SUCCESSFUL PREGNANCY OUTCOME FOLLOWING CHEMOTHEREPY FOR CHORIOCARCINOMA

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ABSTRACT

This case report describes a twenty-two years old woman with successful pregnancy outcome following Chemotherapy for Choriocarcinoma

Key Words: *Successful pregnancy, chemotherapy, choriocarcinoma.*

INTRODUCTION

Choriocarcinoma is a pure epithelial tumor composed of syncytiotrophoblastic and cytotrophonlastic cells. It may accompany or follow any type of pregnancy. Histologic examination discloses no villi, but instead sheets of foci of trophoblasts on a background of hemorrhage and necrosis. Choriocarcinoma though rare, reported in 2-5% of all cases of gestational trophoblastic neoplasia. The incidence in the United States of America is 1 in 40,000 pregnancies, but it is higher in Asia. In about half of all cases of choriocarcinoma, the antecedent gestational event is hydatidiform mole, in one fourth term pregnancy and the remainder occur following abortion.[1-4] These lesions are initially misdiagnosed as there are no specific clinical signs. It must be considered in patients who present with persistent symptoms of bleeding per vaginum -hCG is probably the only investigation, which can lead to preoperative diagnosis. Choriocharcinoma may also arise from ectopic pregnancy. The diagnosis is often established by histopathology and serum -hCG.[4] The treatment depends upon the age, antecedent pregnancy, site, size; number of metastasis and the time elapsed. The purpose of this case report is that pregnancy can occur following successful chemotherapy. A study of 445 long-term survivors following chemotherapy showed that 86% of patients wishing to have a further pregnancy succeeded in having at least one live birth (RustiN et al 1984)[5] and risk of eclampsia following delivery is 1%.[1,6-8]

CASE REPORT

A twenty-two years old woman married 4 years came to the antenatal clinic with complaint of pain in abdomen and irregular bleeding per vaginum for the last six months following 3 months of abortion. Her general physical examination and abdominal examination was unremarkable. Pelvic examination suggested bulky uterus and cystic mass of about 6 x 5cm size adherent to the right side of the body of uterus. This raised suspicion of ectopic pregnancy. To confirm the diagnosis we did -hCG and ultrasound of the pelvis. Her -hCG level was 116500 m.i.u/ml. and ultrasound showed normal empty collapsed cavity but there was complex mass of about 6 x 5cm in right corneal region of the uterus. Since she had severe pain in abdomen, emergency laparotomy was done. On laparotomy, uterus was of normal size but there was mass of about 6 x 6cm in the right corneal region of the uterus. Right salpingectomy was done with removal of necrotic material from right corneal region of the uterus. Specimen was sent for histopathology. Histopathology report showed trophoblastic tissue (choriocarcinoma). This patient made satisfactory postoperative recovery and was discharged home after a couple of days. Oncology department was consulted and chemotherapy was advised. She had 5 courses of MAC regimen. Dectinomycin (5mg D_1-$D_{5)}$ chlorambucil, (5mg D_1-$D_{5)}$ methotrexate, (50mg D_1-D_5.). She was advised to follow up with serum -hCG. Though her serum -hCG was normal after 3rd course of chemotherapy but she had regular follow up with -hCG at monthly interval till one year. During follow up she conceived after 1 year and she had regular antenatal check ups but she did not turn up for delivery of baby in the hospital and she delivered an alive male baby at some private hospital and then at 7th postnatal day she presented to us as postnatal eclampsia. She was treated according to eclampsia protocol and

was discharged in good condition.

DISCUSSION

Although cases of successful pregnancy outcome after successful treatment of choriocarcinoma are rare, delay in diagnosis increases risk of complications.[1,2,3] In our patient histopathology report consistent with serum -hCG level confirmed the diagnosis of choriocarcinoma. Chemotherapy is the treatment of choice for choriocarcinoma. The best results are with EMA/CO chemotherapy. The prognosis for malignant nonmetastatic disease with appropriate therapy is quite good even in poor prognostic matastatic disease; the best results are with EMA/CO chemotherapy. Since almost all patients are cured, over 90% of patients have been able to preserve reproductive function. Subsequent pregnancies are not at increased risk for complications such as preterm labor, anomalies, or still birth. These pregnancies should, however be monitored early with ultrasound and -hCG levels because there is a small risk of recurrent gestational trophoblastic disease (1-2%).[5] Following delivery, the placenta should be sent for histopathology and -hCG should be checked at the 6 weeks postpartum visit.

Blagden SP et al[9] after reviewing 230 patients who became pregnant with in one year after chemotherapy, advised avoiding pregnancy within 12 months of completing chemotherapy. Matsui H[10] advised to avoid pregnancy for at least 6 months after completion of chemotherapy. In cases where pregnancy occurs prior to the completion of standard chemotherapy, the pregnancy may be continued with close observation, and the risks discussed with the patient. Most pregnancies end with a good outcome.[9] In our patient both histopathological examination of placenta and -hCG level at 6 weeks were normal.

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