



An unusual presentation of choriocarcinoma mimicking ruptured ectopic pregnancy with fulminant progression

Anuradha De, Amitava Sinha, Subrata Lal Seal, Ajit Ranjan Bhattacharya, Sumit Ranjan Pramanik

Department of Obstetrics and Gynecology, RG Kar Medical College, Kolkata

Key words: choriocarcinoma, metastasis, fulminant progression

A 27 year old para 2 was admitted on 18th June, 2003 complaining of acute pain in the lower abdomen with vaginal bleeding and nausea. There was no history of amenorrhea or of recent intervention like uterine evacuation or curettage. She was para 2+0 with a history of miscarriage at home in 7th month of pregnancy nine months back which was followed by menorrhagia for the last 2-3 cycles.

Her pulse was 100/minute and regular. Blood pressure was 90/70mmHg. She was very pale. The abdomen was tense and tender. No abnormality was detected on systemic examination. Her hemoglobin was 6g/dL. Platelet count, blood urea and serum creatinine were within normal limits. Urine was positive for pregnancy test.

Provisional diagnosis of ruptured ectopic pregnancy was made and exploratory laparotomy performed on 18th June, 2003. There was hemoperitoneum and two uterine perforation sites were detected - one at the left side of the isthmic region and another at the left fundal region. Both tubes were healthy and both ovaries were cystic. Uterine repair could not be done due to excessive bleeding and friability of the tissue at the perforation sites. Bilateral internal iliac artery ligation was performed but it could not stop the bleeding and the laparotomy ended in a total abdominal hysterectomy. Four units of whole blood were transfused and subsequently another three units were given. Invasive mole was suspected and serum β hCG level estimation was asked for. But she refused to undergo the test and went home against medical advice on 25th June, 2003 after an uneventful recovery.

Pathological examination of the hysterectomy specimen revealed that the uterus was bulky and its left lateral side was covered with hemorrhage and necrotic material. There was a perforation on the left side of the fundus measuring 3 cm, a hemorrhagic nodular area in the myometrium and another perforation of 2 cm size near the left upper part of the cervix. But the endometrial cavity was intact (Figure 1).

Microscopic examination of the perforation sites showed syncytiotrophoblastic and cytotrophoblastic elements invading the myometrium with large area of hemorrhage and necrosis. Chorionic villi were absent (Figure 2).

Unfortunately the patient did not come for postoperative follow up as advised. But on 6th August, 2003 she came to the outpatient service with a complaint of excessive bleeding since last two days.

She was very pale and her abdomen was soft.

A friable growth was noted below the vault in the anterior vaginal wall, which was bleeding profusely.

Investigations showed that hemoglobin was 5 g/dL. Platelet count and liver function tests were within normal limits. Serum β hCG level was 5,73,980 mIU/mL.

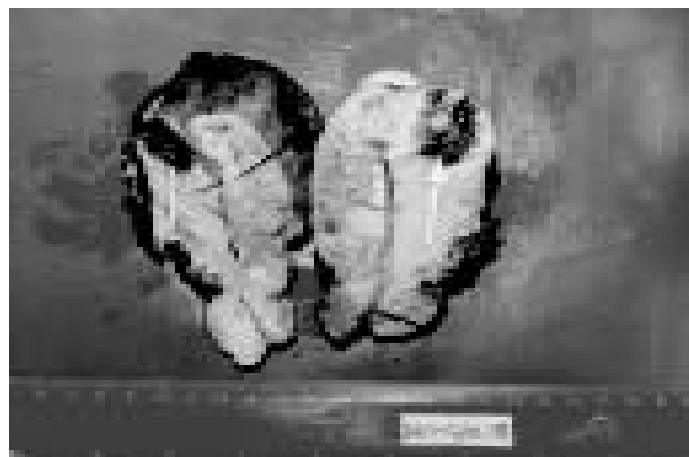


Figure 1. Cut surface of uterus showing hemorrhagic nodule in the myometrium and at isthmic region

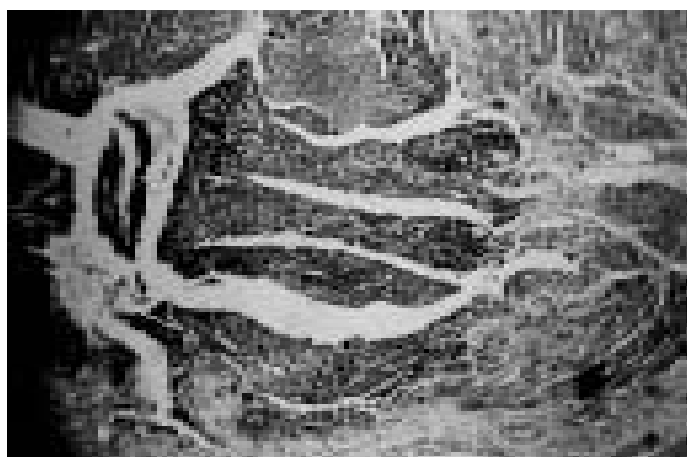


Figure 2. Microphotograph showing sheets of syncytio- and cytotrophoblast infiltrating myometrium with areas of hemorrhage and necrosis.

X ray chest PA view showed multiple rounded opacities in both the lung fields suggestive of metastatic deposits (Figure 3).

