

Choriocarcinoma with Low β -HCG – A Rare Case

Radhika A.G. Neelam B. Vaid, Seema Sinha

Department of Obstetrics & Gynaecology, University College of Medical Sciences & GTB Hospital, Delhi – 110095, India

Choriocarcinoma is usually associated with high levels of β HCG and it is considered a very sensitive marker for trophoblastic activity. Its serial assay forms an important part of the protocol for the management and the follow-up of trophoblastic tumors. Yet, there may be certain trophoblastic tumors not associated with raised levels of β HCG, as is the case presented here.

Case Summary: 45 yrs old, para 4, a resident of Delhi, presented in the Gynaec OPD on 10/9/1997 with the chief complaints of breathlessness, anorexia, haemoptysis and irregular spotting of one month duration. There was no history of any other associated medical illness. Her last childbirth was 22 years ago and was not using any method of contraception. She gave history of amenorrhoea of about a month and a half, followed by the passage of clots and doubtful products of conception, a year back. She had probably undergone spontaneous abortion though the pregnancy was not confirmed. Her previous menstrual cycles were normal.

On examination, pallor was present, pulse – 120/min, regular, BP – 135/70 mm Hg, thyroid was enlarged though she was clinically euthyroid and there was no lymphadenopathy. The cardiovascular and respiratory systems were normal. Abdominal examination revealed a firm, non-tender mass arising from the pelvis corresponding to 14 wks gravid uterus with restricted side to side mobility. On speculum examination, cervix and vagina were healthy. On vaginal examination, uterus was 8-10 weeks in size with a firm non-tender mass in the right adnexa close to the uterus and 4 x 4 cms in size.



Figure 1: Xray Lung Showing Multiple Cannon Ball Opacities

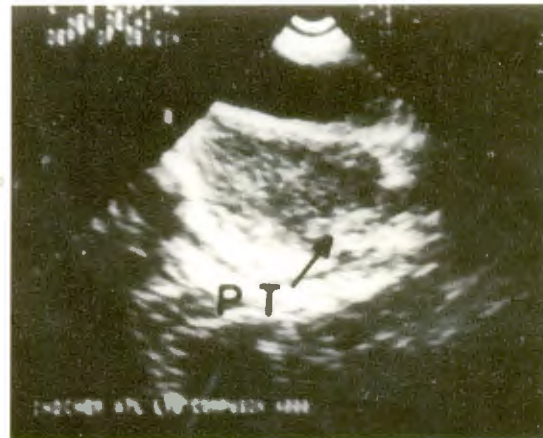


Figure 2: USG Scan Showing the uterine cavity (transverse section) filled with the tumor which is also perforating the uterine wall. PT - Perforating Tumor.

Investigations - Hb - 6.5 gm%, urine pregnancy test-negative, X-ray chest-multiple cannon ball opacities in all zones (Fig 1), USG - uterus measured 10 x 5 cms, the uterine cavity was filled with a mass of mixed echogenic nature and a right adenexal mass 7 x 6 x 5 cms, with mixed echogenic pattern, both the ovaries were normal (Fig-2). Serum β -HCG 16 miu/ml and no rise in the titre was seen in dilutions. Dilatations and curettage-endometrial curettings showed trophoblastic proliferation with cytotrophoblasts, intermediate trophoblasts and syncytiotrophoblasts. The remaining tissue was largely necrotic. There were no chorionic villi seen. Thyroid function test-normal, CT brain-normal, USG Liver-normal.

Based on these clinical and laboratory findings along with D & C report, the diagnosis of choriocarcinoma was made and the patient was put on MAC regime. After 6 courses of chemotherapy, only 70% reduction in the adenexal mass was achieved with no change in the lung

opacities and serum β HCG remained between 16-72 miu/ml. Hence, the patient was taken up for hysterectomy (secondary) along with a change in the chemotherapy regime to BEP of which one course was given pre-operatively and three further courses given post-operatively. The panhysterectomy specimen showed a well-circumscribed nodule 4 x 3cms at the fundus, extending into the myometrium and the rest of uterus was unremarkable. Multiple sections of the nodule showed extensive necrosis, hemorrhage and hyalinization. The necrotic material was walled off with a thick fibrous wall and extensive inflammation composed of lymphocytes and foaming histiocytes. Both the ovaries and fallopian tubes were unremarkable. On completion of the three courses of chemotherapy after hysterectomy, there was marked clearance of the lung opacities in the x-ray and β HCG became negative but unfortunately the patient had severe intractable sepsis following bone marrow suppression and could not be saved.