NORMAL PREGNANCY FOLLOWING CHEMOTHERAPY FOR CHORIOCARCINOMA

(A Case Report)

By

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Introduction

The incidence of choriocarcinoma is 1 in 19734 pregnancies as compared to hydatiform mole which is 1 in 2000 to 1 in 2500 pregnancies. These patients must be followed up at least for 3 years. Actually those patients who relapse from remission do so during first year after attaining primary remission. It is extremely rare that relapse occurs during the second year and least of all after 2 years. The permanent remission rate in choriocarcinoma is 82%, varying from 74% in the metastatic group to 100% in the nonmetastatic group.

Li *et al* (1956) were the first to observe the unique response to the chemotherapeutic agent methotrexate. In 1961, Hertz *et al* (1961) reported 47 per cent complete and sustained remission in 63 patients of choriocarcinoma treated with methotrexate and vinkaleucoblastine. Ross *et al* (1965) reported complete remission in 74 per cent of 50 cases. Brewer *et al* (1971) achieved 87% remission in 72 patients with methotrexate and actinomycin-D.

Thus high success rate in patients with choriocarcinoma with preservation of reproductive function has prompted workers all over the world to utilize chemotherapy as the primary mode of therapy and as a result subsequent pregnancies and deliveries have been reported by many authors (Freedman *et al*, 1963; Hertz *et al*, 1961; Manahan *et al*, 1965; Spellacy *et al*, 1965; Bagshawe *et al*, 1969; Vanthiel *et al*, 1970; Savitri, 1972; Jones and Lewis, 1974).

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CASE REPORT

Mrs. M.P., 32 years old primigravida was admitted in August 1977 with 5 months amenorrhoea and vaginal bleeding. Vesicular mole was diagnosed and abdominal hysterotomy done. Patient was followed up at Tata Memorial Hospital, Bombay, by urinary and ß HCG, X-ray chest, dilatation and curettage and routine investigations.

The ß HCG levels were low until October 1979 when they began to rise again. At this time patient was asymptomatic with no clinical evidence of disease. Dilatation and curettage and X-Ray chest showed no evidence of disease. In view of rise in ß HCG titre prophylactic chemotherapy with methotrexate 25 mg I.M. twice weekly regime was started in February 1980 and stopped in July 1980. During this time the patient had vague symptoms in the form of nausea, loss of appetite, pain in the left maxillary area, stomatitis, pain in abdomen and scanty periods. The titres were normal by April 1980, but showed a rise again in September 1980. There was no clinical evidence of disease for 3 months. In January 1981 the patient complained of irregular menses with loss of appetite. Clinical examination revealed the uterus to be bulky with right ovary being palpable. X-Ray chest showed pulmonary metastases. The dilatation and curettage report was normal. The pulmonary metastases increased over a period of 15 days.

The patient was given 6 doses of Inj. Actinomycin-D 10/ug/kg I.M. day 1 to 5 followed by Inj. Methotrexate 500 mg/m^2 body surface I.V. drip for 24 hours with Citrovorum factor 2 doses. First dose was given in April and thereafter repeated monthly. Patient was given 1

dose of leucoverin 30 mg/m² body surface I.V. infusion over 6 hours on 4th day of Actinomycin-D treatment. Patient was followed up with urinary and ß HCG, X-Ray chest, dilatation and curettage and routine investigations. With the first dose patient had severe adverse effects in the form of extensive stomatitis and glossitis with oral ulcers, desquamation and pigmentation over both wrists, fever, erythematous patches, painful swallowing and thrombophlebitis over right wrist. Patient improved over a period of 20 days, with regression of adverse effects and partial resolution of pulmonary metastases. With the next five doses, the patient had fewer adverse effects.

In July 1981, patient was completely asymptomatic with complete regression of secondaries. There was no clinical or radiological evidence of disease. Chemotherapy was stopped in October 1981 and thereafter patient was regularly followed up with ß HCG X-Ray chest and clinical examination for 2 years. Patient resumed her regular menstrual cycle in December 1981. Patient was advised contraception till April 1983.

Patient conceived in June 1983 and registered in the antenatal OPD at 12 weeks amenorrhoea. Antenatal period was uneventful with spontaneous vaginal delivery at term of a female baby weighing 3.2 kg with no intrapartum or postpartum complications. Patient delivered with us for the second time in October 1985. She had a spontaneous vaginal delivery, male child weighing 2.85 kg. The antenatal, intranatal and postnatal period was uneventful.

There was no recurrence or reactivation of choriocarcinoma after pregnancy or delivery after complete remission with chemotherapy at both times. There were no complications of pregnancy and labour; no abnormalities and complications in the baby.

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