# Cancer Association of South Africa (CANSA)

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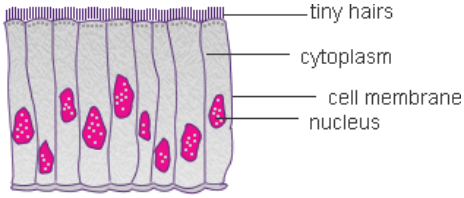
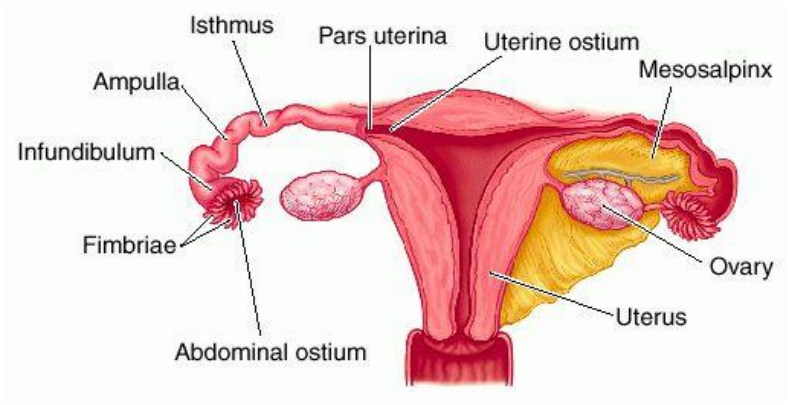
## Fact Sheet on Fallopian Tube Cancer

**Introduction**

The Fallopian tubes, also known as oviducts, uterine tubes, and salpinges (*singular* salpinx) are two very fine tubes lined with ciliated epithelia (cells with fine hair-like structures called cilia which aids to propel ova from the ovaries to the uterus), leading from the ovaries of the female into the uterus, via the utero-tubal junction.




[Picture Credit: Ciliated Epithelium]




[Picture Credit: Fallopian Tubes]

In a woman's body the fallopian tube allows passage of the egg (ovum) from the ovary to the uterus. Its different segments are (lateral to medial):

- The infundibulum with its associated fimbriae near the ovary
- The ampullary region that represents the major portion of the lateral tube
- The isthmus which is the narrower part of the tube that links to the uterus
- The interstitial (also known as intramural) part that transverses the uterine musculature. The tubal ostium is the point where the tubal canal meets the peritoneal cavity
- The uterine opening of the Fallopian tube is the entrance into the uterine cavity, the utero-tubal junction.

(Wikipedia; Encyclopaedia Britannica).

The fallopian tubes are named after their discoverer, the 16th century Italian anatomist, Gabriel Fallopius.


[Picture Credit: Gabriel Fallopius]

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**Fallopian Tube Cancer**
Fallopian tube cancer is cancer that occurs in any part of the fallopian tube.

Primary fallopian tube cancer means the cancer first started to grow in this area. Sometimes cancers that start in other areas, such as the ovaries, womb or cervix, can spread to the fallopian tubes. This is known as a secondary fallopian tube cancer and is treated according to where the cancer started (the primary cancer).

There are different types of fallopian tube cancer. The most common type is adenocarcinoma, which starts in the cells that form part of the lining of the fallopian tubes.

Other types of fallopian tube cancer are very rare and include

- Transitional cell – transitional cells are stretchy cells found in the fallopian tube lining
- Sarcoma – this affects the muscular part of the fallopian tube

(MacMillan Cancer Support; Cancer Research UK).

**Incidence of Fallopian Tube Cancer in South Africa**
The National Cancer Registry (2012) does not provide any information on the incidence of Fallopian Tube Cancer.

**Risk Factors for Fallopian Tube Cancer?**
Given its rarity, the causes and risk factors for developing primary fallopian tube cancer are not clearly defined. There has been some association of the cancer with chronic infection and/or inflammation of the fallopian tubes (due to untreated sexually transmitted diseases, for example), although a cause-effect relationship has not been definitively established.

