# SUMMARIES OF PAPERS ON TROPHOBLASTIC TUMOURS READ AT THE XVTH ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS HELD AT GOA ON 28TH DECEMBER 1969.

## TROPHOBLASTIC TUMOURS-INCIDENCE AND MANAGEMENT

by

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and

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*Summary*

1. Trophoblastic tumours appear to be more common in S.E. Asian and Latin American countries. In India, these tumours are more common in the southern states.
2. During 8 years (1961-1968), 337 cases of trophoblastic tumours (hydatidiform mole 281, chorioadenoma destruens 15 and choriocarcinoma 41) were admitted into the Government Erskine Hospital, giving an incidence of 1 in 194 pregnancies for mole, 1 in 3685 for chorioadenoma destruens and 1 in 1338 for choriocarcinoma.
3. The recurrent mole was seen in 1.06% and malignancy in 3.4% of moles.
4. In 25 cases of hydatidiform mole who had prophylactic methotrexate, no malignancy was seen on follow-up.
5. Secondaries were seen in 80% of cases of choriocarcinoma.
6. The gross mortality for choriocarcinoma in this series was 56%. In 24 cases, where surgery was combined with chemotherapy, 62.5% have survived.

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## "PRIMARY EXTRAUTERINE CHORIOCARCINOMA: CASE REPORT"

by

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and

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Primary choriocarcinoma of ovary is very rare. On the other hand, perhaps, choriocarcinoma of tube would have have been encountered more frequently except that most tubal pregnancies degenerate, die or are surgically removed before the malignant change of chorion become manifest.

First case presented with dysfunctional uterine bleeding. On examination a separate mass was palpable adjacent to the uterus which at laparotomy was found to be very vascular, replacing the ovary. It was histologically proved to be choriocarcinoma of

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ovary. Second case presented with a lump in the abdomen which was found to be a haemorrhagic mass incorporating the tube and involving the sigmoid. It was histologically proved to be choriocarcinoma of fallopian tube. Patient was given methotrexate post-operatively and survived for about 1 year. She developed secondary metastases and presumably died of it as she absconded in a moribund condition.

Primary choriocarcinoma of ovary are histogenetically classified into (a) gestational and (b) non gestational; occurring in pre-pubertal and post-menopausal women. These are teratomatous in origin. Gestational choriocarcinoma occurring in the reproductive period are rare and usually not diagnosed till histopathological examination. Views on their histogenesis are:

1. An ectopic ovarian pregnancy.
2. Trophoblastic emboli which have become malignant.
3. Metastases from a previous uterine or tubal choriocarcinoma in which primary has been completely expelled, regressed or disappeared.
4. A one sided development of an ovarian teratoma.
5. An ab initio malignant transformation of trophoblast without the formation of an embryo.

Views regarding histogenesis of choriocarcinoma of tube are:—

1. Arises from ectopic pregnancy.
2. Intrauterine pregnancy that has spread to the tube via embolic transport of chorionic villi to tube.
3. Arises from teratomatous change within the tube.
4. Metastases from uterine choriocarcinoma with disappearance of primary.

## TROPHOBLASTIC TUMOURS

**(A study of 180 cases)**

by

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and

P. RAJARAM,** M.D., D.S.S.

The incidence of trophoblastic tumours at the Government Maternity Hospital, Hyderabad, during the period January 1961, to August 1969, was 1 in 565 labours and 87.5 abortions. Of the 190 tumours studied, 92 per cent were benign, 5.5 per cent choriocarcinoma, and 0.01 per cent chorioadenoma destruens. The highest incidence was in the third decade of life. Toxaemia occurred in 19.4 per cent. An associated foetus, a recurrent mole and a suburethral nodule were the other complications. The uterus was larger than the period of amenorrhoea in 54 per cent and smaller in 24 per cent.

In 90.4 per cent the mole was evacuated per vaginum, by hysterotomy in 7.1 per cent and hysterectomy in 0.6 per cent. Only 10 per cent could be followed-up for over a year. As the follow-up was unsatisfactory,

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routine prophylactic chemotherapy was instituted after evacuation in the young and nulliparous women and hysterectomy in the older and parous women.

Of the 13 cases of choriocarcinoma, 6 were preceded by mole, 4 by full time pregnancy, 2 by abortion. In one case, there was no preceding pregnancy. Pulmonary metastases were common. When treated with pre and postoperative chemotherapy the survival was longer than with postoperative chemotherapy alone.

