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Case Report

Papillary Serous Cystadenocarcinoma of Salpinge Report of a Case

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Abstract

Background: Primary salpinge carcinoma is a rare tumor with an incidence close to 0.2%. Evidence suggests that it may originate from the fallopian tube, which corresponds to the less common site for the origin of a neoplasm. Mortality results in 5.1% This early detection is the cornerstone for the success of the treatment.

Clinical Case: A 52-year-old patient who came to the emergency department due to abnormal uterine bleeding, pelvic ultrasound revealed uterine myomatosis and complex right ovarian cyst, probable cystadenoma, CA 125 tumor markers with report 29.2, was scheduled for laparotomy explorer for uterine leiomyomatosis and right adnexal cyst, bilateral hydrosalpinx, total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed, surgical piece was sent to pathology where serous papillary cystadenocarcinoma was reported in right salpinge, blood loss was 300cc, reference was made to hospital third level for your attention, where you will find surgical programming for optimal debulking.

Conclusion: For the majority of serous lineage neoplasms we must now translate our understanding of pathogenesis into a more effective prevention and treatment, all physicians must know risk factors and assess early detection in the population at risk, prevention is the only approach proven to reduce the incidence of the disease.

Keywords: *Fallopian Tube Cancer; Ovarian Cancer; Serous Carcinoma; Salpingectomy; Salpingo-Oophorectomy*

Background

Primary salpinge carcinoma is the least frequent tumor of the female genital tract; current evidence suggests that serous papillary ovarian cancer may originate from the fallopian tube, which corresponds to the least common site for the origin of a neoplasm [1].

The incidence is close to 0.2%, remembering that ovarian cancer is the second most common cause of death due to gynecological neoplasia, 95% of these are attributed to epithelial lineage, with serous carcinoma being the most frequent histological subtype with 75% which is closely related to fallopian tube carcinoma, some authors have proposed that all serous carcinomas originate in the fallopian tubes this based on the deletion of the BRCA mutation in the fimbria [2].

Fallopian tube carcinoma is predominantly disseminated through the ostium of the tuba and within the peritoneal cavity, the most frequent sites of metastasis include ovary and uterus, pelvic and para-aortic nodes. Ovarian cancer has an incidence of 9.4 per 100,000 women and mortality is 5.1%, the average age of presentation is approximately 63 years, this risk factor being that it is reported that

50 - 59 years old incidence is between 21.8 to 28.3 per 100,000 patients, increasing to 47.6 for over 70 years, in turn, is associated with endometriosis with a risk of up to 2.5% for malignant transformation, polycystic ovary syndrome although its association is inconclusive study in Sweden shows a relative risk of 2.16, infertility in a study that included more than 5000 women with ovarian cancer there was a significant increase in risk in women who tried to conceive a pregnancy for more than 5 years compared to those who they tried for only one year, use of an intrauterine device (IUD) even though association is not clear, the New Health Foundation showed a relationship between the use of IUD and an increased risk of ovarian cancer with a relative risk of 1.76, however, the type of IUD was not specified, smoking is associated with the histological strain of mucinous type with a relative risk of 2.1, does not increase the risk for serous carcinoma, incessant ovulation since repeated ovulation produces a minor trauma in the ovarian epithelium which in turn can condition a malignant transformation this in comparison with patients with contraception or in pregnancy where they have a lower incidence, early menarche, late menopause these two items based on persistent ovulation with longer exposure to estradiol, the increase in risk has been found from 2 to 7% for each year that is delayed Menopause, nulliparity probably due to the same rationale, is described that with each pregnancy the risk of ovarian cancer is reduced to 8% If multiparity is a protective factor, exposure to gonadotropins and high concentrations of estradiol can be carcinogenic, this hypothesis is well founded since the induced ovarian tumors contain gonadotropin receptors, genetic associations as deletions of the BRCA mutation where they have a great increase in risk for ovarian cancer, this type of mutations are also a risk factor for carcinoma of the fallopian tube and breast, for BRCA 1 the estimated risk for ovarian cancer is 35 to 46% and for BRCA 2 is 13 to 23%, it has been reported in the literature association of invasive cancer in 13 to 15%, in terms of postmenopausal hormone therapy was found a significant increase with the administration alone of estrogen compared to the combined therapy with progestin, the increase in body mass index (BMI) apparently increased ovarian cancer, in a cohort study for 16 years, increased death was found in a patient with ovarian cancer and BMI greater than 35, finally Risk factors for ovarian cancer are the same as for fallopian tube carcinoma.

