TROPHOBLASTIC VAGINAL METASTASIS

(Report of 3 Cases)

by

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Trophoblastic diseases are considered neoplastic lesions of the trophoblast, which metastatise to the lungs, vagina, liver, brain and bone.

Attwood and Park (1961) suggest that trophoblast is found in the lungs of nearly half of all pregnant women (43.6%), although villi are uncommon. Generally these physiological metastasis of trophoblast are not manifested clinically and regress spontaneously but very rarely they may produce symptoms.

In this paper we present 3 cases of metastatic trophoblastic disease of vagina. In one case there was also concurrent pulmonary metastasis.

Case 1

J. S. aged 36 years and having 4 full term pregnancies (last one 4 years back) was admitted on 21-1-78. Her chief complaints were (1) amenorrhoea for 2 months, (2) slight bleeding per vaginam for 10 days followed by severe vaginal bleeding with passage of grape-like structure on the day of admission. She was very pale (Hb 6 gm%). Her blood pressure was 90/60 mm. of Hg. Pulse 140/min. Uterus was just palpable above symphysis pubis. On pelvic examination a blackish mass (3 c.m. x 3 c.m.) in size was seen on the let superolateral wall of vagina which was bleeding. Uterus was 12 weeks pregnancy size. Os was open. Fornices were clear.

Provisional diagnosis was hydatidiform mole with vaginal metastasis. Two Bottles of Group B, Rh + ve blood was transfused. Under general anaesthesia molar tissue was evacuated by suction evacuation. Excision biopsy was taken from the growth on anterior vaginal wall.

INVESTIGATION: On 23-1-78—Chest X-ray NAD. Urine albumin; Urine for pregnancy was positive in 1/200th dilution.

H. P. Report: On 7-2-78—vaginal nodule showed evidence of chorionepithelioma. Material evacuated from uterus—benign molar tissue. Total hysterectomy with bilateral salpingo-oophorectomy was done on 20-2-78. Uterus was cut open. Cavity was absolutely clear. Measurement of cavity 2½". Both the ovaries were cystic. Postoperative Hb—was 8 gm% W.B.C.—5000/m. Patient was given one course of methotrexate postoperatively.

H/P. report: Uterus-endometrium scanty. Ovary showing follicular cyst and corpus lutum on the left Ovary.

Follow up: Gravindex Test was negative on 8.3.78, 8.4.78, 37.5.78 and 26.6.78. The patient is now alive and well. Repeat X-ray chest—N.A.D. Pelvis—N.A.D.

Case 2

J. R. aged 30 years, para 5 + 1, last child birth 10 months back was admitted on 13-1-78. Her chief complaints were (1) amenorrhoea for 3 months, (2) vaginal bleeding for 2 months, (3) lump in the lower abdomen for 2 months, (4)

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pain in the area of lump for the same period, (5) fever and cough for the same period. Past history of tuberculosis 2 years back. She was of average build with poor nutrition.

On abdominal examination a pyriform lump of about 18-20 weeks pregnancy was palpable in the midline of lower abdomen. It was mobile, firm and slightly tender, no foetal parts were felt or foetal heart sounds heard.

On pelvic examination, a marble sized cystic swelling of blackish colour was noticed in the anterior wall of vagina. Cervix was soft. Os was closed and vaginal bleeding was present, Provisional diagnosis was pulmonary tuberculosis with molar pregnancy.

INVESTIGATION: Hb. 8 gm. of W.B.C.—12,000/cmm, poly 80%, mono 1%, lympho 15%, eosino 4%. Stool for O.P.C. Nil. Blood sugar—82 mg%. Blood urea—32%. Urine was positive for pregnancy test in 1/200 dilution. X-ray chest—Suggestive of Koch's lesion in right midzone of lung. Rounded opacity in left lower lobe raises strong suspicion of hydatid cyst, but the possibility of secondary deposit cannot be excluded. X-Ray of pelvis—no evidence of foetal shadow.

Treatment: Two Bottles of group 'O' Rh +ve blood was transfused. She was put on methotraxate on 31-1-78. Total hysterectomy with bilateral salpingo-oophorectomy was done. Excision biopsy was taken from the growth on the anterior vaginal wall.

H.P. examination report: Vaginal nodule shows evidence of choriocarcinoma. Uterus-blood clot only, no evidence of trophoblastic tissue was found. Methotrexate was started on the 14th postoperative day. But on the 4th day after starting the course, the patient developed severe pain in the chest, bloody diarrhoea and angular stomatitis. Methrotrexate was discontinued. Folic acid, as Folinic acid was not available, was given orally. Chest X-ray was taken which showed no significant change in the opacity of secondary deposits. She was given one bottle of blood transfusion. Mitomycin 10 mg. was given in I.V. drip when blood picture improved. She tolerated it well. Another skiagram of chest was taken which showed significant change in the secondary deposits. The patient was discharged 1½ months after operation. The patient was re-admitted on 29-4-78 with complaints of severe dyspnoea. chest pain suggesting evidences of pulmonary metastasis. One bottle of blood was transfused. Patient expired on 30-4-78.

