Choriocarcinoma Choriocarcinoma is A Curable Disease. Case Presentation

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Abstract

A young grand multiparous patient, age 31 years (para seven) all her pregnancies and labours were normal and uneventful.

Her eighth pregnancy was diagnosed as hydatidiform mole and treated by evacuation of the uterus twice. Which was followed by using contraceptive pills for one year.

Her ninth pregnancy (case presentation), the patient consulted me at 12 week of gestation, after investigation another hydatidiform mole was diagnosed and an agreement was made for evacuation of the utreus.

On November 11/1991, suction curettage was made where two pints of blood were given.

Histopathological examination revealed hydatidiform mole.

Two weeks later, the patient was admitted again for the second evacuation at the same time I discovered the presence of metastases to the right side of the vulve and vagine which was diagnosed as metastatic tumor. Small pieces were sent for histopathological examination wich revealed choriocanoma.

I referred the patien to Dr.Shareef Fadhil in Merjan teaching Hospital (tumor unit) for treatment by cytotoxic drugs.

After two years the patient became pregnant again, investigation revealed normal pregnancy which was ended by spontaneous vaginal delivery of a healthy baby boy at term.

Her puerperium was uneventful.

Choriocarcinoma

Malginant trophoblastic disease can exist in two forms, namely in nonmetastic from, invasive mole, or in a metastic from choriocarcinoma; both are treated with chemotherapy and monitored by the levels of tumor marker H.C.G.

Epidemiology

The incidence of choricarcinoma will obviously be influenced by the incidence of hydatidiform mole,

and about 2-4% of patients with hydatidiform mole finally develop choriocarcinoma.

The incidence of choriocarcinoma is one per 10,000 to one per 70,000 pregnancies in the West and between one per 250 to one per 6,000 pregnanies in Asia. The antecedent pregnacy is hydatidiform mole in about 57% of cases of choriocarcinoma , a normal pregnancy in about 26% and abortion or ectopic pregnancy is about 17%.

Choriocaricinoma is more likely to occur after a complete mole, but it also occur after partial mole.

Maternal blood group influence s the inciderce, choriocarinoma has been reported in association with group O and an excess with group A, also choriocarcinoma is more likely to occur after matings between individuals of group A and group O than if both partner are of group O or group A.

Poor prognosis with the patients who are of group B or AB.

Pathological Features

The characteristic morphology is of pleomorphic cytotrophoblast surrounded by some syncytium with extensive area of hemorrhage, necrosis.

Chorionic villi are absent. It invades into the myometium and metastsises readily to lung, vagina, pelvis, liver, bowel, kidney and spleen.

Diagnosi depends on ——>

- Clincal suspicion.
- Measurement of the H.C.G. vels.
- Histological examination of uterine curettigs.

Clinical Features:

The risk of choricarcinoma after hyditidiform mole is a thousand times greater than after a normal pregnancy or a non molar abortion. The presenting symptoms are:

-Vaginal bleeding orblood stained discharge.

-Abdominal pain and mass.

-Extra-uterine masses and ovarian involvement.

- Amenorrhea.

-Dyspnoea and haemoptysis = pulmonary involvement.

-Vaginal metastases present in 30% of patients with trophoblastic tumor

-Cerebal metastases.

-Meatstases in vesira (liver,kidney, spleen or bowel).

- Skin metastases.

-Lymph node and bone metatases.

Occasionally thyrotoxicosis is present in patients with very high H.C.G levels because of cross reaction between the sup unit of H.C.G and T.S.H.

Prognosis

The factors which influence prognosis of paitents with malignant trphoblastic disease are:

-Age.
-Parity.
- Anteccendent pregnancy.
-HGC.
-ABO *malex female*
-Number of metastses.
- Site of metastases
-Lagerst tumour mass.
-Immune status
-Previous chemotherapy.