The protective factors where it has been documented that reduce the risk for ovarian cancer include contraception, multiparity, salpingo-oophorectomy, bilateral tubal occlusion, hysterectomy, breastfeeding and recently the Nurses Health study reported the use of aspirin at low doses i.e. < 100 mg/day, considering its use as a cardiovascular prevention is attributed as a possible protective factor of ovarian cancer [3-6].

The pathogenesis contains mutations of p53 with nuclear accumulation of this protein, in the fimbric epithelium there are segments composed only by secretor type cells, non-proliferative and histologically benign, with strong immunoreactivity to p53, they are called p53 signatures, the presence in the fimbriae of normal women demonstrate that under normal physiological conditions, the epithelial cells fimbricas undergo genetic damage and predispose to a DNA damage, the p53 signatures have been found in tuberous serous carcinoma, the pathogenesis indicates the involvement of the damaged DNA, mutation of p53 and progressive loss of cell cycle control, genotoxic stress leads to clonal expansion of secretory cells, forming a preneoplastic precursor lesion or p53 signature. This has the ability to spread from the fimbria to adjacent pelvic structures [7].

Generally the clinical picture when there is presence of symptoms, the patient is in a stage III, the most common presence is pelvic pain, gastrointestinal symptoms, accompanied or not of adnexal mass as a finding during a physical examination, in the realization of an ultrasound by some other indication, patients with acute symptoms are usually in advanced stage debuting with pleural effusion or intestinal obstruction, as a finding during an exploratory laparotomy, where a dilated fallopian tube is commonly observed, other classic symptoms associated with malignancy have been reported as discharge vaginal serosanguinolenta in 50 - 60% pelvic pain 30-50% and pelvic mass in 12 - 61% called Latzko's triad, a hydrosalpinx with intermittent serosanguinous vaginal discharge accompanied by an adnexal mass could be pathognomonic of malignancy, it has been described that the pain produced by tubal distension that produces a carcinoma A tubal oma allows detecting patients in earlier stages compared to ovarian cancer, however, the final diagnosis is histological when determining the thick tumor in the fallopian tube, if there is histological involvement of the tubal mucosa with papillary pattern and evidence of transition between the malignant and benign tubal epithelium, if the wall of the tuba is involved, therefore the interest to reduce mortality has awakened as possible screening tests since they are not invasive, the tumor markers especially with CA 125 is a glycoprotein present

in celomic-embryonic epithelial tissues, the measurement consists of the serum concentration of the antigen of the glycoprotein CA 125, the serum values are elevated in approximately 50% of the women in the early stage and in more than 80% in women with cancer.

Ovary advanced, its specificity is limited, since it increases its concentration in 1% of all healthy women and fluctuate during the menstrual cycle, it also increases in endometriosis, uterine myomatosis, liver cirrhosis with or without ascites, pelvic inflammatory disease, cancer endometrium, breast, liver and pancreas, pleural effusion, however the focus is on postmenopausal patients, a prospective study of asymptomatic postmenopausal women, found that a serum CA 125 elevation greater than 30 U/ml is a remarkable predictor for cancer ovary, it has even been reported specificity of 98.6 to 99%, other tumor markers consists of detection of protein 4 of the human epididymis which seems to have the same sensitivity as CA 125 [8-10].

The unattainable search to assess the routine use of tests for early detection has allowed us to conduct studies where they have shown that women with suspected hereditary ovarian cancer should be referred for genetic tests, which consider mutations of BRCA 1 and 2 and for syndrome Lynch, or those patients with a relative with breast or ovarian cancer before age 50, however, the current recommendation is not to perform ovarian cancer screening in asymptomatic women who are not known to have a cancer syndrome hereditary [11].