There are several genetic mutations that have been reported in anywhere from 16-43% of women with primary fallopian tube cancer. The mutations involve the hereditary breast and ovarian cancer genes, and particularly BRCA1. Given the relative rarity of fallopian cancer, any woman diagnosed with this disease should undergo thorough family history assessment, and be offered genetic counselling. Conversely, if a woman knows that she carries a BRCA mutation, rigorous screening for fallopian cancer should be considered in order to increase chances for early detection.
(Oncolink).

**Signs and Symptoms of Fallopian Tube Cancer**
Women with fallopian tube cancer may experience the following symptoms or signs. Sometimes, women with fallopian tube cancer do not show any of these symptoms. Or, these symptoms may be caused by a medical condition that is not cancer.

- Irregular or heavy vaginal bleeding, especially after menopause or in between periods
- A swollen abdomen
- Occasional abdominal or pelvic pain or feeling of pressure
- Vaginal discharge, which may be clear, white, or tinged with blood

- A pelvic mass or lump

As a tumour in the fallopian tube grows, it can push against the walls of the tube and cause abdominal pain. If untreated, the cancer can spread into and through the walls of the fallopian tubes and eventually into the pelvis (lower abdomen) and stomach areas. This can cause other symptoms as well.
(Cancer.Net; MacMillan Cancer Support).

**Diagnosis of Fallopian Tube Cancer**
Because fallopian tube cancer is so rare, and its symptoms can resemble other problems, it can be difficult to diagnose. Additionally, in some cases, women don't learn they have fallopian tube cancer until a tube has been removed surgically during an operation to treat another illness or problem.

However, there are several tests that may be performed in order to make a definite diagnosis of the condition. First your doctor will start by asking about any symptoms you may be experiencing, as well as reviewing your medical history and conducting a thorough physical exam. Other tests that may be performed include:

- Pelvic Examination - This test involves feeling the uterus, vagina, ovaries, fallopian tubes, bladder and rectum to find any abnormality in their shape or size.

- CA125 Test - This is a blood test that checks levels of a blood protein known as CA125, which is a tumour marker for gynaecological diseases such as fallopian tube cancer. An estimated 85 percent of women with gynaecological disease have increased levels of CA125. However, it is important to note that increased levels of CA125 may not necessarily mean that a woman has cancer, since CA125 levels also may be increased during pregnancy, menstruation, in the presence of other non-cancerous gynaecologic diseases or cancers affecting other parts of the body.

- Computed Tomography (CT) Scan - This imaging test takes a series of detailed pictures of areas inside the body. The pictures are created by a computer, which is linked to an X-ray machine. A special dye may be injected into a vein or swallowed to help the organs or tissues show up more clearly.

- Ultrasound - An ultrasound of the pelvis may be performed. This test involves the use of high-frequency sound waves to create images of organs and systems within the body. These waves, which cannot be heard by humans, create a pattern of echoes called a sonogram. Healthy tissues, fluid-filled cysts, and tumours look different on this picture.

- Transvaginal ultrasound – a special wand is inserted in the vagina which gives off ultrasound waves that can be read on the ultrasound screen.

- Biopsy – Cells are removed from the fallopian tubes and looked at under a microscope. This is the only way to find out for sure if a person has fallopian tube cancer. It usually requires surgery.

(University of California San Francisco; MD Anderson Cancer Center).

## Staging of Fallopian Tube Cancer

Staging of any cancer is very important as the stage of the cancer determines the type of anti-cancer treatment that is given. There are currently two (2) different types of staging for fallopian tube cancer, namely the FIGO and TNM systems:

**Stage I Fallopian Tube Cancer**

| FIGO Stage | Description | TNM Stage |
|---|---|---|
| I | Tumour is confined to one or both fallopian tube(s) | T1 |
| IA | Tumour limited to one fallopian tube<br>No tumour on the fallopian tub surface<br>No malignant cells in the ascites or peritoneal washings | T1a |
| IB | Tumour limited to both fallopian tubes<br>No tumour on fallopian tube surface<br>No malignant cells in the ascites or peritoneal washings | T1b |
| IC<br><br>IC1<br><br>IC2<br><br>IC3 | Tumour limited to one or both fallopian tubes with any of the following:<br><br>Surgical spill intra-operatively<br><br>Capsule ruptured before surgery or tumour on fallopian tube surface<br><br>Malignant cells in the ascites or peritoneal washings | T1c |

