METASTATIC CHORIOCARCINOMA

(A Case Report)

by

SWARAJ BATRA*

and

B. G. KOTWANI**

When chemotherapy was not available 40% of patients choriocarcinoma treated with hysterectomy survived 5 years. The disease nearly always recurred with fatal outcome! The picture has changed with the advent of chemotherapy. Any surgical interference encourages, the dissemination of the growth and it should be covered by chemotherapy. Now prognosis for choriocarcinoma cases is not so bad.

CASE REPORT

Patient A. 30 years old, was admitted in J.P. Hospital on 6th June 1978. She gave history of being apparently well for last 7 years following abdominal hysterectomy. For last 2 months she had blood stained discharge per vaginum off and on. It was non-irritant and was not foul smelling. For last 2 days she was having fair amount of vaginal bleeding. There was no history of fever, pain, cough, haemoptysis, visual disturbances and urinary complaints. She used to have headache off and on for last 7 years.

She used to have normal 30 days cycles before hysterectomy. Duration of flow was moderate lasting 3-4 days. She was married for last 8½ year and had 2 abortions. First abortion was of 2½ months pregnancy 8 years back. It was a septic abortion for which curettage was done at some private nursing home after controlling infection. During second pregnancy she was admitted in this hospital in August, 1971 with history of amenorrhoea of 4 months and bleeding off and on for 2 months. As the size of uterus was slightly smaller than period of gestation she was diagnosed as a case of either missed abortion or threatened abortion and was kept under observation. Three days after admission she had excessive vaginal bleeding and examination revealed internal os to be open. Size of uterus was 14 weeks. Syntocinon drip was started. She aborted the foetus but placenta was retained. Digital separation was attempted. Only ½" x ½" piece of placenta could be separated and patient started bleeding profusely. Blood transfusion was started and she was taken to operation theatre where another attempt to separate placenta was made under general anaesthesia but it was unsucessful. As the patient was beeding profusely laparotomy was done. At hysterotomy no plane of clevage could be found and placenta was found to be adherent. Quick subtotal hysterectomy was done as she was in low condition. Her postoperative period was uneventful. Cut section of uterus showed that placenta was invading the myometrium almost upto periphery. It was a case of placenta increta and same was confirmed by histopathology. There was nothing relevant in her past history.

On admission she was of average built cooperative and intelligent. Pulse 80/min. Heart and Lungs normal. On abdominal examination there was a midline subumblical scar. Liver was one finger below costal margin. Spleen was not palpable. No other mass was felt. On speculum examination there was a haemorrhagic purple growth at vault. Exact site was not localised as she started bleeding torrentially and collapsed. Vagina was packed without further examination. She was given sedation, intavenous fluids and

*Lecturer, Deptt. of Obst. & Gynaecology.

** Prof. & Head, Deptt. of Obst. & Gynaecology.

Maulana Azad Medical College, New Delhi.

2 units of blood. She was taken to operation theatre for proper examination under general anaesthesia.

Under anaesthesia, speculum examination revealed a healthy cervix. There was 3" x 3" growth in the posterior fornix. It was dark blue haemorrhagic and ulcerated. On vaginal examination it was highly pulsatile. On rectal examination it was felt projecting towards anterior rectal wall but mucosa was intact. No attempt at biopsy was made. Vagina was packed and patient was given another 2 units of blood as she was bleeding. Provisional diagnosis of metastatic choriocarcinoma was made. Urgent haemoglobin, TLC, X-ray chest and urine for pregnancy test was done. Blood was sent for serum HCG. Urinary pregnancy test was positive.

She was put on methotrexate 20 mg. intravenously in 100 cc of 5% glucose over a period of 1 hour daily for 5 days.

Chlorambucil tablets 2 mg. three times a day for 5 days were started on 3rd day when detailed kidney and liver function tests were available. Bleeding decreased with this. Ten days after admission that is on 17th June she started bleeding profusely per rectum. Vaginal and speculum exam. revealed same findings as before. Rectal examination under anaesthesia revealed 4" x 4" growth which was felt through anterior rectal wall and same was ulcerating into rectum. Proctoscopy revealed 2" diameter dark blue growth 3" above the anal sphincter on anterior wall and bleeding was from this growth. Rectal packing was done. She was given blood transfusion and was put on chromostat injections and chlorostrep capsules. Repeat pregnancy test was positive. Second course of methotrexate was given 15 mg. intravenously for 5 days starting from 7-7-78. Bleeding decreased after that. Another course of chlorambucil 2 mg. tablets 3 times a day for 5 days was given starting from 21-7-78. She started passing stool per vagina. She was again examined in the theatre on 26-7-78. On vaginal, speculum and proctoscopy examinations no growth could be made out but there was rectovaginal fistula admitting one finger 3" above the anal sphincter. Pregnancy test in urine by gravindex was negative and serum H.C.G. was also negative on 10-8-78. Third course of methotrexate was given for 5 days orally starting from 14-8-78. Chlorambucil was repeated after a fortnight followed by a course of methotrexate after one month as she developed upper respiratory cattarh. Treatment by cytotoxic drugs was being controlled by TLC on alternate days and repeated Hb and liver function tests. She was being examined regularly at fortnightly intervals. Last examination was done in first week of December and there was no evidence of choriocarcinoma and repeat serum HCG was also negative. All investigations including blood count, bleeding and clotting time, blood chemistry, liver functions tests, liver scan, X-ray chest, and skull were normal.

Discussion

This case is interesting because metastatic choriocarcinoma followed placenta increta and that too 7 years after the hysterectomy. Centre of trophoblastic disease at Chicago had studied 228 cases of choriocarcinoma and invasive mole and followed them up for minimum 3 years. In their series permanent remission rate in choriocarcinoma was 82% and in invasive mole 100%. In metastatic choriocarcinoma remission rate was 74%. This centre advocates 3 to 4 courses of cytotoxic drugs after serum HCG is normal to avoid relapses. The incidence of relapses is maximum within first year. We propose to give her chlorambucil and methotrexate alternatively at 3 monthly interval for 6 months so that the first year in which relapse rate is maximum is covered. The patient will be followed by repeated examinations and pregnancy test upto 5 years. This is a case of high risk metastatic choriocarcinoma and idealy speaking she should be put on Li's triple therapy but as Actinomycin D was not available she was put on sequential therapy.