CHORIOCARCINOMA — AN UNUSUAL CASE

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INTRODUCTION

CHORIOCARCINOMA most commonly develops after a molar pregnancy, most cases occurring within two years. The development of choriocarcinoma 18 years after a molar pregnancy and in a post-menopausal woman is both very unusual and rare.

CASE REPORT

S.B.I., a 63 year old Malay lady was admitted on 3.11.76 with a two day's history of bleeding per vagina. In 1975, she had a similar episode of post-menopausal bleeding and was admitted to another hospital where a diagnostic curettage was done. The diagnosis then was probably a malignant condition as she developed symptoms suggestive of cytotoxic therapy after a course of drug. She defaulted from further follow-up and was next seen one year later at General Hospital, Malacca. There was a history of a molar pregnancy in 1957. This was her last pregnancy. On examination, the uterus was found to be evenly enlarged to 14 weeks size. No other abnormalities were detected.

INVESTIGATIONS

The chest X-ray was normal. Urine for pregnancy test (Gravindex) was positive in normal concentration but negative at 1:4 dilution. A diagnostic curettage was carried out on 10.11.76. The histological report indicated a neoplastic lesion, but its exact nature could not be identified.

CLINICAL PROGRESS

A total abdominal hysterectomy was performed on 17.11.76. The uterus was enlarged to 12 cm. in size. A necrotic, fungating mass was found at the upper half of the uterus. There was no invasion of the myometrium. Both ovaries were normal.

Histopathologically, the diagnosis was Choriocarcinoma. The pregnancy test was still positive on the 10th post-operative day. Oral Methotrexate 5 mgm every six hours was given for five days. The pregnancy test became negative on 6.12.76. The patient was then given a further 5 courses of Methotrexate at 2 to 3 weekly intervals. The pregnancy test remained negative, chest x-rays were normal and physical examination revealed no abnormalities.

She was well on follow-up until 3.6.77, when a chest x-ray showed numerous round shadows. She was started on Actinomycin-D alternating with 6-Mercaptopurine at 2 to 3 weekly intervals. The response to this regime was dramatic. The lung shadows disappeared completely after three courses each of the two drugs. A further two courses were given to ensure complete eradication. At last check-up on 20.6.78, the patient was well with no respiratory, neurological or gynaecological symptoms.

DISCUSSION

The case presents with two unusual features. The long (and possibly the longest) interval between a molar pregnancy and the occurrence of choriocarcinoma, a span of 18 years. The previous longest reported interval was 17 years. (Lewis, 1956). Choriocarcinoma in a post-menopausal woman is very rare.

There is at present no acceptable theory to explain this late development of malignancy. The answer probably has an immunological key. Novak and Novak as early as 1958 had postulated that trophoblasts were held in check by a maternal immune defense mechanism. Advancing age with the resultant failure of immunosurveillance then permits the trophoblasts to proliferate.

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Another interesting feature about this case was the development of lung secondaries after surgery and treatment with Methotrexate. The possibility that the cytotoxic therapy, by suppressing the immune system of the body thus permitting the trophoblastic emboli to grow, cannot be excluded.

At this stage, it would be relevant to emphasize that the haemagglutination-inhibition test for Human Chorionic Gonadotrophin is unreliable to accurately monitor trophoblastic diseases. (Ratnam, 1977 personal communication). Present commercial reagents measure HCG concentration in excess of 800 i.u. per litre. Hence, trophoblastic tissue can be present in spite of a negative pregnancy test by these preparations. This is clearly illustrated by this case where the pregnancy test was negative in spite of obvious secondaries in the lungs. The insensitivity of the haemagglutination test in the management of trophoblastic disease must be realised as cessation of cytotoxic therapy prior to complete eradication of all trophoblastic tissues can lead to exacerbation of the disease which can prove fatal.

Chemotherapy is the mainstay in the treatment of metastatic choriocarcinoma. (Tow and Cheng, 1967). If a tumour shows resistance, an early change to other cytotoxic drugs is vital. Hammond and Parker (1970) advocated a multidrug regime. However, this was associated with a high morbidity and a mortality of 10 to 15 per cent directly attributable to the drugs. Local experience favours hysterectomy followed by single drug therapy.

The long term prognosis of this patient has to be guarded as metastases to the brain is a high possibility in patients who have late development of choriocarcinoma.

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