CHORIONEPITHELIOMA CERVIX

(A Case Report)

by

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Primary cervical chorionepithelioma is an extremely rare condition. There are very few authentic cases reported in the literature. To the best of the author's knowledge the only available literature is that of Maurice Rashbaum and I.C. Rubin.

Rashbaum's critical review is very informative. He reviewed the literature in 1952 and reported a case of his own. He mentions Alferin having reported 25 cases in 1925. Rashbaum rejects many of these cases on the criteria that they began in the fundus of the uterus and says that these should not be classified as primary cervical chorionepithelioma. Rashbhaum also rejects some cases which began as uterine moles and regards these as metastatic and not primary cervical choriocarcinoma. According to him choriocarcinoma of cervix should be preceded by cervical pregnancy or a cervical mole. He further mentions that Rubin's case is the only one found in the American literature. After proper screening he has accepted only 12 authentic cases of primary cervical choriocarcinoma.

The following case is reported in view of the interesting clinical findings, difficulties in deciding the line of treatment and the extreme rarity of the condition.

Case Report

Mrs. I.R., aged 28 years attended the Outpatients' Department of the St. George's Hospital, Bombay, on 28th August 1958, with a history of bleeding per vaginam of 28 days' duration. Her past menstrual cycles consisted of 30-35 days with a bleeding phase of 3-4 days. The cycles were more or less regular and the flow was scanty.

Past obstetric history revealed that she had two abortions of two months each, followed by full-term normal delivery in February 1957. In November 1957, she expelled a vesicular mole spontaneously. A curettage was not done at this time. From November 1957 till June 1958 the patient was well and the periods were regular and normal, i.e. 3-4/30-35 days. On 8th June 1958, i.e. about 7 months after her last conception (which was a vesicular mole), the patient started bleeding per vaginam after 38 days' amenorrhoea. The patient first thought it to be her normal period. The bleeding, however, continued irregularly for one month. On 8th July 1958 she reported herself to a general hospital where the findings on internal examination were as under:

External os patulous, uterus retroverted, soft, bulky, bleeding present. A provisional diagnosis of an incomplete abortion was made. On the following day she was curetted under general anaesthesia. The curettings were scanty and were not subjected to histological examination. There

was no more bleeding after the curettage. The patient was discharged on 19th July 1958 and advised to report after a month for a check-up. On 8th August 1958, she again started bleeding per vaginam which she thought to be normal menstrual period. The bleeding continued for three weeks. At this time, i.e. on 29th August 1958, she reported at St. George's Hospital. On internal examination, cervix was irregular, uterus anteverted and of normal size, fornices were clear. Visualisation of the cervix showed a necrotic growth arising from the right side. The exact nature of the lesion could not be ascertained at this time. There was very little bleeding after manipulations. The patient was admitted on the same day. Next day in the theatre the growth was seen to be arising from the right side of the cervix. The left side and the surrounding vaginal vault were clear and uninvolved. On attempting biopsy the entire growth got detached leaving the cervix raw but of smooth surface. There was comparatively little bleeding which stopped after firm pressure on the cervix. An Ascheim-Zondek test of urine was done on the same day and was negative. Histological examination of the removed tissue was non-contributory. A small area of proliferating Langhan's cells and a few syncitial cells and giant cells with no definite evidence of malignancy was reported. It was decided to keep the patient under observation in view of the negative Ascheim-Zondek test, age and no definite evidence of malignancy histologically. The patient was discharged on 3rd September 1958 and advised to report a week later. There were no complaints when the patient reported on 10th September 1958 and a speculum examination revealed the cervix to be normal. A repeat examination after two weeks (24th September) showed that the cervical canal was occupied by similar small necrotic growth. There was no bleeding at this time. Two weeks later (8th October) patient had blood-stained discharge when she was referred to Tata Memorial Hospital for opinion. A biopsy examination reported chorionic carcinoma. On 15th October a big cauliflower-like mass arising from the cervix was detected. The vaginal walls were not invaded by the growth. The patient was readmitted on 15th October 1958. An Ascheim-Zondek test on the urine was positive in 1:100 dilution. The X-ray of the chest was clear. On 17th October 1958 an abdominal panhysterectomy with removal of as much of vaginal cuff as possible was performed. Histopathological report of the tissue removed was as follows:

Naked eye: the growth was arising from the cervix below the level of the internal os; no lesion was detected in the body of the uterus and the region of internal os was clear. Histological examination of the sections showed normal cervical glands and fibro-muscular tissue. There were areas of haemorrhage, congestion and necrosis. There were areas of large polygonal cells with large pale ovoid nuclei. The cells had a faint basophilic cytoplasm. Few cells showed large hyperchromatic nuclei. Large syncitial cells with 10-12 small ovoid hyperchromatic nuclei were also present. All these features are very typical of a choriocarcinoma. The body of the uterus did not reveal any tumour tissue on histological examination.

The patient made an uneventful recovery and was discharged two weeks after the operation (31st October 1958). An A.Z test of the urine on the day of discharge was negative. The patient reported after four weeks. An internal examination was non-contributory. On speculum examination granulation tissue was found at the vault. There was no bleeding. An A.Z. test of the urine was sent again but the rats died before the results could be read. Two subsequent examinations of the urine (A.Z. test) at four weeks' interval and third one 8 weeks later were negative. A vaginal examination three months after the operation did not reveal any recurrence of growth. To date the patient is symptom-free and is being followed by A.Z. test of urine every two months.

