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Case Report: Open Access

Supraclavicular Lymph Node as a Presentation of Fallopian Tube Cancer

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Abstract

Background: Supraclavicular lymph node metastasis is a rare presentation of primary fallopian tube cancer and there have only been three cases reported in the literature.

Case: A 44-year-old female presented with a large firm mass involving the left side of her neck; she denied any other symptoms. A CT scan was performed which was consistent with a 5.9 cm left-sided neck mass. A fine needle aspiration biopsy was consistent with poorly differentiated adenocarcinoma, and a serum CA125 was normal. Subsequently, a PET scan was performed and revealed increased uptake in the para-aortic and retroperitoneum lymph nodes; a soft tissue mass was seen in the left hemi-pelvis. Robotic laparoscopic left salpingo-oophorectomy and right peri-aortic lymph node removal was performed for diagnostic purposes. Diagnosis of stage IV adenocarcinoma of fallopian tube was made. The patient was not a good candidate for debulking surgery due to her retroperitoneal lymphadenopathy and large supraclavicular lymph node. The patient was started on paclitaxel and carboplatin with good response.

Conclusion: Fallopian tube adenocarcinoma can initially present with an enlarged supraclavicular lymph node.

Background

Fallopian tube cancer is very rare and accounts for only 1 to 2 percent of all gynecological cancers. The incidence of fallopian tube carcinoma is 3.72 per million annually in the United States [1]. Demographic distribution is similar to ovarian cancer, and the highest incidence was found in white, non-Hispanic women and women aged 60-79 years [2]. The signs and symptoms and of tubal cancer include: irregular or heavy postmenopausal vaginal bleeding, occasional abdominal or pelvic pain, feeling of pressure, vaginal discharge (which may be clear, white or tinged with blood), and or a pelvic mass or lump [3]. Supraclavicular lymph node metastasis is a rare presentation of primary fallopian tube cancer and there are only three cases reported in the literature [4-6].

Case

A 44-year-old African American para 0 female, presented with a large firm mass involving the left neck extending from just below the ear down to the left supraclavicular region measuring 5 to 6 cm in all dimensions. Upon presentation she denied any other symptoms. A computed tomography (CT) scan with contrast of the neck demonstrated a large mass in the left neck measuring 5.9 cm. A fine needle aspiration biopsy of the mass was performed, cytology was positive for malignancy, and stains were consistent with poorly differentiated carcinoma. Tumor cells were positive for cytokeratin but negative for vimentin, CD3, CD20 and S100 consistent with a probable adenocarcinoma. CT scan of the chest, abdomen and pelvis performed with contrast which showed a mass with central necrosis in the retroperitoneum on the left side measuring 2.9 cm. The uterus appeared slightly enlarged with multiple enhancing nodules measuring between 2 cm to 4 cm with a complex cystic lesion in the left adnexal region measuring 3.8 cm; serum CA125 was normal. A positron emission tomography (PET) scan was performed revealing a left supraclavicular mass measuring 5.9 cm, with increased uptake at the para-aortic lymph node, as well as multiple hyper-metabolic nodes in the retroperitoneum at the level of aortic bifurcation. A soft tissue mass was seen in the left hemipelvis measuring 3.5 cm in size. Robotic laparoscopic left salpingo-oophorectomy and right peri-aortic lymph node removal was performed for diagnostic purposes. Pathology identified a high grade serous adenocarcinoma involving the left fallopian tube as well as the right peri-aortic lymph node along with the left ovary showing atrophic changes. Diagnosis of stage IV fallopian tube was made, although the patient was not a good candidate for debulking surgery due to her retroperitoneal lymphadenopathy and large supraclavicular lymph node. She was eventually started on paclitaxol and carboplatin for total of 8 cycles. After 4 cycles she has had 50% reduction in her left supraclavicular lymph node.

Discussion

The differential diagnosis of supraclavicular lymphadenopathy is broad it includes: tuberculosis, sarcoidosis, toxoplasmosis and malignancy of lymph node, blood, lung, upper GIT, breast, ovary, testes, and other sites of body [7,8]. Supraclavicular lymphadenopathy is often malignant (58-83%) and it occurs mainly on the left side [9,10]. Most of the metastases originate from sites other than the

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head and neck including lung, breast and cervix [7-9]. In the English literature, few cases reported that supraclavicular lymph node enlargement can be an unusual presentation of primary fallopian tube cancer. There are other case reports about unusual presentation of fallopian tube cancer mainly presenting as axillary, inguinal or retroperitoneal lymphadenopathy [11].

Teaching Points

1. We presented a patient with fallopian tube adenocarcinoma who presented with supraclavicular lymph node enlargement which is a very rare and unusual presenting symptom.

2. Fallopian tube cancer should be considered in females presenting with metastatic supraclavicular lymphadenopathy with an unknown primary cancer site.

Conflict of Interest/Disclosure

None of the authors have any conflicts of interest.

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Precis

The objective of this article is to highlight a case of unusual presentation of fallopian tube cancer.

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