Sonography of pelvic organs showed growth in the pelvis suggestive of theca leutin cyst.

She received five units of whole blood transfusion and chemotherapy was started with methotrexate, actinomycin D and etoposide on 16th August, 2003.

But she developed hemoptysis on 18th August, 2003 and suddenly became unconsciousness after falling down by the side of her bed while trying to get off the bed.

On 19th August, 2003 her pulse was irregularly irregular. There was no external injury. She was referred to neuromedicine department and was provisionally diagnosed as - (1) cerebral metastasis (2) subdural hematoma

with mass effect, and (3) chemotherapy induced problem. CT scan of the brain was done and showed intracerebral hemorrhage in right middle cerebral artery territory with mass effect (Figure 4).

The next day she regained consciousness but was disoriented and confused. Her pulse rate fell to 58/minute, pupils became dilated reacting sluggishly to light and planters were extensor. Despite all resuscitation measures she expired on 20th August, 2003. Postmortem could not be performed due to refusal by the relatives.

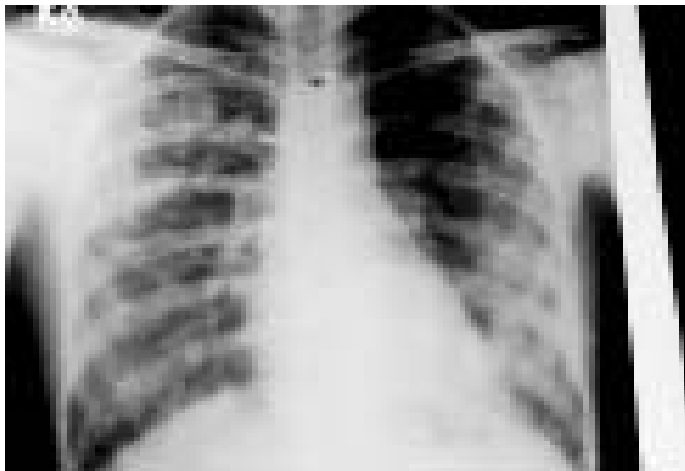


Figure 3. Xray chest showing metastatic deposits.



Figure 4. CT scan showing intracerebral hemorrhage with mass effect.

* * * * *

Silent fundal rupture due to placenta percreta in a women with previous lower segment scar

Gupta Vineeta, Kukreti Manishi, Goel Geetika, Harsh Meena

Himalayan Institute of Medical Sciences, Swami Rama Nagar, Dehradun-248140.

Key words : placenta percreta, rupture uterus, previous cesarean section

Discussion

Choriocarcinoma is an extremely malignant form of trophoblastic tumor. The characteristic gross picture is that of a rapidly growing mass invading the uterine muscles and blood vessels, and causing hemorrhage and necrosis. Ovarian theca leutin cysts are identified in over a third of the cases ¹. They were observed in our patient.

The natural history of untreated choriocarcinoma is characterized by development of early hematogenous metastases the common sites being lungs, brain, liver, kidney and bowel. Risk factors affecting the disease are serum βhCG > 100,000 miu/mL and duration of disease > 6 months from termination of antecedent pregnancy ².

In the present case the patient did not receive chemotherapy immediately after surgery and she developed early metastasis in the lungs and brain within a short period of time, with a high serum βhCG level (5,73,980 miu/mL).

A long interval between the antecedent pregnancy and the onset of chemotherapy is an adverse prognostic factor and may result in failed chemotherapy ³.

FIGO revised the staging of gestational trophoblastic diseases in 2000. The total score of a patient is obtained by adding individual scores for each prognostic factor like age, antecedent pregnancy, interval from index pregnancy, pretreatment βhCG level, tumor size, site and number of metastases, and previous failed chemotherapy. A total score of 0-6 is considered low risk and > 7 as high risk ⁴. Our patient was definitely in the high risk group with a score > 7.

References

1. Cunningsham G, Gant NF, Leveno K et al (eds). Williams Obstetrics. 21st edn. New York, McGraw-Hill Medical Publishing Division. 2001: 843-4.
2. Rosai J (ed). Ackerman's Surgical Pathology. 8th edn. St. Louis. Mosby. 1997:1553.
3. Grudzinkas JG. Miscarriage, ectopic pregnancy and trophoblastic disease. In: Dewhurst's Text Book of Obstetrics and Gynecology for Postgraduates. 6th edn. Blackwell Scientific. 1999:73.
4. Soper JT. Staging and evaluation of gestational trophoblastic disease. Clinical Obstet Gynecol 2003;46:570-8.

Paper received on 08/10/2004 ; accepted on 25/07/2005

Correspondence :

Dr. Ajit Ranjan Bhattacharya
204/1/8 Raja Rammohan Roy Road,
P. O. Barisha
Kolkata - 700008.

Introduction

Silent rupture of uterine fundus during pregnancy is a rare event.

Case report

A 24 year old 3rd gravida was admitted with complaints of loss of fetal movement since 3 days following amenorrhea of 9 months. There was no history of labor pains or leaking per vaginam. She was G₃P₂L₁ with a previous LSCS done 2 years back for cephalopelvic disproportion and one preterm vaginal delivery followed by a doubtful history of manual removal of placenta