Discussion

On reviewing the available literature, only two case reports were found, viz., those of M. Rashbaum and I. C. Rubin. Rubin in 1941 had

reported a case. His patient had a dark purplish growth on the cervix which looked like a placental polyp or an extruding molar pregnancy. There was profuse bleeding. The growth was sharply demarcated from internal os. The growth was removed and the uterus curetted. The nature of the growth was only revealed after the histological examination which showed it to be a choriocarcinoma. Hysterectomy was performed. Pathological examination of the uterus showed a small remnant of chorionepithelioma in the endometrium near the cervical canal.

The salient features of the case reported by Mr. Rashbaum et al are as follows:

The patient had a four months' pregnancy which terminated in an abortion of a macerated foetus. Curettage was done for retained placenta when the patient bled so profusely that repeated transfusions were necessary. After this the first clinical, but at that time unrecognised, symptom occurred after eleven months when the patient reported with a history of 5 months' amenorrhoea followed by bleeding. A diagnosis of missed abortion was made and curettage done. Moderate amount of placenta-like tissue was removed which revealed trophoblastic tissue histologically. The patient bled profusely at this time and also when a second curettage was done six weeks later for bleeding per vaginam. Both times the patient was in shock and massive transfusions were necessary. Even a simple vaginal examination four weeks after the second curettage precipitated profuse haemorrhage necessitating packing and repeated transfusions. After another week another curettage was done and the tissue examined. On both occasions the histological report was proliferation of trophoblastic tissue with presence of chorionic villi. Rashbaum thinks that the tendency to severe bleeding every time on even gentlest manipulation and the histological picture are two features characteristic of this case. The first, he says, is very suggestive of cervical pregnancy and the second of choriocarcinoma. Bleeding however continued and ultimately hysterectomy was performed. Histopathologically it showed abnormal trophoblastic tissue reaching close to squamocolumnar junction. Endometrium and myometrium were normal. Six weeks after the operation the patient expired. Postmortem revealed extensive metastatic lesions.

In Rashbaum's opinion in his case the choriocarcinoma originated from the first pregnancy which terminated in the expulsion of a macerated foetus and which he says was probably a cervical pregnancy in view of the profuse bleeding; the placenta which could not be removed completely acted as a nidus for subsequent choriocarcinoma. The gap of eleven months he explains as due to well known latency in the development of choriocarcinoma and the subsequent amenorrhoea of 5 months as due to tumour itself. He concludes that the patient had a cervical pregnancy and the choriocarcinoma developed at the site of the adherent placenta. Thus Rashbaum labels only those cases as primary cervical carcinoma which arise from cervical pregnancy or a cervical mole.

The diagnosis of cervical pregnancy is only presumptive in the case of both Rashbaum and Rubin. The only suggestive feature was profuse haemorrhage. In Rubin's case diagnosis of choriocarcinoma was confirmed by histological examination. In Rashbaum's case the diagnosis was confirmed on postmortem.

In the present case there was no profuse bleeding when the patient reported first. This could be explained by the necrotic nature of the growth. Hence also the difficulty in the histological diagnosis. Later on, when the patient was admitted for hysterectomy the vaginal and speculum examination did cause considerable haemorrhage though not producing shock nor necessitating a blood transfusion. The origin of the tumour can only be speculated. It might have been from the previous vesicular mole, some part of which may have lodged in the cervix. This case is classified as primary choriocarcinoma of the cervix for the following reasons:

1. Clinically the body of the uterus was found to be free from any growth. The tumour tissue was seen to be arising from one side of the cervix and not involving internal os, cervical canal and the left half of cervix.
2. Histological examination revealed it to be a choriocarcinoma arising from cervix.

Acknowledgments

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References

1. Rashbaum M., Daub W. W., and Lisa J. R.: Am. J. Obst. & Gyn.; 64, 451-455, 1952.
2. Rubin I. C.: Am. J. Obst. & Gyn.; 41, 1063, 1941.

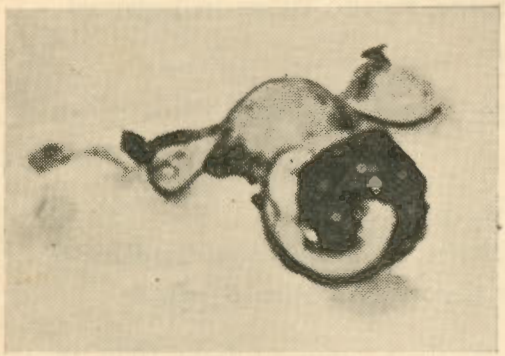

Fig. 1
Macroscropic appearance of the specimen.

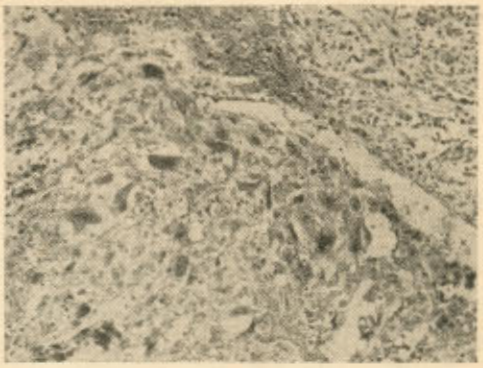

Fig. 2
Photomicrograph low power.

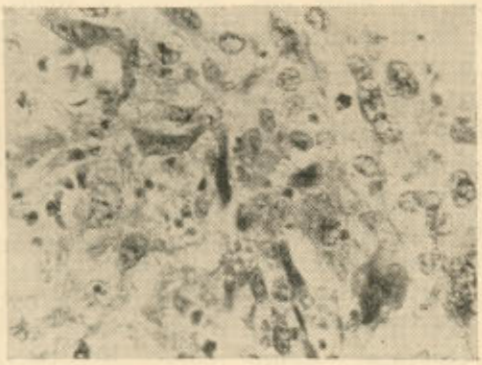

Fig. 3
Photomicrograph high power.