**Stage II Fallopian Tube Cancer**

| FIGO Stage | Description | TNM Stage |
|---|---|---|
| II | Tumour involves one or both fallopian tubes with pelvic extension (below pelvic brim) | T2 |
| IIA | Extension and/or implants on the uterus and/or fallopian tubes and/or ovaries | T2a |
| IIB | Extension to other pelvic intra-peritoneal tissues | T2b |
| IIC | Pelvic extension (IIA or IIB) with malignant cells in ascites or peritoneal washings | T2c |

**Stage III Fallopian Tube Cancer**

| FIGO Stage | Description | TNM Stage |
|---|---|---|
| III | Tumour involves one or both fallopian tubes, or primary peritoneal cancer, with cytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis (spread) to the retroperitoneal lymph nodes | T3 |
| IIIA<br><br>IIIA1<br><br><br><br>IIIA2 | Metastasis (spread) to the retroperitoneal lymph nodes with or without microscopic peritoneal involvement beyond the pelvis<br><br>Positive retroperitoneal lymph nodes only (cytologically or histologically proven)<br><br>IIIA (i) Metastasis ≤ 10mm in greatest dimension<br>IIIA (ii) Metastasis > 10mm in greatest dimension<br><br>Microscopic extrapelvic (above the pelvic brim) peritoneal involvement with or without positive retroperitoneal lymph nodes | T1, T2<br>T3aN1<br><br><br><br><br>T3a,<br>T3aN1 |
| IIIB | Macroscopic peritoneal metastases beyond the pelvic brim ≤ 2cms in greatest dimension, with or without metastasis to the retroperitoneal lymph nodes | T3b<br>T3bN1 |
| IIIC | Macroscopic peritoneal metastases beyond the pelvic brim<br><br>>2cms in greatest dimension, with or without metastases to the retroperitoneal nodes (includes extension of tumour to capsule of liver and spleen without parenchymal involvement of either organ) | T3c/T3cN1 |

**Stage IV Fallopian Tube Cancer**

| FIGO Stage | Description | TNM Stage |
|---|---|---|
| IV | Distant metastasis excluding peritoneal metastases | |
| IVA | Pleural effusion with positive cytology | |
| IVB | Metastases to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity)<br><br>Note: Parenchymal metastases are Stage IVB | Any T, Any N, M1 |

(AGO)

**Stage Grouping of Fallopian Tube Cancer**
The following depicts the Stage Grouping for fallopian tube cancer:

| FIGO | T | N | M |
|---|---|---|---|
| IA | T1a | N0 | M0 |
| IB | T1b | N0 | M0 |
| IC | T1c | N0 | M0 |
| IIA | T2a | N0 | M0 |
| IIB | T2b | N0 | M0 |
| IIC | T2c | N0 | M0 |
| IIIA | T3a | N0 | M0 |
| IIIB | T3b | N0 | M0 |
| IIIC | T3c | N0 | M0 |
| IV | Any T | Any N | M1 |

(AGO).

**Treatment of Fallopian Tube Cancer**
As always, the optimal treatment regimen should ultimately be individualized as much as possible. It should take into account the patient's stage of disease, other medical history, and personal preference, among other things.

Surgery - fallopian tube cancer is typically diagnosed with surgery. The new FIGO staging system requires an extensive surgical procedure very similar to the one used for ovarian cancer. It includes sampling of pelvic fluid, pelvic and abdominal washings, trans-abdominal removal of uterus (hysterectomy), removal of both ovaries and fallopian tubes (bilateral salpingoo-ophorectomy), removal of some connective tissue folds (omentectomy), selective removal of pelvic lymph nodes (lymphadenectomy), and selective biopsies of the lining of the abdominal walls and organs (peritoneum).

In cases of very advanced disease, the goal of surgery is primarily to remove as much tumour bulk as safely possible (cytoreduction). Some surgeons also advocate performing a ‘second-look’ surgery, in which a repeat abdominal surgery is done to look for residual or recurrent disease at a later time.

