CHORIOCARCINOMA OF THE UTERUS WITH INTRA UTERINE DEVICE IN-SITU

(A Case Report)

by

B. PALANIAPPAN,* M.S., D.G.O. and SARE PAUL,** M.D.

There is no authentic record of any case of choriocarcinoma developing in a woman who had intrauterine device inserted four years prior to the onset of the disease.

CASE REPORT

Mrs. A., 46 years, old, who had ten full term deliveries and two abortions through a consanguinous marriage was admitted on 21st April 1973. Her last pregnancy ended in an abortion at fourth month when evacuation was done in another city hospital and an I.U.D. inserted on the third day just before discharge. She did not have any check up examinations afterwards. Later she was having irregular and frequent periods for six months and continuous bleeding episodes off and on during the next six months.

She was anaemic and weak. The uterus was enlarged to fourteen weeks' size of pregnancy and there was a bluish suburethral nodule 4 cm. in diameter. She was having continuous bleeding from the nodule and excision of the nodule was carried out. When endometrial biopsy was proceeded with and friable and necrotic material was being removed by the curette, the nylon threads of the device appeared from the cervical canal. There was brisk bleeding and two attempts to pull out the device were made. During the next 48 hours the general condition of the patient was improved with blood transfusions and other measures and an abdominal hysterectomy with bilateral salpingo-oophorectomy was done. The uterus was grossly enlarged and filled with necrotic, haemorrhagic growth (Fig. 1). The I.U.D. was embedded in the growth. The device which was of 27.5 mm size, was normal in shape and appearance along with the nylon threads. The ovaries were slightly enlarged and cystic. Histological examination revealed that the tumour was choriocarcinoma (Fig. 2). Multiple sections taken from the tumour showed extensive areas of haemorrhage and necrosis with clump and sheets of trophoblastic cells. The superficial part of the myometrium showed extensive necrosis of the muscle and invasion by trophoblastic cells. Mitotic figures were also seen. There was no evidence of chorionic villi. The suburethral nodule resembled the parent tumour, composed mainly of blood clots and tumour cells.

She had three courses of methotrexate therapy after the operation and was in normal health for six months. During the middle of December '73, she was readmitted with severe cachexia and debility. X-ray chest revealed multiple pulmonary metastases. She got herself discharged against medical advice in a moribund condition within two days.

Discussion

A long latent period between the emergence of choriocarcinoma and the antecedent pregnancy is acceptable only if one can exclude the possibility of an unrecognised or concealed pregnancy. In this case if there was no failure on the part of the device, a long latent period has to be accepted. Novak and Woodruff (1967) describe a case developing choriocarcinoma nearly four years after a normal pregnancy at which time tubal ligation

*Obstetrician and Gynaecologist, State Insurance Hospital, Madras-23.

**Pathologist, State Insurance Hospital, Madras-23.

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was carried out because of hypertension. However, it is difficult to rule out a subsequent pregnancy ending in abortion in spite of the device in position. Teitze (1966) estimates that atleast a third of the pregnancies which do occur while a device is in place terminate in abortion, presumably spontaneous.

Wilson (1968) found no glandular changes in the endometrium even after several years and stated that there is no known relationship between chronic irritation and uterine cancer. To date there is no evidence to suggest that the development of choriocarcinoma can be attributed to the device. On the other hand, it will be wishful thinking to surmise that the device delayed the onset of the disease or its progress.

Menon (1970) made a detailed study of 170 patients with I.U.D. and late haemorrhages. He did not have any invasive cancer in his series of 1846 postpartum and postabortal insertions and yet he cautions that we should not be too sanguine about intrauterine device as there are many factors requiring elucidation.

Rao (1970) reviewing 1094 trophoblastic tumours which include 121 cases of choriocarcinoma concludes that these tumours appear to be as common in India as in South-east Asia and Far-eastern countries. However, several authors from the orient including Wolfers and Ratnam (1970) reporting on the complications as well as associated diseases following I.U.D. insertions have not reported any case of choriocarcinoma with the device.

Scott (1972) points out that one of the great mysteries of placentate reproduction is the mechanism whereby the trophoblastic invasion of the maternal host is halted. In the occasion when this fails the consequence may be a hydatidiform mole or choriocarcinoma. Anyhow it is disturbing to note that malignant trophoblastic growth has developed in the presence of I.U.D. which was meant to prevent trophoblastic invasion.

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See Fig. on Art paper V