Clinical Case

Patient of 52 years of age and gynecological-obstetric history of 3 vaginal births, family planning method bilateral tubal occlusion. He went to the emergency department for abnormal uterine bleeding, the physical examination did not yield important data, protocol was performed in the outpatient clinic documenting the following studies: Papanicolaou negative, with cellular changes reactive to nonspecific inflammation, pelvic ultrasound which revealed uterine myomatosis of small elements, intermediate secretory endometrium with data from hematometra, right ovary with complex cystic formation, probable cystadenoma, endometrial biopsy was reported by reporting secretory endometrium, tumor markers CA 125 were requested, which reported 29.2 U/ml, was programmed for exploratory laparotomy due to leiomyomatosis uterine and right adnexal cyst, finding a uterus with multiple myomas, bilateral hydrosalpinx and hemorrhagic cyst in the right ovary, therefore a total extrafascial abdominal hysterectomy and bilateral salpingo-oophorectomy was performed, no transoperative study was performed because the resource was not available; The patient was diagnosed with papillary serous cystadenocarcinoma in the right salpinge of 2.5 cm of the major axis with two neoplastic thrombi in the cervical lymphatics, the rest of the samples without alterations, the blood loss was 300cc, a referral to the hospital was made. third level for your care, where you will find surgical programming for pelvic and paraaortic lymphadenectomy.

Discussion

Ovarian carcinoma is a highly lethal disease, more than 60% of affected women die from it, most diagnosed at advanced stage with a 5-year survival rate, between 9 - 34%, the current approach consists of the improvement in overall survival in recent decades, currently there is no effective screening test that can lead to prevention or early diagnosis, there are no significant differences in the detection of ovarian cancer in an average follow-up of 9 years, comparing patients who received detection with CA 125 and ultrasound endovaginal and a control group that did not have detection studies, reserving only in cases of high risk for hereditary cancer, however, a study showed that in patients with high hereditary risk for breast cancer, ovary, in which prophylactic salpingectomy was performed , the histopathological examination found tubular cancer hidden in the fimbria, as well as in patients in whom salpingectomy is performed for some other indication, assert the importance of sending these specimens to pathology after benign or postpartum surgery, even if there are no clinical features that suggest a risk of hereditary syndrome of breast and ovarian cancer, for that reason it is proposed since it can be an early detection mode, the treatment lines for fallopian tube carcinoma are identical to those of ovarian cancer, as well As the staging proposed by the FIGO, the staging in the sites has been combined but ex There is a great diversity among histological subtypes, ovarian carcinomas.

Tubal and peritoneum are no longer considered a single entity, but a heterogeneous set of diseases that vary in pathogenesis, histology and clinical behavior, with 70% of ovarian, fallopian tube and peritoneal carcinomas being the high-grade serous subtype [12,13].

Criteria have been postulated by the gynecologic oncology group to determine the primary site, in which they describe if there is invasive intraepithelial neoplasia in the fallopian tube, independently of the disease in other sites, if there is no intraepithelial neoplasia in the tube of Fallopian and if there is at least 0.5cm of carcinoma within the ovarian parenchyma, primary peritoneal if none of the above criteria is applied, the current recommendation is to perform total abdominal extrafascial hysterectomy with bilateral salpingo-oophorectomy, pelvic lymph node dissection and para-aortic, infracolic and infragastic omentectomy, is the standard procedure for carcinoma of the ovary, fallopian tubes and peritoneal, cytoreductive surgery is the cornerstone of therapy for ovarian, tubal and peritoneal carcinoma, with potential benefits of primary surgical management , the optimal response to systemic chemotherapy Postoperative ca is achieved in the context of a minimal disease burden, this is associated with an increase in survival, the mechanism for the survival benefit is given by the drugs chemotherapeutics which exert their maximum effects on small tumors that are well permed and therefore mitotically active [14,15]. In this case, the CA 125 serum detection did not give positive results, there was no Latzko triad, or other associated risk factor, in the physical examination it was not possible to palpate adnexal mass, so when performing exploratory laparotomy, It was identified as a transoperative finding.

Conclusion

Given the plausible concept of a tubal origin for the majority of serous lineage neoplasms, we must now translate our understanding of pathogenesis into a more effective prevention and treatment for patients with this disease, all physicians must know associated risk factors, to assess early detection in the population at risk, understanding the pathogenesis, which is such an important factor for early mortality, opportunistic salpingectomy during benign gynecological surgery appears to be safe and may offer some protection against ovarian cancer without compromising endocrine function of the ovary, in essence all the fimbrias must examine yourself microscopically Regardless of the clinical context, prevention is the only proven approach to reduce the incidence of the disease.

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