Radiation Therapy - according to a national retrospective study that compared postoperative chemotherapy to postoperative whole abdomen-pelvis radiation therapy in patients with early stage disease, there was no significant difference in survival between the two treatment groups. However, this is not a randomized study, and so the ability to make conclusions from this data is limited. Unfortunately, there are no randomized trials comparing the efficacy of abdominopelvic radiotherapy and cisplatin-containing chemotherapy in the postoperative

setting; given the rarity of this cancer, randomized data may never be available. Treatment after surgery should be determined by the patient and physicians together, based on location of any remaining disease, as well as the patient's lifestyle and overall health.

Chemotherapy - fallopian tube cancer is fairly responsive to multi-drug regimens containing the agent cisplatin, as compared to non-cisplatin single agents or multi-drug regimens. Again, an individual chemotherapeutic regimen should be developed by the oncologist with the patient's specific needs in mind.

Hormonal Therapy - the role of hormonal treatment for fallopian tube cancer is not clear, although both medroxyprogesterone acetate and megestrol acetate have been used together with chemotherapy with varying degrees of success.

Combined Modality - the latest in combined modality approaches for advanced disease consists of cytoreductive surgery, post-surgical chemotherapy to reduce remaining tumour burden to microscopic levels, and possible radiation to the abdomen and pelvis following chemotherapy.

**About Clinical Trials**

Clinical trials are research studies that involve people. These studies test new ways to prevent, detect, diagnose, or treat diseases. People who take part in cancer clinical trials have an opportunity to contribute to scientists' knowledge about cancer and to help in the development of improved cancer treatments. They also receive state-of-the-art care from cancer experts.

Types of Clinical Trials

Cancer clinical trials differ according to their primary purpose. They include the following types:

Treatment - these trials test the effectiveness of new treatments or new ways of using current treatments in people who have cancer. The treatments tested may include new drugs or new combinations of currently used drugs, new surgery or radiation therapy techniques, and vaccines or other treatments that stimulate a person's immune system to fight cancer. Combinations of different treatment types may also be tested in these trials.

Prevention - these trials test new interventions that may lower the risk of developing certain types of cancer. Most cancer prevention trials involve healthy people who have not had cancer; however, they often only include people who have a higher than average risk of developing a specific type of cancer. Some cancer prevention trials involve people who have had cancer in the past; these trials test interventions that may help prevent the return (recurrence) of the original cancer or reduce the chance of developing a new type of cancer

Screening - these trials test new ways of finding cancer early. When cancer is found early, it may be easier to treat and there may be a better chance of long-term survival. Cancer screening trials usually involve people who do not have any signs or symptoms of cancer. However, participation in these trials is often limited to people who have a higher than average risk of developing a certain type of cancer because they have a family history of that

type of cancer or they have a history of exposure to cancer-causing substances (e.g., cigarette smoke).

Diagnostic - these trials study new tests or procedures that may help identify, or diagnose, cancer more accurately. Diagnostic trials usually involve people who have some signs or symptoms of cancer.

Quality of life or supportive care - these trials focus on the comfort and quality of life of cancer patients and cancer survivors. New ways to decrease the number or severity of side effects of cancer or its treatment are often studied in these trials. How a specific type of cancer or its treatment affects a person's everyday life may also be studied.

## Where Clinical Trials are Conducted

Cancer clinical trials take place in cities and towns in doctors' offices, cancer centres and other medical centres, community hospitals and clinics. A single trial may take place at one or two specialised medical centres only or at hundreds of offices, hospitals, and centres.

Each clinical trial is managed by a research team that can include doctors, nurses, research assistants, data analysts, and other specialists. The research team works closely with other health professionals, including other doctors and nurses, laboratory technicians, pharmacists, dieticians, and social workers, to provide medical and supportive care to people who take part in a clinical trial.

## Research Team

The research team closely monitors the health of people taking part in the clinical trial and gives them specific instructions when necessary. To ensure the reliability of the trial's results, it is important for the participants to follow the research team's instructions. The instructions may include keeping logs or answering questionnaires. The research team may also seek to contact the participants regularly after the trial ends to get updates on their health.

## Clinical Trial Protocol

Every clinical trial has a protocol, or action plan, that describes what will be done in the trial, how the trial will be conducted, and why each part of the trial is necessary. The protocol also includes guidelines for who can and cannot participate in the trial. These guidelines, called eligibility criteria, describe the characteristics that all interested people must have before they can take part in the trial. Eligibility criteria can include age, sex, medical history, and current health status. Eligibility criteria for cancer treatment trials often include the type and stage of cancer, as well as the type(s) of cancer treatment already received.

