Case Report

**Gestational choriocarcinoma of uterus with vaginal metastasis**

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Abstract

Choriocarcinoma is a highly malignant tumour that arise from trophoblastic tissue. It metastasize rapidly to vital organs including lungs and brain. It shows very good response to appropriately chosen chemotherapeutic regimen. A case of gestational choriocarcinoma with vaginal metastasis is reported. She responded very well to EMACO regime. Considering poor compliance for long term follow up, hysterectomy was done after 3 cycles of chemotherapy. She was disease free during three years of follow up.

Keywords: Choriocarcinoma, EMACO regime, Vaginal metastasis

1. Introduction

Choriocarcinoma is a highly malignant tumor of chorionic epithelium. Approximately half of the cases follow a hydatidiform mole, 25 percent follow an abortion, and 25 percent develop after an apparently normal pregnancy.1A rapidly growing mass invading both myometrium and blood vessels causing hemorrhage and necrosis is the most characteristic gross finding of choriocarcinoma. Most common sites of metastasis are lungs, vagina, vulva, kidneys, and brain. Although it is an aggressivemalignancy, it responds very well to appropriately chosen chemotherapy regimen.2,3

2. Case Report

Twenty seven year old multipara with past history of vesicular mole evacuation, presented with the chief complaints of per vaginal bleeding since 4 days before admission. She had intermittent per vaginal bleeding since 8 months, lower abdominal pain and generalized weakness since 2months, nausea and vomiting since 15 days, swelling over vulval region since 15 days and cough since 3 days. She was second para with previous two normal uneventful vaginal home deliveries. She was not using any contraceptives. She was a young woman, thin built, a febrile with a pulse rate of 110/min, BP- 130/70 mm Hg and RR- 20/min. Her abdomen was soft, but minimum tenderness was noted in the lower abdomen. There was no guarding or rigidity. Uterus was just palpable in suprapubicregion. Vulval and per speculum examination showed a round fleshy elliptical growth of 4X4 cm (soft to firm)over right side of introitus extending to posterior vaginal
wall. [Figure 1-A] Growth was pale pink in color with smooth surface with central ulcerated area containing dark black necrotic material. There was no bleeding or discharge from the growth. Growth was not fixed to the underlying perineal muscles. Per vaginal examination showed 12wks size firm uterus with restricted mobility. There was no palpable adnexal pathology. Her Hemoglobin was 7gm%, Serum βhCG value was 3890 mIU/ml, Ultrasound of abdomen and pelvis showed 7.2X7.1cm heterogeneous lesion with multiple anechoic channels within the uterus suggestive of partial (Incomplete) mole. [Figure 2-A] Uterus measured 11X8.2X5.8 cm. X ray Chest was suggestive of lymphangitis carcinomatosa. X ray Spine was normal. Computerized Tomography of the brain was normal. Uterine curettage revealed necrotic material. As patient started bleeding profusely during diagnostic curettage, the procedure was abandoned. She was transfused with two pints of blood. Biopsy from the introital growth showed metastatic deposit of choriocarcinoma [Figure 2–B].

She was diagnosed as a case of choriocarcinoma of uterus (FIGO anatomic stage III) with vaginal metastasis. On further evaluation, she was categorized in high risk group as per modified WHO criteria (prognostic score of 8). She was treated with three cycles of EMACO regimen. Serial β-hcg titres showed steep decline. Vaginal growth completely disappeared after three cycles [Figure 1-B]. Although βhCG titres showed rapid decline, after every chemotherapy cycle, there was no reduction in the size of the uterine growth. As she was not able to afford the cost of the further chemotherapy, total abdominal hysterectomy with bilateral salpingo-ophorectomy was performed after 4 chemotherapy cycles with EMACO regimen. Intra-op findings revealed 12wks size of uterus. Both ovaries were normal. There was no obvious growth on the surface of the uterus. Cut section of the uterus revealed 5-6cm friable growth on the postero-lateral wall of uterus. Histopathology of the uterine specimen confirmed the diagnosis of gestational choriocarcinoma. She was advised for regular follow up. She was disease free for 3 years after the treatment and subsequently was lost to follow up after 3 years.

**Figure 1--Growth at introitus before (A) and after (B) chemotherapy.**

![Figure 1](image1.png)

**Fig. 2- Ultrasound image of uterine growth (A) and Histopathology of vaginal growth (B)**

![Figure 2](image2.png)
3. Discussion

The incidence of vaginal metastasis in choriocarcinoma is 8.6 percent. The metastatic tumors are mostly located in the anterior wall of the lower part of vagina. Majority of patients present with haemorrhage and rupture. The cure rate, even for metastatic gestational choriocarcinoma, is around 90-95%. At present, treatment with single-agent methotrexate is recommended for low-risk disease, while intense combination regimens including EMACO (etoposide, methotrexate, actinomycin D, cyclophosphamide and vincristine (Oncovin) are recommended for intermediate or high-risk disease. Hysterectomy (surgical removal of the uterus) can also be offered to patients > 40 years of age or those for whom sterilisation is not an obstacle. It may be required for those with severe infection and uncontrolled bleeding. Patients are treated with 5-Fu combined chemotherapy. Vaginal packing may be employed to stop bleeding. Selective angiographic embolization can also be tried. Vaginal metastatic lesions usually disappear after chemotherapy. Proper staging of the disease and selection of chemotherapeutic regimen are essential for attaining best results. Good compliance from patient and her relatives is extremely important especially in rural areas following molar evacuation. Patient and relatives must be counselled adequately by treating physician regarding importance of complete treatment and regular follow up in trophoblastic diseases. High cost of the treatment in high risk patients, longer duration of follow up, need for avoidance of pregnancy during treatment result into poor compliance and sub optimum outcome.

References