huge ovarian cystic mass occupying the entire abdomen was seen with no free fluid in the abdomen and pelvis. The cyst was aspirated at the most prominent point and drained of 2 liters of straw colored fluid. Following decompression, cyst was exteriorized and was found to be arising from the left tubal area and the entire ovarian tissue could be found separate from the lesion. Right ovary, tube and uterus were found to be normal. Left tubal cystectomy was done. On cut section, a focal area of hard papillary excrescences was seen, rest entire cyst lining appeared normal. The aspirated fluid and cyst was sent for frozen section. Fluid was negative for malignancy and the cyst revealed a borderline serous cystadenoma. Decision to conserve the opposite ovary and uterus was made. Abdomen was closed in layers after achieving hemostasis.

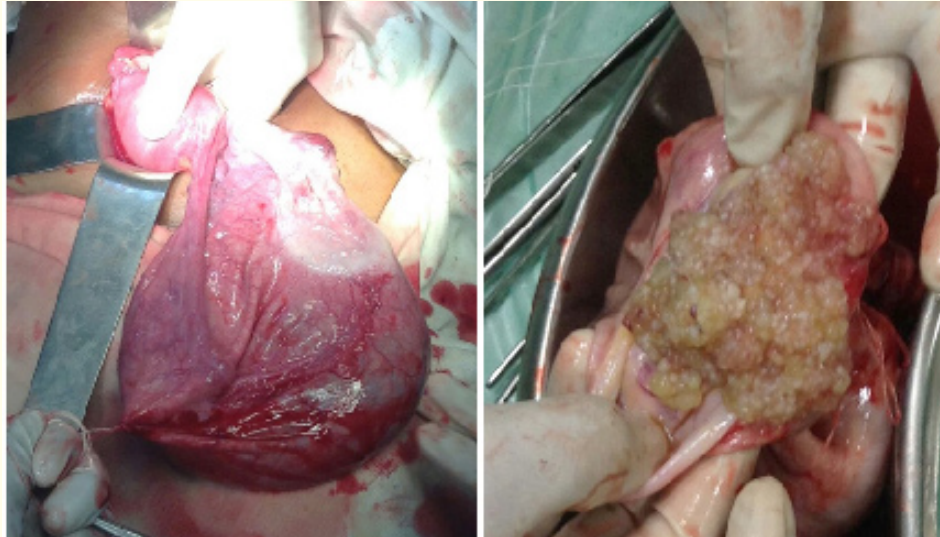
Her post-operative course was uneventful and suture removal done on day 10 and the wound was healthy. Final histopathology report was benign tubal cystadenofibroma and patient did not require any treatment post-operatively and has been advised regular follow-up.

### Discussion

Cystadenofibroma presents as a round, solitary mass that is either intra-luminal or attached to the fimbriated end or the serosal surface and may have a smooth or papillary surface [5]. Cystadenofibroma are more prevalent in the fourth and fifth decades of life. Symptoms includes abdominal pain, palpable mass, vaginal bleeding and urinary and bowel symptoms [3]. In our case patient was atypical due to her age, presenting symptoms and the unusual size of the tumour. The differential diagnosis of a tumor of tubal origin includes tubal carcinoma (primary or metastatic), serous tumor of low malignant potential (STLMP) and borderline papillary serous tumor of the fallopian tube.

Histologically they are similar to their ovarian counterpart. Two components are present, a connective tissue stroma without nuclear pleomorphism or mitoses and papillary structures on the surface or tubal surface lined by epithelial cells. The epithelial cell type has been most commonly serous but occasionally may be endometrioid. The topographic localization of the tumour, findings of mullerian

type epithelium, immune-phenotypic profiles of vimentin-cytokeratin co-expression and diffuse atypical epithelial membrane antigen immunoreactivity suggest that tumour was an embryological remnant originating from the mullerian epithelium [2].



**Figure 2:** Intra-op Pictures of the Cyst seen separate from the Left ovary and Cut section showing papillary excrescences.

### Conclusion

Cystadenofibroma are rare benign tumours of the fallopian tube and are usually incidentally detected [3]. However they need to be differentiated from the other fallopian tube tumours as the management, prognosis and follow up of patients may vary. Moreover cystadenofibroma are benign tumours with rare malignant potential and hence decision for radical surgery needs to be reconsidered as it may impact future fertility potential of the patient.

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Volume 1 Issue 2 February 2015

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