Enrolling people who have similar characteristics helps ensure that the outcome of a trial is due to the intervention being tested and not to other factors. In this way, eligibility criteria help researchers obtain the most accurate and meaningful results possible.

## National and International Regulations

National and international regulations and policies have been developed to help ensure that research involving people is conducted according to strict scientific and ethical principles. In these regulations and policies, people who participate in research are usually referred to as "human subjects."

Informed Consent

Informed consent is a process through which people learn the important facts about a clinical trial to help them decide whether or not to take part in it, and continue to learn new information about the trial that helps them decide whether or not to continue participating in it.

During the first part of the informed consent process, people are given detailed information about a trial, including information about the purpose of the trial, the tests and other procedures that will be required, and the possible benefits and harms of taking part in the trial. Besides talking with a doctor or nurse, potential trial participants are given a form, called an informed consent form, that provides information about the trial in writing. People who agree to take part in the trial are asked to sign the form. However, signing this form does not mean that a person must remain in the trial. Anyone can choose to leave a trial at any time—either before it starts or at any time during the trial or during the follow-up period. It is important for people who decide to leave a trial to get information from the research team about how to leave the trial safely.

The informed consent process continues throughout a trial. If new benefits, risks, or side effects are discovered during the course of a trial, the researchers must inform the participants so they can decide whether or not they want to continue to take part in the trial. In some cases, participants who want to continue to take part in a trial may be asked to sign a new informed consent form.

New interventions are often studied in a stepwise fashion, with each step representing a different “phase” in the clinical research process. The following phases are used for cancer treatment trials:

Phases of a Clinical Trial

Phase 0. These trials represent the earliest step in testing new treatments in humans. In a phase 0 trial, a very small dose of a chemical or biologic agent is given to a small number of people (approximately 10-15) to gather preliminary information about how the agent is processed by the body (pharmacokinetics) and how the agent affects the body (pharmacodynamics). Because the agents are given in such small amounts, no information is obtained about their safety or effectiveness in treating cancer. Phase 0 trials are also called micro-dosing studies, exploratory Investigational New Drug (IND) trials, or early phase I trials. The people who take part in these trials usually have advanced disease, and no known, effective treatment options are available to them.

Phase I (also called phase 1). These trials are conducted mainly to evaluate the safety of chemical or biologic agents or other types of interventions (e.g., a new radiation therapy technique). They help determine the maximum dose that can be given safely (also known as the maximum tolerated dose) and whether an intervention causes harmful side effects. Phase I trials enrol small numbers of people (20 or more) who have advanced cancer that cannot be treated effectively with standard (usual) treatments or for which no standard treatment exists. Although evaluating the effectiveness of interventions is not a primary goal of these trials, doctors do look for evidence that the interventions might be useful as treatments.

Phase II (also called phase 2). These trials test the effectiveness of interventions in people who have a specific type of cancer or related cancers. They also continue to look at the

safety of interventions. Phase II trials usually enrol fewer than 100 people but may include as many as 300. The people who participate in phase II trials may or may not have been treated previously with standard therapy for their type of cancer. If a person has been treated previously, their eligibility to participate in a specific trial may depend on the type and amount of prior treatment they received. Although phase II trials can give some indication of whether or not an intervention works, they are almost never designed to show whether an intervention is better than standard therapy.

Phase III (also called phase 3). These trials compare the effectiveness of a new intervention, or new use of an existing intervention, with the current standard of care (usual treatment) for a particular type of cancer. Phase III trials also examine how the side effects of the new intervention compare with those of the usual treatment. If the new intervention is more effective than the usual treatment and/or is easier to tolerate, it may become the new standard of care.

Phase III trials usually involve large groups of people (100 to several thousand), who are randomly assigned to one of two treatment groups, or "trial arms": (1) a control group, in which everyone in the group receives usual treatment for their type of cancer, or 2) an investigational or experimental group, in which everyone in the group receives the new intervention or new use of an existing intervention. The trial participants are assigned to their individual groups by random assignment, or randomisation. Randomisation helps ensure that the groups have similar characteristics. This balance is necessary so the researchers can have confidence that any differences they observe in how the two groups respond to the treatments they receive are due to the treatments and not to other differences between the groups.