Treatment

The main stay of tratment is chemotherapy. The first drup to be used was the folic antagonist menthotrexate, and of the most valuable therpeutic agent. One of the side effect of methotrexate is myelouppersion wich is infrequent but it is essential to measure Hb,WBC and palatet count brfore each course of therapy. Renal and hepatic functions should be measures at least every week during treatment.

The use of radio therapy in the management of choriocorcinoma is limied and value uncertain. So the use of radio therapy is limited to a small number of drugs resistant cases.

Aim

Choriocarcinoma is a curable disease. Pregnancy and labour could occur successfelly after good treatment and follow up.

Case presentation

KAREEMA FAISAL : a young grand multiparae housewife, age 31 years, moselm from Hilla was admitted to Babylon Hospital for Maternity and Children on Novermber 10,1991 with hydatidiorm mole.

Examination

* Appearance:
  Fully conscious.
  oriented.
  Slightly pale.
  No dyspnea.

* VitaI 1 Signs
  Temperature 37 C
  Blood pressure 120/80.
  Pulse rate 73 beat per minute.

*Chest
  Normal vesicular breathing.
  No added sounds.

* Heari
  Normal doubel rythem.
  No added sounds.

*Abdomen.

Soft abdomen.
Uterin size 18-20 weeks (larger then date).

*Pelvic Examination.

Vulva vagina were normal.
External cervical OS was closed.
Slight vaginal bleeding.
Uterus enlaged up to 20 week of gestation.

Investigation:

HB 10.2 mg/dl
Blood group A
General urine examination = yellow, acidic, R.B.C.0.1 Pus cell 2-3.
Chest X-ray= both lungs are clear, normal cardiac shadow.
Ultra sound = missed aortion with mollar changes of placenta.

Treatment:

An arragement was mde for evacuation of the uterus in theatre.2 pints of blood were prepared group A.

Operation:

On novrember 11/1991- at 10:00 an evacuation of uterus was done by suction curettage which revealed hydatidiform mole. The first pint of blood was given at that time. he patient regain her conciousness shortly after opeartion.

On the secondpost operattive day: The patient looked well, but anemic, her Hb was 8.2 mg/dl, so the second pint of blood was given.

On the post operative day : the patient looked well, uterus was well contracted with slight vaginal bleeding and clear chest. The patient was discharged home with advice to come again after two weeks for the second evacuation of the uterus.

On November 1991, the patient consulted me with histopathology report which show section show hydropic degeneration of chorionic villi with mild trophpblastic hyperpasia , consistant with hydatidiform mole.

Second operatin:

On november 25/1991, at 9:30 am examinaation under anaesthesia was made.

Findings:

-Two small violet black masses were seen in the side of the vulva and vagina.

-Uterus was bulky enlarge to about 12 weeks of gestation with bilateral cystic masses in both adenexia.

Curettage was done, endometrial pieces sent for histopathology.

Biopsies from the vagina and vulva were made and sent for histopathology. The Patient recover from anaesthesia.

On the third post operactive day: the patient discharged home until the results of the biopsis appeared.

On December 5/1991, the patient consulted me for checking. At that time. the findings were:

- The vulva and vaginal masses still there.
- External cervical os was closed
- Silght vaginal bleeding.
-Bulky uterus, aterverted.

On december 14/1991, histology report showed

*Biopas no.1 section shows hydropic villi with proliferated trophoblastic tissue and marked haemorrhage consistant with marked invasive mole.

*Biopsy no. 2 section show degenerated tissue with fragments of active trophoblastic tissue choricaricinoma.

On December 22/1991, the patient was readmitted to the gynaecological ward for further investigation wich were:
-Complete blood picture
W.B.C 4x 10/L
R.B.C.5.4x10/L
Hb 15.8 gm/dl
MCV 85
p/t 267

-General urine exmination= yellow , acidic,R.B.C.0.1 pus cell 4.5.

- Ultra sound = 2 small ovarian cysts. Liver, Kidney, spleen, all normal.

-Chesr x-ray both lung fileds are clear, normal cardiac shadow.