Case 3

S. D. aged 23 P1 + 0, had her last childbirth 1 year back was admitted on 12-6-76. Her chief complaints were—(1) absence of menstruation for 3 months, (2) vaginal bleeding for 7 days. She was very pale, her pulse was 92/min.

On abdominal examination uterus was 16 weeks size. On pelvic examination a haemorrhagic growth of 2.5 cm. x 2.5 cm. was found on right side of the anterolateral vaginal wall and also over suburethral region (1 cm. x 1 cm.). Vagina was full of blood clots. Os was closed. Vaginal bleeding was present. Uterus was 16 weeks size. Fornices were clear.

Invesigation: Hb% —9.5 gm%.

Provisional diagnosis was molar pregnancy with vaginal metastasis. Two Bottles of group 'B' Rh + ve blood was transfused. Suction evacuation of uterine content was done. Molar vesicles were noticed. Excision biopsy was taken from the anterior vaginal wall.

Pathological Report: Vaginal nodule consists of chorionic villi, no evidence of malignancy. Patient was put on 2 courses of methotrexate. Urine was positive for pregnancy test on 15-6-76, 26-6-76 and became negative on 27.7.76, 25.8.76 and 24.9.76. She was followed upto 24-6-78 and is still keeping good health and having normal menstruation.

Discussion

Trophoblastic secondaries of the vagina manifest in the form of dark reddish or blackish raised nodules. This type of dark reddish or blackish mass may also be due to some other causes like metastasis from endometrial carcinoma, carcinoma ovary, hypernephroma, direct extension from carcinoma cervix, bladder, rectum, or may be due to primary carcinoma of vagina, angioma, and a haematoma. From macroscopic features it is not possible to differentiate them. Ultimate diagnosis is made from histopahological examination.

Trophoblastic diseases of vagina may occur in two ways: (1) by extension,

(2) by metastasis. Metastatic nodules are more common, which occur through retrograde transport of tumour emboli to vagina and the spread is haematogenous (Novak).

The importance of these metastatic nodules lie in the fact that mere presence and/or exicision of such nodules with subsequent microscopic examination may be the first clue to the existence of chorionic-epithelioma.

In our first case presence of vaginal metastasis roused suspicion of trophoblastic disease particularly chorion-epithelioma. But the case is somewhat difficult to explain as histopathological report of vaginal nodule showed evidence of chorionepithelioma but that of tissues evacuated from the uterus showed the picture of benign Mole. It may be said that malignant degeneration of metastatic trophoblast occurred and gave rise to primary choriocarcinoma at that site. Although it is very rare, it is a possibility.

Vaginal metastasis or extension may occur in nearly (50%) of cases of chorionepithelioma. But it must be remembered that trophoblastic metastasis in the vagina is not due to chorion-epithelioma only. Metastatic trophoblastic nodule may occur in chorio-adenoma destruens, benign H. Mole and even normal pregnancy.

In our third case vaginal metastasis occurred in presence of benign Mole, Metastatic nodule showed the picture of typical benign mole.

The natural course of metastatic nodules are also unpredictable. Sometimes they regress spontaneously or after evacuation of mole, or after parturition or after treating the primary tumour in case of choriocarcinoma (Haines 1955; Browne 1950). Chances of regression of metastatic nodule in chorio-carcinoma are more when syncytiotrophoblasts are predominent in the primary growth. But according to Novak and Seah (1954) both layers of trophoblastic epithelium participate in the malignant process though there may be a predominance of one over the other. This has got no significance.

It is not the fact that only malignant tumours will progress and cause extensive metastasis and fatal termination, as in our first case the vaginal metastasis (which on histopathological examination showed picture of choriocarcinoma) completely subsided after evacuation of molar tissue from the uterus. On the other hand, there are examples in the literature where a benign metastasis in vaginal fornix caused fatal haemorrhage in a girl of 18.

Metastasis may occur both in the vagina and lungs simultaneously as occurred in case 2. The metastic nodules in lungs offer some diagnostic difficulty. In case of vaginal metastasis we can diagnose it by taking biopsy from the nodule but in case of lung metastasis we have to depend on X-ray and H.C.G. estimation.

In 2 of our 3 cases no separate treatment for the metastatic trophoblastic tumours was required, but in case 2 the vaginal tumour was excised and pre and postoperative chemotherapy was given. Every case should be dealt according to its own merit. But the general plan of treatment should be exicision and histopathological examination of the nodule first and treatment of primary tumour (e.g. evacuation of mole). But

when histopathological examination report gives a clue to choriocarcinoma, treatment should be on for choriocarcinoma, i.e. chemotherapy and/or surgery.

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Erratum

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Because of oversight of the Press the designation of the first author S. M. Gosavi had been omitted. It should read as follows.

Estimation of Foetal Maturity By Shake-Text

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The Editor regrets this omission