CHORIOCARCINOMA CAUSING PERFORATION OF THE UTERUS

(A Case Report)

by

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Choriocarcinoma many times poses a diagnostic problem. The following is a case report of choriocarcinoma causing perforation of the uterus with massive intraperitoneal haemorrhage and pulmonary metastases. The other interesting feature of this case was, although choriocarcinoma was suspected three months prior to the acute episode, the diagnosis could not be proved and treatment was deferred.

CASE REPORT

Mrs. S., 26 years, Para 2 + 5, attended the gynaecological outpatients' department of the Christian Medical College Hospital, Vellore, South India, on 30th January, 1976, for irregular vaginal bleeding for 10 months, following an induced abortion of 2 months duration.

Menstrual History was normal and regular before the last pregnancy. Last normal period was 12 months ago.

Obstetric History: She was married for 14 years, having had two full term normal deliveries, 12 and 8 years ago, and 5 abortions. All the abortions were spontaneous, except the last one which had been induced by a stick, 10 months ago.

On examination, her general condition was good, and systemic examination was normal. Pelvic examination revealed a soft and bulky uterus, and bleeding through the os. No history of cachexia, cough or haemoptysis was obtained. Choriocarcinoma of the uterus was strongly suspected, and she was admitted for investigations.

The Gravindex test was negative, and a diagnostic curettage report was "syncytial endometritis". She continued to bleed after the curettage so a second curettage was performed, which was reported as "acute endometritis, with no evidence of choriocarcinoma". She was discharged on 17-2-1976, and was advised to come for close follow up.

On 2nd May, 1976, the patient came to the Casualty, with 40 days amenorrhoea, severe, acute lower abdominal pain 12 hours prior to admission and a fainting attack. No history of bleeding per vaginam was present.

On examination, she was in haemorrhagic shock, with a pulse rate of 160/min., blood pressure was 90/60 mm. Hg., air hunger and severe pallor were present. Haemoglobin was 8.2 Gm.%. Abdominal examination revealed generalised tenderness and guarding, especially in the lower abdomen. On vaginal examination the os was closed, with no vaginal bleeding. The uterus was very tender, especially on the left side, soft and enlarged to 8 to 10 weeks' size. No appendages were palpable, but tenderness was present in all the fornices. Colpocentesis was positive. A diagnosis of intraperitoneal haemorrhage, probably due to a disturbed ectopic pregnancy was made.

An emergency laparotomy was performed. On opening the abdomen in the peritoneal cavity was full of blood. The uterus was irregularly enlarged and perforated by a friable and necrotic growth on the upper left lateral surface. There was a broad ligament haematoma on the left side. Both fallopian tubes and ovaries were grossly normal. A total hysterec-

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tomy and left salpingo-oophorectomy was performed. The patient was given three bottles of blood transfusion. She stood the procedure well.

The specimen showed the uterine cavity to be filled with a friable, polypoidal growth, which had perforated through the serosa in the left lateral wall (Fig. 1). The left fallopian tube and ovary were normal. Microscopic examination, showed choriocarcinoma, with extensive replacement of the uterine wall by the tumour. In areas the choriocarcinoma had broken through the serosa of the uterus. The left tube and ovary revealed no significant lesion. The final diagnosis was established as choriocarcinoma causing perforation of the uterus.

The postoperative period was uneventful, and the wound healed by first intention. X-ray Chest (10-5-76) showed multiple pulmonary metastases, and the Gravindex (15-5-76) was positive upto 1:32 dilutions. She was given Methotrexate 5 mgm. B.D. x 7 days from 15-5-76 to 21-5-1976, and 5 mgm. B.D. x 5 days from 2-6-76 to 6-6-76. After each course she developed leucopenia and oral ulcerations. After the second course, she had severe and persistent neutropenia. The Gravindex was negative, and X-ray Chest showed no evidence of secondaries. She was discharged on 3-7-1976, when the blood count and neutropenia had improved, and was advised to come for further follow up, and Methotrexate therapy.

Discusion

The pitfalls in the diagnosis of choriocarcinoma have been well illustrated by Acosta-Sison (1949) and Paranjothy (1968), who have found negative curettings and pregnancy tests in several cases of choriocarcinoma. According to Acosta-Sison (1949), history of a recent pregnancy, abnormal vaginal bleeding and a pelvic examination showing a soft and bulky uterus should be given great weightage in the diagnosis of choriocarcinoma. These criteria were present in this patient when she first attended hospital. Unfortunately, due to lack of further evidence, hysterectomy was deferred.

Choriocarcinoma causing perforation of the uterus and presenting with features of a ruptured ectopic pregnancy is unusual. The mortality of these cases is unusually high, as has been reported by Acosta-Sison (1949). In her study, four out of 17 deaths due to chorionepithelioma, were due to perforation of the uterus by the tumour causing haemoperitoneum. In the case reports of Hazra and Paul (1961) and Mukherjee (1970) also, both the patients died postoperatively due to associated pulmonary and brain metastases respectively. In our case also, the patient had multiple pulmonary metastases, causing a high Gravindex titre. Fortunately, she survived the postoperative period, and the secondaries were responsive to Methotrexate therapy.

Summary

A case of choriocarcinoma causing spontaneous perforation of the uterus, and simulating a disturbed ectopic pregnancy has been reported. The pitfalls in the diagnosis of the disease, have also been discussed briefly.

References

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See Fig. on Art Paper VII