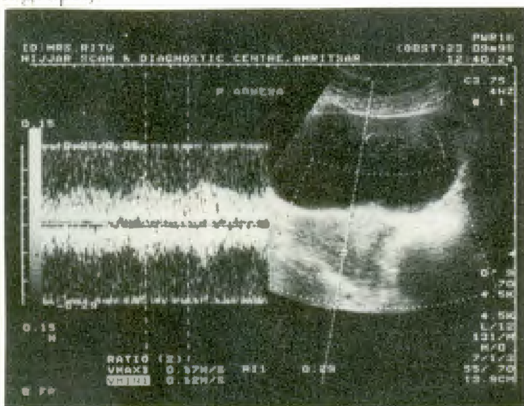
Primary Choriocarcinoma Ovary Simulating Ectopic Tubal rupture – A Rare Presentation

Madhu Nagpal, Davinder Pal

Department of Obstetrics and Gyanecology, Govt. Medical College, Amritsar, Punjab

Mrs. R.S., 25 years old patient married for the last six months with previous regular menstrual history missed her periods in July, 1998. Her LMP was 22.6.98. Pregnancy test was strongly positive on 24.7.98. She started bleeding P/V on 2.8.98. Ultrasound three days later revealed empty uterine cavity with normal adnexa. Duoluton-L was given by the private practitioner which could control bleeding but there was no withdrawal bleeding on stoppage of drug. Repeat pregnancy test was again strongly positive.

Patient reported on us on 23.9.98 along with ultrasound report done 6 days earlier revealing right tubo-ovarian mass of 4.9cm x 4.3cm with minimal fluid in cul-de-sac. Review ultrasound on the day of admission showed uterus without gestational sac, but with central cavity accentuation and right adnexal mass of 6.2 x 5 cms lying adjacent to ovary with small hypoechoic structure in it along with small amount of fluid in the pelvis. Colour Doppler imaging velocity (R.I. = 0.29) diagnosed the condition as ruptured ectopic gestation (Photograph).



Photograph showing colour doppler imaging velocity of right adnexal mass

On laparotomy a 6 x 5cm well circumscribed right ovarian mass of variable consistency and suspicious look with lacerated haemorrhagic surface was found actively bleeding. Omentum and gut was involved in adhesions. Right tube and left adnexa were normal. Uterus was soft, multiparous size. Right sided salpingo oophrectomy along with partial omentectomy was done. Patient passed decidual cast per vaginum 48 hours after operation which was confirmed on HPE. Serum beta HCG level postoperatively was 11139 mIU/ml and fell down to 183 mIU/ml 12 days later. All other investigations inclusing X-ray chest, CT chest, CECT abdomen were normal.

Postoperative period was uneventful. HPE report revealed actively proliferating trophoblastic tissue consisting of cytotrophoblasts and syncitiotrophoblasts without chorionic villi along with haemorrhage and necrosis in the ovarian tissue. So diagnosis of primary choriocarcinoma ovary was made. However, omental biopsy did not show any tumour tissue and only haemorrhage and inflammation was seen.

Patient had full course of chemotherapy (multi drug regime) at Rajiv Gandhi cancer Institute, New Delhi after investigations. Her HCG levels were followed up properly and are now consistently below 1 mIU/ml.

The present case is being reported because of unique presentation of primary choriocarcinoma ovary simulating ruptured ectopic pregnancy requiring emergency laparotomy which revealed the true diagnosis. Though the prognosis is good with multidrug chemotherapy, yet her obstetrical performance remains to be assessed with time.

Photograph showing colour Doppler imaging velocity of right adnexal mass