Gestational Choriocarcinoma in Recurrent Spontaneous Abortions: A Case Study

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Abstract:
Gestational choriocarcinoma may occur subsequent to a molar pregnancy (50% of instances), an abortion (25%), an ectopic pregnancy (2.5%), or a normal gestation (22.5%). We present a case of 37 year old woman who has unusual pregnancy related history. The patient had one normal pregnancy at age of 26 year after that she had recurrent loss of pregnancies. The last abortion was occurred 6 months back. The patient was come to gynecology department of RIMS Ranchi, with the complaint of vaginal bleeding. Then patient was admitted and advised for pelvic ultrasonography. Pelvic ultrasound revealed 68x62 mm mass located in the anterior fundal wall of corpus uteri. Marked elevation in the level of beta hCG level (301921mIU/mL). Her hemoglobin was 8gm/dl and other biochemical parameters were within normal limit. After preoperative investigation, the patient was undergone total hysterectomy with bilateral salpingoopherectomy. The specimen was received in histopathology section of Department of Pathology, RIMS Ranchi. On microscopic examination we diagnosed Gestational Choriocarcinoma.

Keywords: Gestational choriocarcinoma, recurrent Abortions.

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I. Introduction:
Gestational choriocarcinoma may occur subsequent to a molar pregnancy (50% of instances), an abortion (25%), an ectopic pregnancy (2.5%), or a normal gestation (22.5%) [1].Choriocarcinoma is an aggressive malignant tumor comprised of sheets of anaplastic cytotrophoblast syncytiotrophoblast cells, arising in 1 in 20,000 25,000 pregnancies in Western countries [2]. Vaginal bleeding is the most common symptom of choriocarcinoma. [3]. In cases of choriocarcinoma following abortion—whether molar or not—the latent period is almost always less than 1 year, although it can be considerably longer (“latent choriocarcinoma”) [4]. At the time of the diagnosis of the malignancy, the average age of the patient is 29 years. Grossly, choriocarcinoma characteristically forms soft, dark red, hemorrhagic, round nodular tumor masses. Microscopically, the tumor is composed of clusters of cytotrophoblast separated by streaming masses of syncytiotrophoblast, resulting in a characteristic dimorphic plexiform pattern [5]. Here we present a case of 37 year old woman having history of recurrent abortions diagnosed as gestational choriocarcinoma in biopsy.

II. Case Report
A case of 37 year old woman who has unusual pregnancy related history. The patient had one normal pregnancy at age of 26 year after that she had recurrent loss of pregnancies. The last abortion was occurred 6months back. The patient was come to gynecology department of RIMS Ranchi, with the complaint of vaginal bleeding. Then patient was admitted and advised for pelvic Ultrasonography. Pelvic ultrasound revealed uterus is anteverted and measures 98mm in length. Endometrial thickness is 4 mm. 68x62 mm mass located in the anterior fundal wall of corpus uteri. Marked elevation in the level of beta hCG level (301921mIU/mL). Her hemoglobin was 8gm/dl and other biochemical parameters were within normal limit. After preoperative investigation, the patient was undergone total hysterectomy with bilateral salpingoopherectomy. The specimen was received to histopathology section of Department of Pathology, RIMS Ranchi. The endometrial specimens were received in 10% formalin solution. The received tissue specimen of uterus, cervix and bilateral adnexa. Uterus and cervix measure 10x8x7 cms. Endo - myometrial junction is not defined. A mass measuring 7x6 cms is occupied uterine cavity. Grossly mass appears black brown in color and soft in consistency with area of hemorrhages. The tissues were processed, sectioned and stained with hematoxylin and eosin. The slides were studied under light microscopy. On microscopic examination, the sections from tumor show malignant

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trophoblast cells consisting of cytotrophoblast rimmed with syncytiotrophoblast with absence of chorionic villi. There is marked area of hemorrhages and necrosis. We diagnosed this case as a Gestational Choriocarcinoma.

Figure 1: Gross appearance of choriocarcinoma, showing mass in the endometrium with marked area of hemorrhages.

Figure 2: H&EX 40: Choriocarcinoma, showing admixture of syncytiotrophoblast and cytotrophoblast
Gestational Choriocarcinoma

in
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III. Discussion:

In younger women, the incidence of gestational trophoblast neoplasia is typically 5% following trophoblast disease [6]. Choriocarcinoma is generally observed in woman of a reproductive age within a year of an antecedent pregnancy, but can also be observed in postmenopausal woman in rare cases, following a long latent period from previous pregnancies. Desai et al. reported a choriocarcinoma case in a 73-year-old woman developing 38 years after pregnancy and 23 years after her final menstrual period [3].

The study done by Bariki L. Mchome et al, they describe a patient who previously had history of choriocarcinoma and was treated with six courses of combination chemotherapy and was not followed up consistently and 14 months later conceived and delivered a live 1.3 kg female baby at 31 weeks of gestation. Two weeks post-delivery she was diagnosed with ruptured uterus. Long term complication following choriocarcinoma is a rare event.

Moreover, coexistence of choriocarcinoma with normal pregnancy and a subsequent ruptured uterus two week after delivery constitutes an atypical presentation.

The study done by Vo Minh Tuan et.al, they concluded that Choriocarcinoma on live pregnancy is a rare disease. Diagnosis is often difficult if genetic and histopathologic testing is not available. Therefore, facing a case with abnormal bleeding during pregnancy, careful monitoring and assessment must be made. The most frequent symptom in uterine choriocarcinoma is abnormal vaginal bleeding. High B-HCG levels and immunohistochemical tests for B-HCG may also be indicative of choriocarcinoma. An early and correct diagnosis of choriocarcinoma is important because it is a chemosensitive tumor with a good prognosis even in advanced stages [9].

An accurate, early diagnosis and treatment are important because the choriocarcinoma is considered the most curable gynecological cancer. Chemotherapy may occasionally cause fatalities due to treatment-related complications.

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