## A HOPEFUL OUTLOOK FOR TROPHOBLASTIC GROWTHS. OUR EXPERIENCE WITH METHOTREXATE IN CHORIOCARCINOMA

by

D. PARANJOTY, M.R.C.O.G., D.G.O., D.T.M.

Choriocarcinoma is a highly malignant growth of the uterus, and carries a high mortality. It is common in India as in other oriental countries. Low socio-economic, low protein intake, poverty, high fertility are said to be some of the aetiological factors. The advent of chemotherapy has radically improved the prospects of cure beyond what is achieved by surgery alone. This disease which usually kills the patient in 1 year, is suppressed by these drugs for a period of 10 years or over in about 70% of cases and we have good reasons to believe that the suppression of tumour cell is permanent if the patient is alive and well for over 2 years.

This paper is based on 58 cases of choriocarcinoma and 17 cases of malignant mole, all treated at C.M.C. Hospital, Vellore. The drug of choice was Methotrexate. Our mortality in choriocarcinoma with surgery only was 100%. With surgery and Methotrexate, there was complete remission in 48.2%, partial remission in 44.4% and no response in 7.4%. The longest survival in our series is 7 years. All the patients in complete remission enjoy good health with no recurrence.

With malignant mole response to Methotrexate is better. We got complete remission in 100.0% of cases. Although there is great similarity in age, parity and symptomatology between choriocarcinoma and malignant mole, we see significant difference between the two in mortality and in response to Methotrexate. The exact relationship between the two is yet to be defined. At present the distinction between them is a purely histopathological one.

Methotrexate is used prophylactically when molar pregnancy occurs in women of 40 and in gravida over 3. These are called high risk patients and the incidence of choriocarcinoma in them is said to be increased.

## TUMOURS OF TROPHOBLAST

**(A clinical study)**

by

S. C. SAXENA, M.S.

The paper is an analytic study of 61 cases of vesicular moles, 4 cases of invasive moles, and 5 cases of choriocarcinoma.

80% cases with vesicular mole were below the age of 30 years. All patients with invasive mole, and 60% cases of choriocarcinoma were above the age of 30 years.

Incidence of primipara in vesicular mole, invasive mole and choriocarcinoma was 13.3%, 25%, and 40% respectively.

In 75% cases of vesicular mole, the uterus was bigger than normal size. The incidence of toxaemia was 10%.

Hysterotomy was the treatment in 25%, and hysterectomy in 13.3% cases of vesicular mole.

In one case of invasive mole the diagnosis was made by curettage.

The type of previous pregnancies in choriocarcinoma cases was, vesicular mole 2, abortion 2, and no conception(?) in one case.

Incidence of cystic ovaries in cases with vesicular mole, invasive mole, and choriocarcinoma was 8.3%, 50%, and 20% respectively.

## TUMOURS OF TROPHOBLASTS

**(A study with special reference to their pathologic diagnosis and prognosis)**

by

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and

P. S. Manjrekar,** M.D.

The study is an attempt to evaluate the value of curettage in cases of trophoblastic growths in giving a diagnosis, and forecasting the prognosis of the case.

Sixty-one cases of vesicular moles were classified according to the criteria of Hertig and Mansell in three grades. (Gr. I, 55; Gr. II, 3; Gr. III, 3 cases).

The diagnosis of invasive mole was made by curettage in one case out of the 4 cases.

While giving the histologic diagnosis, the diagnostic variabilities and behaviour of the trophoblastic tumours should be kept in mind.

The importance of absence of well formed chorionic villi in a case of choriocarcinoma is stressed.

The examination of the whole uterus is a must for confirming the diagnosis of invasive mole and choriocarcinoma.

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## A REVIEW OF 31 CASES OF MALIGNANT TROPHOBLASTIC TUMOURS

by

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and

P. Madan, F.R.C.O.G.

Thirty-one cases of malignant trophoblastic tumours including 28 cases of choriocarcinoma and 3 cases of chorioadenoma destruens, treated at Lady Hardinge Hospital, New Delhi, for the years 1959-1968 (10 years) were reviewed.

Incidence found was 1 in 2506 pregnancies which is well comparable to the reports of other Asian countries where it occurs with a more increased frequency than in the western countries. 83.8% of the patients

were below 30 years of age; parity varied from 1-8. Vesicular mole was the commonest type of preceding pregnancy (46.6%). Metastases were mostly seen in the lungs and vagina. Overall results were unsatisfactory in our series where patients were treated with surgery and chemotherapy, and the maximum period a patient lived was 2½ years.

Mortality rate in 28 cases of choriocarcinoma was 61.2%. (20 cases were followed up, 8 were lost for follow-up). Whereas among 3 cases of chorioadenoma destruens, 2 were alive over 2 years and one was lost for follow-up.

The problem of high mortality in malignant trophoblastic tumours and role of chemotherapy is discussed.