SUCCESSFUL PREGNANCY AFTER GESTATIONAL CHORIOCARCINOMA: A CASE REPORT

S. Nayyab Bilal

Department of Obstetrics and Gynecology
Tehsil Headquarter Hospital Tangi, Charsada NWFP, Pakistan

ABSTRACT

Gestational choriocarcinoma is not rare. It is a life threatening disease but complete remission can be obtained in majority of patients by administration of appropriate chemotherapy. Prognosis depends on early diagnosis and management. We report a case who had successful pregnancy after taking chemotherapy for gestational choriocarcinoma.

Key Words: *Choriocarcinoma, Chemotherapy, Pregnancy.*

INTRODUCTION

Choriocarcinoma is an aggressive neoplasm arising in the body of the uterus. It arises from fetal tissue within the maternal host. It is composed of synsytiotrophoblastic and cytotrophoblastic cells. In half of the cases it develops from hydatidiform-mole. In one fourth it follows a term pregnancy and the remainder occurs following abortion, ectopic pregnancy or genital tumor.[1] It secretes a characteristic tumor marker,i:e human chronic gonadotrophin (hCG) and has proved to be highly sensitive to chemotherapy. After treatment, more than 90% of women with this malignant disease are able to maintain their reproductive function.[2] One such cases is reported here.

CASE REPORT

A thirty year old housewife presented on 21st of October 2004 with the complaint of continuous vaginal bleeding since ten month, following evacuation and curettage (E&C) done in January 2004 for missed abortion in a private clinic. Uterine curettage was done third time in august 2004. On examination she was pale, uterus was of 16 weeks pregnancy size and ultrasound revealed disorganized product of conception in uterus. Her hemoglobin was 9.2gm%- BhCG was 41,234 miu/ml. Liver and renal function test were normal. X-Ray chest was clear. One unit of blood was transfused and curettage repeated. The products removed from uterine cavity were sent for histopathology which revealed degenerative and hyalanized chorionic villi. She was referred to onchologist, who put her on EMA-CO (etoposide methotraxate, actinomycin and chloambucil or cyclophosphanide) regime for six months. After completing her chemotherapy course her BhCG was 0.002 miu/ml. She was advised to avoid pregnancy for a year and to come regularly for check up. She was put on oral contraceptive pill. Some how she missed a pill and conceived. Pregnancy test turned out positive on 26/8/2005. She came regularly for antenatal check up and delivered an alive baby on 14/4/2006. At her six weeks postpartum visit her BhCG was normal.

DISCUSSION

The incidence of choriocarcinoma varies with figures as high a 1:120 in some countries of Asia and South America, as compared to 1:200 in United States and 1:45000 pregnancies in other western countries.[3]

It is a highly malignant epithelial tumor arising from trophoblastic tissue of any gestational event, most often after hydatadiform mole. It is not uncommon to find secondary nodules in cervix and vagina. Liver, lungs and brain are the site of distant metastases. Metastatic disease occurs in 4% of patients mostly after local management of hydatadiform mole and rarely after term pregnancy or abortion. Liver and brain metastasis has the worse prognosis with survival rate of 60-80 %.[4,5]

In non-reproductive age group the tumor can arise from ovarian germ cell. However our patient presented with irregular vaginal bleeding after abortion. Three out of five cases presented by

Raisa Izhar also followed after abortion. [3] Evacuation and curettage (E&C) was done three times in the first case but specimens were not sent for histopathology. This shows that some times cases are mismanaged resulting in delay in diagnosis and management, therefore influencing prognosis. Time interval between antecedent pregnancy and outset of chemotherapy is a crucial factor influencing prognosis. [6] The duration of the disease in both the cases was more than four months and BhCG level more than 40000 miu/ml. In addition there was histological confirmation of secondaries in the vagina in the second case. Therefore after initial evaluation both the patients were put on combined chemotherapy, i.e. MAC methotraxate, actinomycin and chlorambucil or cyclophosphamide and EMA-CO (etoposide-methotraxate dactinomycin, cyclophosphemide and vincristine) regimes. Full blood count, liver and renal function test were done to monitor side effects of these toxic drugs.

A delay of twelve months before conception is advised following cytotoxic chemotherapy to reduce the risk of teratogenesis and avoid false positive BhCG reading. [7] The subsequent pregnancies are not at increase risk of complications such as preterm labour, congenital anomalies or still birth. However these pregnancies should be monitored early with ultrasound and BhCG level because there is a 2% risk of recurrent gestational trophoblastic disease. [8]

In this case pregnancy occurred prior to completion of postmolar surveillance due to patient's negligence. However the pregnancy was continued with close observation and the risk discussed with the patient. Following delivery placenta should be sent for histopathology and BhCG level checked at 6 week postpartum visit. [6-8] Such patients should have a further urine and serum BhCG assay at 3 weekly interval after each subsequent pregnancy. Out of 265 patients treated for choriocarcinoma by Song HZ et al from 1959-1980 in Beijing, China, 205 became pregnant after recovery. [9] Cytogenetic study of the peripheral lymphocytes of 94 of the children revealed no increased risk of chromosomal aberration. Even a patient treated for cerebral metastases by Sivanesaratnam had two subsequent uneventful pregnancies. [10]

REFERENCES

1. Balagopal PG, Panday M, Chandramohan K. Sonanathan T, Kumor A. Unusual presentation of choriocarcinoma. World J Oncol 2003; 1:4
2. Chaturvedi M, Vaideeswar P, Pundit A. Metastatic choriocarcinoma: An unusual cause of severe anemia. J Postgrad Med 2005;51(3):230-1.
3. Izhar R, Aziz-un-Nisa. Prognosis of Gestational choriocarcinoma at Khyber teaching hospital Peshawar. J Ayub Med Coll 2003; 15(2): 45-8.
4. Gestational tropohplastic disease [Online] 2004 (cited on October 25th 2006) available from URL//http// www. Medline plus-medical encyclopedia.
5. Selpisorkosol S, Theetranont C, Chan Mai. Pregnancy following chemically treated choriocarcinoma. ChiangMai Med Bull 1984;23:3-6.
6. Dubeshter B, Bernstein MR. Management of complete molar pregnancy. J Reprod Med 1987;32:634-639.
7. Goldstein DP Berkowitz RS. Current management of complete and partial mole pregnancy. J Reproduct Med 1994; 39: 139-46.
8. Markusen TE, Gale A, Quim O. Gestational Trophoblastic disease. In: Current Obstetric and Gynecology. 9th edition\2003: 947-58.
9. SongHZ, Wu PC, Wang YE, Yang XY, Dong SY, Pregnancy out comes after successful chemotheraphy for choriocarcinoma and invasive mole: long term follow-up. Am J Obstet Gyneco 1988;158:538-45.
10. Sivanesaratnam V, Sen DK. Normal pregnancy after successful treatment of choriocarcinoma with cerebral metastases, a case report. J Report Med 1988;33 (4): 402-3.

Address for Correspondence:
Dr. S. Nayyab Bilal
Department of Obstetrics and Gynecology,
Tehsil Headquarter Hospital,
Tangi Charsadda,
NWFP, Pakistan.