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Successful, Management of a Rare Case of Placental Site Trophoblast Tumor Following Partial Hydatidiform Mole

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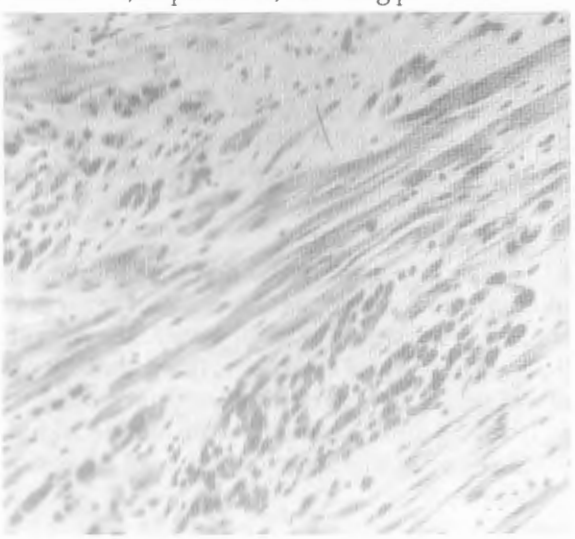
Smt. S. B., aged 28 years, para 3 (normal full term home deliveries), last child aged 3 years, was admitted to Gynaecology ward on 17-4-2000 with a history of 3 months amenorrhoea followed by persistent vaginal bleeding. She had undergone dilatation and curettage; blood clots and products of conception were removed on 2-4-2000 at her native place. She was diagnosed to have vesicular mole. She attained menarche at the age of 12 years and her menstrual periods had seen regular. Since vaginal bleeding continued, 2 units of compatible blood were transfused and patient was referred to JLN Hospital & Research Centre. On examination, she was average built, anemic, with blood pressure of 110/80 mm of Hg. Cardiovascular system, respiratory system, abdomen and thyroid clinical examination revealed no abnormality. Per speculum examination: cervix and vagina were normal. Profuse bleeding was noted from within the cavity. Per vaginal examination: uterus was soft, enlarged 8-10 weeks size; os patulous; bleeding pv noted.



Placental site trophoblast tumour

Investigations : Hb 8gm/dL, pcv 28%, total leukocyte count 10,800/c.m.m. (neutrophils 75%, lymphocytes 25%); bleeding time, clotting time, prothrombin time: normal values. Sickling of RBC: negative. Hepatic, renal, thyroid function test results and blood biochemistry were normal. Blood group "O" Rh+ve. Electrocardiogram and x ray chest : normal. Serum beta human chorionic gonadotrophin (βhCG): 2958 mIU/ml (normal 5-20mIU/ml). Ultrasonography of abdomen revealed enlarged uterus 190.0x53.7 mm; an echogenic area near uterine fundus noted; interpreted as retained products of conception or piece of vesicular mole; adenexa normal. No hepatosplenomegaly. Patient was transfused with 2 units of fresh blood. Dilatation and curettage and packing of uterine cavity with roller gauze was done on 20-4-2000. Bleeding per vaginum was continuous, profuse and the patient became hypotensive, tachypneic, and showed signs of early cardiac failure. Her hemoglobin was 3 gm/dL. She was given broad spectrum antibiotics, diuretics, and 2 units of packed blood cells. On 21.4.2000 under general anaesthesia, laporotomy was done. Uterus was 12 weeks sized, very vascular. Both tubes and ovaries were normal. Total hysterectomy with conservation of ovaries was done. Uterus cut section showed cavity full of blood, and a cauliflower like growth (7.5x5cm) arising from fundus and posterior wall projecting into the endometrial cavity. She received one unit of blood during and two more units immediately after the operation. Post operative period was uneventful. Histopathology of the uterine growth revealed intermediate trophoblasts arranged in sheets on the surface with occasional multinucleated syncitial trophoblasts and prominent intact venous sinuses and capillaries within the tumor mass. There was neither vessal wall infiltration nor tumor cell intravascular proliferation. Myometrium did not reveal necrosis or hemorrhagic areas. Impression: placental site trophoblastic tumor (Microphotograph). On

12th hospital day, serum βhCG was 26.4 mIU/ml. Patient was well on follow-up after 3 month and βhCG was < 5mIU/ml. When last seen in December 2000, she was free from disease.

Placental site trophoblast tumor (PSTT) commonly follows term pregnancy but also may follow antecedent molar pregnancies, ectopic pregnancy and spontaneous abortion. PSTT mainly consists of intermediate trophoblasts and produces βhCG. Between 10-15% of the patients with PSTT have a malignant outcome, with an overall mortality rate upto 10%. Hysterectomy provides complete cure, and has an added advantage of proper assessment of extent of local involvement and malignant transformation.

This case is reported, because PSTT has rarely been reported from India, presented with persistent vaginal bleeding leading to severe anemia and cardiac failure after a molar pregnancy, and patient was completely cured by hysterectomy.

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