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CLINICALLY DIAGNOSED CASE OF SUBMUCOSAL FIBROID TURNED AS CHORIOCARCINOMA -A RARE CASE REPORT

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ABSTRACT

Gestational trophoblastic disease is used to describe various group of diseases related to abnormal proliferation of placental trophoblast. Locally invasive and metastatic GTN are about 15 % and 4% respectively after suction and evacuation. Incidence of non gestational choriocarcinoma - <1% A 37year old patient with Para 4 living4 abortions 2, admitted with complaints of heavy menstrual bleeding since 1yr. On GPE -pallor present. Perabdomen- soft, NT. Perspeculum - bleeding present through the os. Bimanual examination- uterus bulky(8wks size). Underwent TAH with left salphingoophorectomy. Gross apperance of cut section - soft in consistency, torturous vessels, bleeds on touch. (? Submucosal fibroid or choriocarcinoma). Specimen sent for HPE. Gestational choriocarcinoma can present with various clinical signs, symptoms at anyage. Always high degree of clinical suspicion is essential for early diagnosis and management.

KEYWORDS: Choriocarcinoma, Histopathology, Metastatsis.

INTRODUCTION

Gestational trophoblastic disease (GTD) is the term used to describe the heterogeneous group of interrelated lesions that arise from abnormal proliferation of placental trophoblasts.[1] It is categorized into hydatidiform mole and gestational trophoblastic neoplasia.

Incidence in INDIA: 1:160

Low socioeconomic condition, decreased intake Of protein and vitamins, early marriage and high fertility rate may play a part in causation.[2]

Choriocarcinoma can be divided into two categories - gestational and non gestational.when choroiocarcinoma present as a component of a germ cell tumor or is associated with somatic mutations in hypofractionated carcinomas, it is non gestational choriocarcinoma.[3]

Gestational choriocarcinoma is a rare variety .Its highly malignant nature is due to early vascular invasion causing widespread Metastatsis.[4]

Gestational and non gestational have different genetic origins and levels of immunogencitiy, their sensitivity to chemotherapy and treatment protocols also differ.[5]

CASEREPORT

A 37year old patient, with para 4 living 4, 2 abortions presented with complaints of heavy menstrual bleeding since 1year at regular intervals, with no passage of clots or dysmenorrhoea with previous cycles being normal and regular.

Past History -operated for torsion of right ovary 1year back.
On GPE : pallor -present. Vitals- stable.
Systemic examination - CVS/CNS / RS – NAD
Per abdomen : soft, non tender
Local examination - vulva appears healthy
Per speculum examination: Vaginal appears healthy, cervix patulous os and bleeding present.
Bimanual examination - uterus 8wks size, Bilateral fornices free and non tender, no cervical motion tenderness.
Usg findings: Uterus measures (12×8.5×5.3)
A well defined, heterogenous lesion measuring 6.1 ×4.4cms with significant peripheral vascularity on color doppler is seen distending endometrial cavity.(s/o submucosal fibroid)
Investigations : Hb - 10.2gm%
Blood group - B positive.
Surgical profile - normal.

MANAGEMENT

The patient diagnosed as submucosal fibroid, underwent total abdominal hysterectomy with left salphingoophorectomy

Intraoperatively : Uterus flabby and bulky in size highly vascular with torturous vessels, with submucosal fibroid (6×4cm).

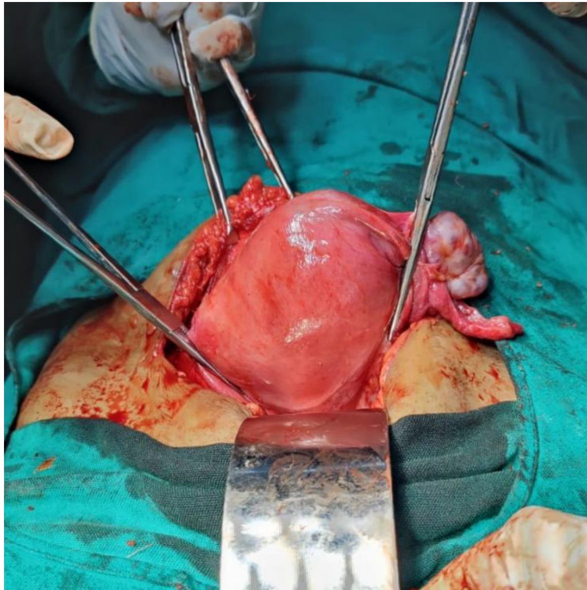

Figure 1: Intraoperative apperance of uterus and adnexa.

