Successful Reproductive Outcome Following Treatment of Metastatic Choriocarcinoma

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Mrs R, a 22 year year old lady with history of two previous first-trimester fetal losses, arrived in the emergency room with history of 2-months amenorrhoea and profuse vaginal bleeding. Her first pregnancy was a spontaneous abortion at 8 weeks followed by check curettage. Her second pregnancy was a 10 weeks vesicular mole evacuated in a District Hospital 8 months ago. She had not used any contraceptive method after that and was not on β-HCG follow-up. She gave history of regular menstrual cycles with irregular spotting on & off for the last 6 months. She now complained of vomiting & vaginal bleeding with 2-months amenorrhoea.

She was pale with a pulse of 120/min, BP 100/60 mmHg, abdomen was soft and pervaginal examination identified a bulky 6 weeks uterus with bilateral palpable ovaries. The internal os was closed and no products of conception were obtained from the vagina or external os. The provisional diagnosis was incomplete abortion and an emergency D&C was done. Her haemoglobin was 6 gm% for which she was transfused 2 units of blood. Two days later, the patient again complained of severe vaginal bleeding. At that time, a per speculum examination revealed a 2 cm wide, purplish-red, haemorrhagic mass in the middle one-third of the left-lateral vaginal wall. The mass had a central bleeding artery. A figure-of-8 haemostatic suture was taken at the site of the bleeder with catgut. The histopathology report of the D&C done 2 days ago confirmed the diagnosis of choriocarcinoma. A complete baseline blood count, haemoglobin, platelet count, renal and liver function profile were done, which were normal. X-Ray chest & USG abdomen were normal. Pelvic sonography revealed a normal-sized uterus with normal endometrial echo with bilateral theca-lutein cysts. Serum -β-HCG was 16.3 lacs μ/ml. CT abdomen and brain was normal.

The patient was designated as Stage II gestational trophoblastic tumour in view of vaginal metastasis. Her risk score was 8 by Bagshawe's Prognostic Score of 1976 (previous pregnancy to initiation of treatment interval being 8 months-2 points, Initial β-HCG 16.3 lacs i.e. more than 1 lac μ/ml-3 points, one vaginal metastatic nodule-1 point, the nodule being 2 cm gives 2 points). She was thus classified as a high-risk gestational trophoblastic tumour and combination chemotheraphy-MAC was instituted. (Methotrexate 15mg IV daily for 5 days, actinomycin 0.5 mg IV daily for 5 days and tablet chlorambucil 10 mg daily orally for 5 days). This schedule was repeated every 3 weeks for 5 such cycles. β-HCG levels were evaluated every 2 weeks and blood analysis for complete blood count, platletes, liver and renal function tests were done prior to each course of chemotherapy. By the end of the third chemotherapy cycle, the β-HCG values had dropped drastically to 18 μ/ml from 16.3 lacs μ/ml. After that, two more chemotherapy cycles were given. The follow-up β-HCG continued to remain zero. At each follow-up visit, history of amenorrhoea, irregular vaginal bleeding, cough and haemoptysis were evaluated, a pelvic examination was done and findings on USG abdomen and pelvis and X-Ray chest were ascertained.

She was advised contraceptive pills for a period of 2 years. β-HCG values done at 3 months intervals continued to remain zero. At the end of 2 years, the patient stopped OC pills and conceived 2 months later. Transvaginal sonography confirmed a single, live, intrauterine pregnancy of 6 weeks with normal chorionic echoes. She came for regular antenatal visits. Anomaly scan at 18 weeks was normal. She had an uneventful antepartum period till 35 wks at which time she was admitted in the antenatal ward for mild PIH with IUGR. BP was well-controlled with tablet aldomet 250mg 4 times daily. Fetal kick count and non-stress test were within normal limits. At 37 weeks, labour was induced by intracervical PGE2 gel. The patient went into labour 8 hours later and had an uneventful intrapartum course. She delivered a 2.24 kg baby boy with a 9/10 Apgar score. Gross and microscopy of placenta was normal. D&C was done one week after delivery, the histopathology of which revealed decidua with inflammatory cells. β-HCG done 6 weeks and 3 months postpartum was zero. She has been advised barrier contraception for 3 years.