CHORIOCARCINOMA WITH HAEMOPERITONEUM

(A Case Report)

by

M. Sood,* D.G.O., M.D.

and

S. Y. Eduljee,** D.G.O., M.D.

Although choriocarcinoma is considered a rare tumour in the West, epidemiological data indicate that it is about 10 times more prevalent in Asia and Latin American countries. The majority of cases are reported following hydatidiform mole or abortion, less commonly they may follow a term pregnancy and rarely after ectopic gestation. The interval between the pregnancy and onset of tumour varies between 6 weeks to 13 years. Due to early haematogenous spread of the disease there may be a variety of interesting clinical features posing problems in diagnosis. An interesting case of invasive choriocarcinoma with diffuse intraperitonial haemorrhage following an abortion is presented.

CASE REPORT

Mrs. S., a 21 years old para 1 had spontaneous abortion at 14 weeks of gestation. As it was incomplete, an evacuation was done on 9th April, 1974 by a private practitioner. Thereafter she developed low grade pyrexia and continued to bleed per vaginam for which she was admitted to Irwin Hospital, New Delhi on 24th April, 1974. On admission, patient looked anaemic (Hb—6 gm%) and toxic. On pelvic examination the uterus was retroverted bulky, mobile and fornices were free. Slight bleeding per vaginam was present. She was given a course of streptopenicillin and total dose infusion of iron.

Dilatation and curettage was done on 3rd May 1974. Histopathological report of curettings was non-secretory endometrium. Patient was discharged on 7th May, but readmitted on 18th May with the history that bleeding per vaginam had continued since the initial admission.

M/H—30 days regular cycle, flow average, L.M.P.—exact date not remembered by the patient.

O/H one full term normal delivery 2 years back, male baby alive.

On examination. A young patient of average build and nutrition, pallor present, pulse 80 per minute, B.P. 120/80 mm. Hg., Temp. normal, liver and spleen not palpable and other systems were normal. On pelvic examination uterus was retroverted enlarged to size of 8-10 weeks pregnancy, fornices free, cervix blue, bleeding per vagina present. Patient was put on antianaemic treatment. On 18-5-74 at 9 A.M. patient complained of pain in abdomen and had developed slight abdominal distension. By 12 noon she developed marked distension, pulse went to 128/min. Temp. 38°C., bowel sounds present. She also had developed guarding of lower abdomen and rigidity. On vaginal examination exact size of uterus could not be made out. There was fullness in right and posterior fornices. Provisional diagnosis of perforation of uterus or ectopic pregnancy was made. Patient was prepared for needling and laparotomy. On colpocentesis few cc. of altered blood were drawn. So an emergency laparotomy was performed.

Laparotomy findings: Abdomen was opened by midline subumbilical incision. The bluish appearance of the peritoneum was suggestive of

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**Lecturer.*

***Assoc. Prof.*

Dept. of Obst. & Gynec., M.A.M.C., New Delhi.

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intraperitoneal haemorrhage. As the peritoneum was incised blood came out from the peritoneal cavity.

Approximately 600 cc. of blood was removed from the peritoneal cavity. On lifting the uterus it was found to be enlarged to the size of 8-10 weeks pregnancy. Ovaries were apparently normal, and tubes also had no evidence of pathology on macroscopic examination. The right cornu of the uterus was enlarged and there was a haemorrhagic growth on it. On the posterior aspect of the uterus there were 3 haemorrhagic nodules with fresh blood oozing from them. Diagnosis of an invasive choriocarcinoma with intraperitoneal haemorrhage was confirmed. A quick panhystrectomy was done. Attempts were made to localise secondaries but no secondaries in bowel or liver were detected. The peritoneal cavity was cleared of blood clots and the abdomen was closed in layers. Patient had 2 units of blood transfusion during operation.

Specimen: On cutting open the uterus, there was a friable growth bluish in colour, size about 1" x 1½" arising from the fundus and posterior wall of the uterus near the right side.

In the postoperative period she was put on streptopenicillin and I.V. fluids. Postoperative period was uneventful except that she developed low grade fever which settled down with antibiotic therapy. On 25-5-1974 she complained of pain on right side of chest. Clinically and radiologically however no pathology was detected. On 29-5-1974 she complained of slurrring of speech and developed deviation of tongue to the right side. The neurologist was consulted and an infranuclear lesion was suspected. Funduscopy, X-ray skull and lumbar puncture revealed no abnormality. Pregnancy test was also negative. She was put on methotrexate therapy, 5 mg TDS for 5 days ‹ 29-5-1974. Four such courses were given during a 6 weeks period.

During methotrexate therapy monitoring of blood counts, liver and renal functions were done to diagnose drug toxicity. With methotrexate therapy deviation of tongue disappeared. Patient was discharged on request on 20-7-74 with the advice to report after 2 weeks but she was lost to follow up.

Histopathological report of the uterus confirmed the diagnosis of choriocarcinoma. Both the tubes had vascular permeation.

Discussion

Choriocarcinoma has a high incidence of metastases in different vital organs due to early haematogenous spread. Pulmonary deposits are the commonest forms of secondary metasteses in choriocarcinoma (Park and Lees, 1950; Novak and Seah, 1954; Bhaskar Rao, 1970). Liver and Brain stem metasteses occur less commonly. Small Braak (1957) observed cerebral metastases in 5 out of 17 reported cases. In his series one case had transient neurological disturbance in the form of aphasia and hemiplegia, which gradually disappeared together with disappearance of chorionic gonadotrophins in the urine.

Peel *et al* (1955) reported 1 case having brain stem metasteses. In the present case clinical picture was suggestive of intraperitoneal haemorrhage. However, the diagnosis of invasive choriocarcinoma was confirmed on laparotomy, hence preoperative methotrexate therapy was not given. In the postoperative period inspite of removal of the uterus with the growth, patient developed brain stem metasteses leading to deviation of tongue which responded to methotrexate. An interesting feature of the present case was that the first pregnancy test done on 3rd postoperative day and the repeat test on the 6th postoperative days were both negative despite the highly invasive nature of the tumour and also the fact that there was obvious secondary metasteses in the brain and possibly lungs also.

Various explanations have been put forward to explain the findings of negative test in choriocarcinoma. Jeffcoate (1957) stated that in choriocarcinoma pregnancy test may be negative where the malignant chorionic tissue is covered by fibrin deposit. According to Durburg

(1946) thrombosis of maternal vessels preventing escape of trophoblast into maternal circulation is possibly responsible for a negative pregnancy test. According to Brewer (1964) in some cases of trophoblastic diseases pregnancy test may be negative because the capability of chorionic tissue to produce gonadotrophin is variable.

Summary

A case of invasive choriocarcinoma presenting as an acute abdomen and with brain stem metastases developing in the postoperative period has been reported. Response to brain stem lesion with methotrexate has been observed resulting into correction of deviation of tongue. Postoperative pregnancy test was negative inspite of the highly invasive nature of the tumour.

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