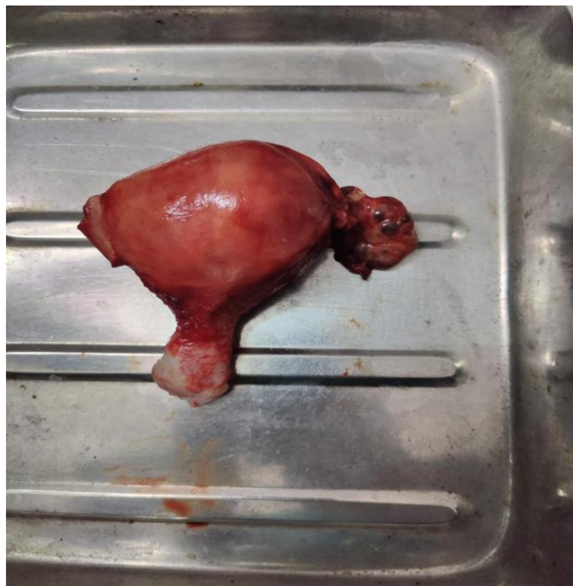

Figure 2: Gross apperance of uterus.

Cut section - soft in consistency, torturous vessels, bleeds on touch (?submucosal fibroid or choriocarcinoma) as depicted in FIGURE 3.

Specimen sent for HPE - reported as choriocarcinoma

Reports were informed to patient, after which they detailed about past History of molar pregnancy, underwent suction and evacuation followed by serial Beta - hcg monitoring with methotrexate therapy.

Further, patient was counselled about beta-hcg monitoring and chemotherapy.

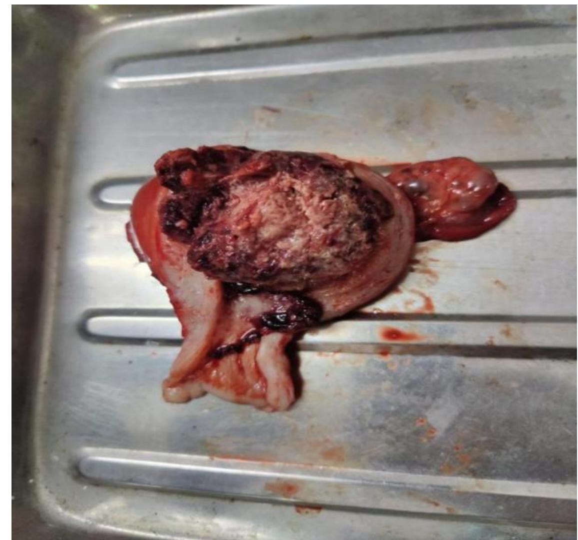

Figure 3: Cut section of submucosal fibroid (6*4CMS).

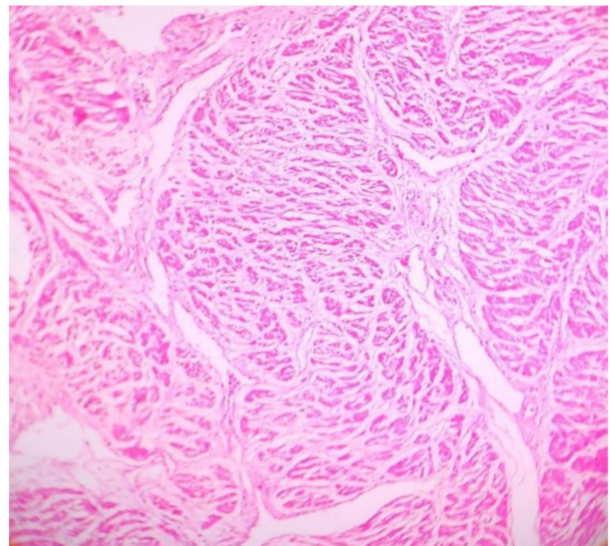

Figure 4: Histopathology of choriocarcinoma.

DISCUSSION

Gestational choriocarcinoma is a highly malignant and aggressive trophoblastic tumor. About 50% of GTN arise from hydatidiform moles, 25% from the term or preterm pregnancies and another 25% from abortions or tubal pregnancies.[6]

Patient had preceding, four normal pregnancies, and two miscarriages. The interval between pregnancies was 2.5 to 3years.

The common gynecological presentations are abnormal vaginal bleeding and pelvic masses.

Gestational trophoblastic neoplasia (GTN) including choriocarcinoma is highly sensitive to chemotherapy.

The treatment is guided by FIGO staging and scoring system.[7]

Low-risk disease (score <7) responds well to single-agent methotrexate or actinomycin-D, cure rate approaches 100%.

Patients with high-risk and ultrahigh risk diseases are given multi-agent EMACO regimen, cure rate approaches 80–90%.

CONCLUSION

The incidence of choriocarcinoma is high in India when compared to western countries.

The disease is common in low socio-economic groups.

History about previous pregnancies to be asked in detail with all women in reproductive age group.

Though we diagnose clinically or by ultrasound, sending the specimen for Histopathology will give us accurate diagnosis.

The important message is that, this condition is extremely uncommon, but when diagnosed is potentially treatable and curable.

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