So at that day,I referred the patient to Dr. Shareef Fadhil in Merjan Teaching Hospital (tumour unit) for treatment by cytotxic drugs.

In Merjan Teaching Hospital, the pitent was sent for H.C.Glevel which 30 IU/L. The paitent was treated with two courses of chemotherapy in the from of methotrexate 25 mg daily intravenously wich alternate with leucovorin calcium 15 mg 1x4 at *Februal 20,1992*. Dr Shareef Fadhil referred the paitent back to me for review of gynaecological examination (after the completion of two conrses of chemotherapy), the examination showed:

*Normal size uterus.
*Normal size ovaries.
*Normal vulva and vagina.
*No metastases.
*All well.

On Augest, 1992. Dr Shareef Fadhil referred paitent again to me for gynaecological examination and follow up as she has finished six courses of chemotherapy in a sort of methotrexate 25 mg alternate with calcium leucovorin.

Examination= all well.

After two years, the paitent consulted me as was pregnant, invesitgation revealed normal pregnancy.

On july 20, 1994, the paitent devilered a healthy baby boy by spontaneous vaginal delivery, her puerperium was normal.

Result:

Careful follow up of patient with hydatidiform mole should be made, contraceptive pills for about six months up to one years should be given.

If recurrent mole occur, special attention and careful folow up are essential because of high risk of choriocorcinoma after hydatidiform mole. It has been custoamry to adivce a woman who has a hydatidfrom mole to avoid pregnancy for two or three years, largely because of the fear of confusing an early-pregnancy with the recurrence of the mole.

Conclusion:

Cytotoxic drugs is the treatment of choice for patients with choriocarcinoma who are willing to regain their fertility and who desire to have more children.

Because of the potential of choriocarcinoma to reaccre after a period of several years, it is necessary to continue H.C.G follow for the rest of the patient life. If she becomes pregnant, follow up is then discontinued until the end of pregnancy and then resumed in the normal three weeks after delivery. Patients who have not received chemotherapy shold also have their H.C.G. measured every three weekss and then three months after the end of any further pregnancy because of the increased risk of trophoblastic tumors in the group.

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سرطان المشيمة

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الخلاصة

تم القيام بدراسة لسيدة تبلغ من العمر احدى وثلاثون سنة وهي ام لسبعة اطفال (جميعهم ولدوا بصورة طبيعية وخالية من المضاعفات).

وفي الحمل الثامن اكتشفت اصابتها بحمل عنقودي وعولجت بواسطة تفريغ الحمل مرتين ثم نصحت باستعمال حبوب منع الحمل لمدة سنة مع المراجعة.

في الحمل التاسع (موضوع البحث) راجعتني المريضة في الشهر الثالث من الحمل وبعد الفحص والتحري اكتشف بانها مصابة بحمل عنقودي للمرة الثانية. ادخلت المريضة الى المستشفى بتاريخ ١١ تشرين الثاني- نوفمبر-١٩٩١ وقد تم اجراء عملية تفريغ الرحم مع اعطائها قنينتي دم اثناء العملية وعندها اكتشف وجود اورام منتشر الي الجهة اليمنى من الفرج و المهبل .

وقد تم اخذ عينة من الورم وارسلت الى الفحص النسيجي وكانت النتيجة سرطان المشيمة.

ولقد قمت باحالة المريضة الى الدكتور شريف فاضل في مستشفى مرجان للامراض الباطنية (وحدة الاورام) لغرض المعالجة بالادوية الكيميائية.

بعد حوالي السنتين جاءت المريضة لغرض الفحص وكانت حامل في الشهر الرابع وبعد اجراء الفحوصات ومن خلال المتابعة الدورية للحمل تبين ان حملها طبيعي وحالة الام والطفل جيدة طيلة الفترة وبعدها ادخلت المريضة الى المستشفى لغرض الولادة حصلت الولادة بتاريخ ٢٠ تموز-يوليو- ١٩٩٤ وقد ولدت ذكر حي طبيعي وكانت حالتها الصحية بعد الولادة جيدة.