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AN UNUSUAL CASE OF POSTPARTUM CHORIOCARCINOMA WITH VAGINAL METASTASIS AND UTERINE PERFORATION

Obstetrics & Gynaecology

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KEYWORDS

INTRODUCTION

Gestational trophoblastic disease is a heterogenous group of interrelated lesions that arise from abnormal proliferation of placental trophoblasts[1]. Choriocarcinoma differs from any type of villous trophoblast and is the most aggressive GTN and is highly chemosensitive. When a patient reports with irregular bleeding during her postpartum or postabortion, pregnancy related causes should be ruled out. We describe a patient who presented to us after a term pregnancy and was diagnosed to have stage III choriocarcinoma.

CASE REPPORT

A 23 year, para 2 who had a term delivery 2 months back, reported to emergency unit of Kamala Nehru Hospital, Shimla with complaints of multiple episodes of heavy bleeding per vaginum and hemoptysis. She had visited a local hospital and she underwent check curettage twice but her bleeding continued. She was breastfeeding her infant. There was no significant past or family history.

On general physical examination she was pale, tachycardic.On abdominal examination- uterus was palpable.Systemic examination was normal. On bimanual examination the size of the uterus measured about 10-12 weeks gestation and the cervical os was open. FIG 1: chest Xray showing cannon ball appearance – metastasis.

Her investigations were Hb – 7.7g/dl, thyroid function test and other biochemistry test – WNL, urine pregnancy test – positive, βhCG - >2,25,000 mIU/ml. her transabdominal ultrasound showed 3.2 X 3.8 cm heterogenous content within the upper part of endometrial cavity-?RPOC. Chest Xray showed 'cannon ball' metastasis, CT scan confirmed it. CECT head and abdomen was normal.

A diagnosis of GTN FIGO stage III was made and WHO prognostic score was 9. Received one dose of single agent chemotherapy But as the patient was bleeding per vaginally she was referred back. On examination, her finding were same but there was evidence of a 2 x 2cm growth in the posterior vaginal wall.

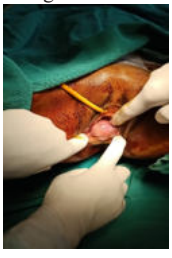

fig 2: vaginal growth about 2x2 cm.

CECT pelvis showed loss of endo-myometrial interface ?uterine perforation. A decision of hysterectomy was taken. She underwent total abdominal hysterectomy with bilateral salphingectomy with left oophorectomy with omental biopsy and excision of vaginal growth.

Intraoperatively, there was e/o hemoperitoneum. There was evidence of uterine perforation from fundic and posterior wall of uterus and 8x10cm growth protruding from the serosal wall. Uterus enlarged to about 10-12 weeks.

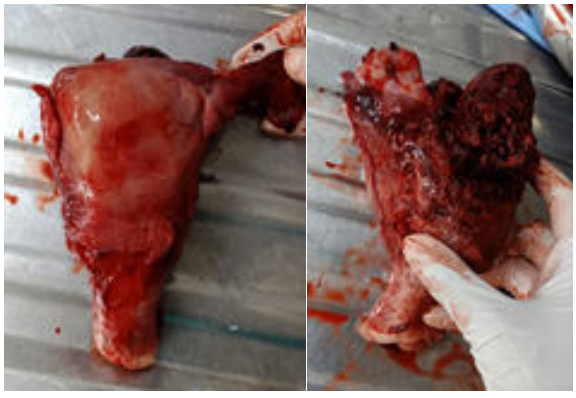

fig 3: anterior (a) and posterior(b) wall of uterus On cut section, evidence of multiple growth in the endometrial cavity invading the myometrium and serosa.

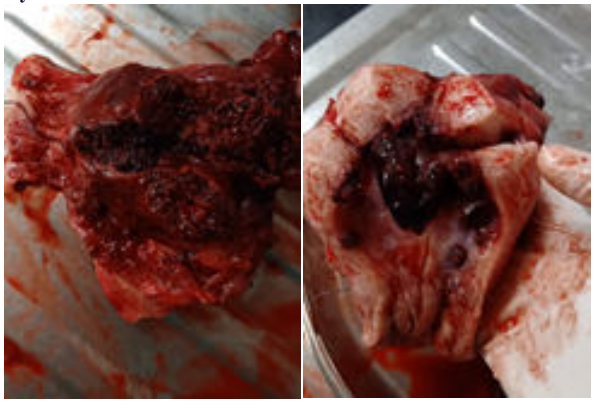

fig 4: cutsection view of the uterus, showing multiple friable areas with cystic spaces and necrosis.

Excision of the vaginal growth was done and on cut section it showed similar features. Her postoperative βhCG was 38,674.

The histopathology features were suggestive of choriocarcinoma with lymphovascular invasion. With tumor invasion into left fallopian tube and ovary. Vaginal growth histology was consistent with chorioc arcinoma.

	βhCG (mIU/ml)
Preoperative	>2,25,000
Postsurgery	38,674
7-11-2019	1368
28-11-2019	51.3
26-12-2019	5
14-1-2020	2.5
5-2-2020	<1.2
27-2-2020	<1.2

She was discharged on postoperative day 10 and referred to Cancer institute for further management. She received 6 cycles of EMA-EP multiagent chemotherapy. She responded well to chemotherapy. βhCG has shown drastic fall. She is currently on regular follow up.

DISCUSSION

Postpartum choriocarcinoma is a very rare complication of pregnancy with a reported UK incidence of 1 in 50,000 live births[2]. Gestational choriocarcinoma initially invades the endometrium and myometrium but tends to develop early blood borne metastasis. The exact pathogenesis of rupture of the uterus in choriocarcinoma is not known. Malignant trophoblasts invade the uterine veins and damages the blood vessel. Subsequent to the vascular damage, multiple infarctions do occur due to thrombosis, vascular aneurysms and intratumoral bleeding[3]. Inherent sensitivity of trophoblastic neoplasms to chemotherapy, and hCG for diagnosing disease and monitoring therapy, makes it good prognosis and treatment success. Though there is 3% risk of relapse after completion of therapy.

CONCLUSION

As delay in diagnosis can lead to increased morbidity and lead to the need of higher or multiagent chemotherapy, an early detection of choriocarcinoma should be made by simply sending curetting for histopathology, blood test for βhCG level or having a high suspicion in case of abnormal bleeding post delivery.

It is easy to diagnose and treat with 100% survival. Choriocarcinoma with vaginal metastasis with uterine perforation is a rare clinical presentation.

Timely intervention in form of surgery and chemotherapy can save a precious life.

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