Randomisation is usually done by a computer program to ensure that human choices do not influence the assignment to groups. The trial participants cannot request to be in a particular group, and the researchers cannot influence how people are assigned to the groups. Usually, neither the participants nor their doctors know what treatment the participants are receiving.

People who participate in phase III trials may or may not have been treated previously. If they have been treated previously, their eligibility to participate in a specific trial may depend on the type and the amount of prior treatment they received.

In most cases, an intervention will move into phase III testing only after it has shown promise in phase I and phase II trials.

Phase IV (also called phase 4). These trials further evaluate the effectiveness and long-term safety of drugs or other interventions. They usually take place after a drug or intervention has been approved by the medicine regulatory office for standard use. Several hundred to several thousand people may take part in a phase IV trial. These trials are also known as post-marketing surveillance trials. They are generally sponsored by drug companies.

Sometimes clinical trial phases may be combined (e.g., phase I/II or phase II/III trials) to minimize the risks to participants and/or to allow faster development of a new intervention.

Although treatment trials are always assigned a phase, other clinical trials (e.g., screening, prevention, diagnostic, and quality-of-life trials) may not be labelled this way.

Use of Placebos

The use of placebos as comparison or “control” interventions in cancer treatment trials is rare. If a placebo is used by itself, it is because no standard treatment exists. In this case, a trial would compare the effects of a new treatment with the effects of a placebo. More often, however, placebos are given along with a standard treatment. For example, a trial might compare the effects of a standard treatment plus a new treatment with the effects of the same standard treatment plus a placebo.

Possible benefits of taking part in a clinical trial

The benefits of participating in a clinical trial include the following:

- Trial participants have access to promising new interventions that are generally not available outside of a clinical trial.
- The intervention being studied may be more effective than standard therapy. If it is more effective, trial participants may be the first to benefit from it.
- Trial participants receive regular and careful medical attention from a research team that includes doctors, nurses, and other health professionals.
- The results of the trial may help other people who need cancer treatment in the future.
- Trial participants are helping scientists learn more about cancer (e.g., how it grows, how it acts, and what influences its growth and spread).

Potential harms associated with taking part in a clinical trial

The potential harms of participating in a clinical trial include the following:

- The new intervention being studied may not be better than standard therapy, or it may have harmful side effects that doctors do not expect or that are worse than those associated with standard therapy.
- Trial participants may be required to make more visits to the doctor than they would if they were not in a clinical trial and/or may need to travel farther for those visits.

Correlative research studies, and how they are related to clinical trials

In addition to answering questions about the effectiveness of new interventions, clinical trials provide the opportunity for additional research. These additional research studies, called correlative or ancillary studies, may use blood, tumour, or other tissue specimens (also known as ‘biospecimens’) obtained from trial participants before, during, or after treatment. For example, the molecular characteristics of tumour specimens collected during a trial might be analysed to see if there is a relationship between the presence of a certain gene mutation or the amount of a specific protein and how trial participants responded to the treatment they received. Information obtained from these types of studies could lead to more accurate predictions about how individual patients will respond to certain cancer treatments, improved ways of finding cancer earlier, new methods of identifying people who have an increased risk of cancer, and new approaches to try to prevent cancer.

Clinical trial participants must give their permission before biospecimens obtained from them can be used for research purposes.

When a clinical trial is over

After a clinical trial is completed, the researchers look carefully at the data collected during the trial to understand the meaning of the findings and to plan further research. After a phase I or phase II trial, the researchers decide whether or not to move on to the next phase or stop testing the intervention because it was not safe or effective. When a phase III trial is completed, the researchers analyse the data to determine whether the results have medical importance and, if so, whether the tested intervention could become the new standard of care.

The results of clinical trials are often published in peer-reviewed scientific journals. Peer review is a process by which cancer research experts not associated with a trial review the study report before it is published to make sure that the data are sound, the data analysis was performed correctly, and the conclusions are appropriate. If the results are particularly important, they may be reported by the media and discussed at a scientific meeting and by patient advocacy groups before they are published in a journal. Once a new intervention has proven safe and effective in a clinical trial, it may become a new standard of care.
(National Cancer Institute).

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