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CASE REPORT

Atypical Presentation of Choriocarcinoma: A Report of Two Cases

Shraddha K Shetty[1], Rashmi Polnaya[2]

Abstract

Background: Choriocarcinoma is a gestational trophoblastic tumor commonly seen in the reproductive-age group. It is an aggressive tumor with high malignant potential and responds well to chemotherapy. Lungs and vagina are the most common sites for metastasis, and brain involvement is seen in 20–25% of cases. It usually presents within 6 months to 1 year following a molar or normal pregnancy.

Case descriptions: We are presenting two interesting cases of choriocarcinoma who reported with atypical symptoms.

Case 1: A 47-year-old P3L3 reported with abnormal uterine bleeding and cough with expectoration. Suction and evacuation suggested choriocarcinoma, and she was started on EMACO regimen of chemotherapy in view of lung metastasis.

Case 2: A 23-year-old P1L1 presented with irregular vaginal bleeding for 15 days, 2 months following delivery. She developed left-sided hemiparesis, diagnosed as choriocarcinoma with brain metastasis and started on chemotherapy with etoposide, methotrexate, actinomycin D, cyclosphosphamide, and vincristine (oncovin) (EMACO) regimen. Both the cases had a prior history of molar pregnancy but failed to follow-up after the evacuation.

Conclusion: Women with prior history of molar pregnancy need to be counseled to follow-up with serum beta-human chorionic gonadotropin (β-hCG) following evacuation. Choriocarcinoma is an aggressive tumor that can present with atypical symptoms such as abnormal uterine bleeding in postpartum period or perimenopausal age. Early diagnosis and treatment with or without metastasis have excellent prognosis.

Clinical significance: Choriocarcinoma can present with atypical symptoms, especially in postpartum period and perimenopausal age. Clinicians need to have an index of suspicion of choriocarcinoma in treating women with atypical features.

Keywords: Chemotherapy, Choriocarcinoma, Gestational trophoblastic neoplasia.

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Introduction

Gestational trophoblastic diseases (GTD) consist of hydatidiform mole, invasive mole, choriocarcinoma, and placental site trophoblastic tumor.[1] Gestational choriocarcinoma is a highly aggressive tumor with metastasis to lungs, vagina, and brain. It occurs following a complete or partial molar pregnancy.[2]

Case Descriptions

Case 1

A 47-year-old lady P3L3 presented to Gynecology OPD with history of heavy menstrual bleeding and cough with expectoration for 2 months. Her general condition and systemic examination were normal. On bimanual examination, the uterus was bulky. Transvaginal ultrasound showed thickened endometrium. Suction and evacuation were done, and histopathology showed choriocarcinoma. Serum beta-human chorionic gonadotropin (β-hCG) was 7.5 lakh mIU/mL. Chest X-ray and thoracic computed tomography (CT) showed bilateral lung opacities suggesting pulmonary metastasis (Fig. 1). She had a history of molar pregnancy 2 years ago, and histopathology had revealed a complete mole. She failed to follow-up with β-hCG after evacuation. Oncology opinion was sought, and she was started on etoposide, methotrexate, actinomycin D, cyclosphosphamide, and vincristine (oncovin) (EMACO) regimen of chemotherapy following the diagnosis of stage III gestational trophoblastic neoplasia (GTN) with WHO prognostic score of 10.

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Case 2

A 23-year-old P1L1 reported to casualty with history of irregular bleeding per vagina for 15 days. She had a preterm vaginal delivery 2 months ago. Her general condition and systemic examination were normal. On bimanual examination, uterus was bulky. Urine pregnancy test was positive, and transvaginal ultrasound showed incomplete abortion, and suction and evacuation done showed choriocarcinoma (Fig. 2). Serum β-hCG was 144,523 IU/L. Patient developed left-sided hemiparesis, and CT brain suggested brain metastasis. Oncology opinion was sought, and she was started on chemotherapy with EMACO regimen following the diagnosis of stage IV GTN. She received 1V cycles of chemotherapy and was

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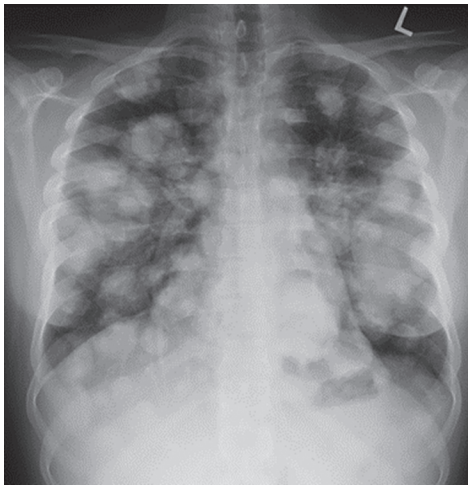

Fig. 1: Chest X-ray showing lung opacities suggesting pulmonary metastasis (Case 1)

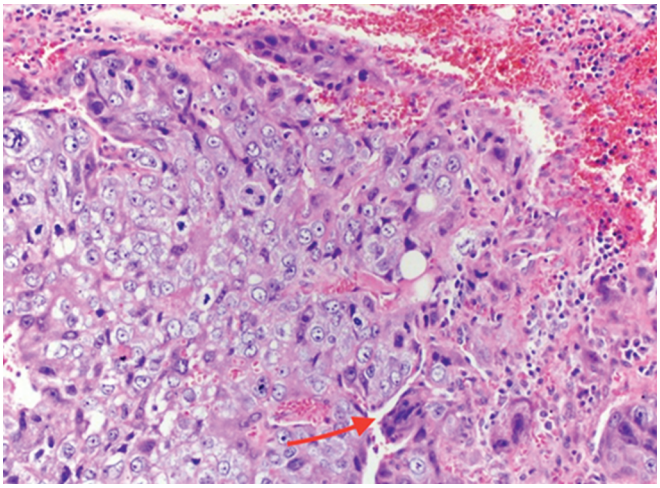

Fig. 2: Cytotrophoblast with syncytiotrophoblast, central hemorrhage and necrosis, cytologic atypia, mitotic figures, absence of chorionic villi—choriocarcinoma (Case 2)

recovering well. She had a history of complete hydatidiform mole 4 years back and was advised follow-up with serum β-hCG. Patient failed to follow-up with β-hCG after evacuation.

Discussion

Gestational trophoblastic disease develops from abnormal trophoblastic cells.[3] Fifty percent of gestational choriocarcinoma occur due to previous history of molar pregnancy.[4] Lung metastasis is present in 80 to 85% and brain metastasis in 10–20% of choriocarcinoma cases.[5] Outcome of choriocarcinoma depends on time interval between the pregnancy and the development of GTD.[6] Choriocarcinoma responds to chemotherapy and has a very high cure rate. Low-risk metastatic GTN (FIGO stage II-III) are treated with methotrexate or actinomycin D monotherapy and high-risk metastatic GTN (FIGO stage IV) with EMACO (Etoposide, Methotrexate, actinomycine D, cyclophosphamide, Vincristine) regimen with or without adjuvant radiotherapy or surgery.[7,8] Irregular vaginal bleeding in the puerperium, or following abortion or perimenopausal age, is the common symptom with choriocarcinoma in women following prior molar pregnancy.[9] Clinicians should have a high suspicion of choriocarcinoma in women presenting with abnormal uterine bleeding with prior history of hydatidiform mole.

Clinical Significance

Choriocarcinoma can present with atypical symptoms, especially in postpartum period and perimenopausal age. Clinicians need to have an index of suspicion of choriocarcinoma in treating women with atypical features. Early diagnosis and treatment with or without metastasis have excellent prognosis.

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