Malignancies arising in the fallopian tube are extremely rare, accounting for less than 1% of gynecologic malignancies. This rarity makes it unlikely that any single institution will have managed enough patients in a uniform manner to be able to critically evaluate different treatment plans. Most institutions agree that diagnosis, staging, and treatment are analogous to ovarian cancer. Often, the matter of whether an advanced adnexal malignancy is of ovarian or tubal origin cannot be determined until the final pathologic diagnosis is made.

All ages may be affected, but most patients are postmenopausal and greater than age 50. In the past, chronic tubal inflammation from pelvic inflammatory disease or tuberculosis was thought to be associated with primary fallopian tube carcinoma. With careful evaluation of these two entities, however, it is impossible to determine whether the inflammation came before, during, or after the tubal carcinoma.

**Screening**

There is no effective method for screening asymptomatic women for the detection of tubal cancer.

**Diagnosis**

The classic triad of symptoms—abdominal or pelvic pain, watery vaginal discharge, and pelvic/abdominal distention—has been taught for years as being suspicious for the diagnosis of fallopian tube carcinoma. However, in reality this triad does not function as effectively as one would think. “Hydrops tubae profluens,” or watery vaginal discharge, has been reported by some investigators as pathognomonic for tubal carcinoma, but even in the face of this triad, rarely is a preoperative diagnosis of fallopian tube carcinoma made. Vaginal bleeding occurs in greater than 50% of patients, and some authors have proposed that persistent postmenopausal bleeding with negative endometrial sampling requires consideration of fallopian tube carcinoma. Papillary serous adenocarcinoma is the most frequent subtype and occurs in 90% of patients.

Certain criteria have been proposed for making the diagnosis of tubal carcinoma due to the difficulty of differentiation between primary tubal and primary ovarian malignancy:

1. The tubal carcinoma should arise from the endosalpinx.
2. The histologic pattern should resemble epithelium of the tubal mucosa.
3. Transition from benign to malignant epithelium should be present.
4. The endometrium and ovaries should be normal or should contain a malignant neoplasm that by histologic appearance, small size, and distribution appears to be metastatic from a tubal primary.

**Staging**

Due to the rarity of this disease process, no International Federation of Gynecology and Obstetrics (FIGO) staging was official until 1991. Most authors in the past used a modification of the ovarian carcinoma staging system to report their results. As with ovarian carcinoma, very careful and appropriate staging should be done at the time of the original surgery, as prognosis and treatment will be determined by the stage.

**Treatment**
Fallopian tube carcinoma, like ovarian carcinoma, is initially surgically diagnosed and staged. Again, as in ovarian cancer cases, the patient should have bowel preparation, prophylactic antibiotics, and deep venous thrombosis prophylaxis. There is probably no role for conservative surgery (less than complete surgical removal of uterus, tubes, and ovaries) in fallopian tube carcinoma, as there is inadequate literature to support the conservative management of this disease process.

**Chemotherapy**

At the present time, chemotherapy for fallopian tube carcinoma mirrors that for ovarian carcinoma. Most institutions currently favor paclitaxel (Taxol) combined with cisplatin (Platinol) or carboplatin (Paraplatin), although cyclophosphamide, Adriamycin, and cisplatin (CAP), used in combination, have been the traditional drugs of choice.

**Radiation Therapy**

Initially, radiation to the whole pelvis was a primary treatment modality. Whole-abdominal radiotherapy has recently been employed, as has phosphorus-32 (32P) for early disease. At the present time, however, most institutions use either chemotherapy as a primary treatment and radiation as a palliative measure, or a combination of chemotherapy and large-field radiotherapy.

**Special Considerations**

**Choriocarcinoma**

This rare clinical entity arises in conjunction with an ectopic pregnancy and is managed like the usual gestational trophoblastic disease with apparently similar cure rates.

**Sarcoma**

The fallopian tube is an extremely rare site of origin of sarcomas. Most of these are classified histologically as mixed mullerian tumors. Five-year survival rates are less than 15%. No adjunctive therapy is considered curative.

**Follow-up**

Due to the rarity of this disease process, the role of second-look operation has not been adequately evaluated. The patient has to be counseled that this operation would be investigational but at times may give information relevant to further treatment.

An office history and physical examination every 3 to 4 months for 2 years and then every 4 to 6 months for up to 5 years are appropriate follow-up measures. Ultrasonography, CT, or MRI may be helpful if clinically indicated. CA-125 may only be reliable if elevated preoperatively.

**Recurrence**

Surgical treatment of recurrent disease should be guided by realistic goals involving quality-of-life considerations. Chemotherapy has a similar role as it does for recurrent ovarian carcinoma, and second-line cures are rare. Radiotherapy can be used palliatively to improve quality of life.

**References:**


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Links:
[1] http://www.cancernetwork.com/ovarian-cancer