

# Gestational Choriocarcinoma: Report Case

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**Abbreviations:** GTT: Gestational Trophoblastic Tumour

## Introduction

Gestational trophoblastic disease is a number of different clinical and pathological entities [1]. Treatment of complete and partial hydatidiform mole involves evacuation of the uterus by aspiration, and requires monitoring of hCG levels. In the event of a diagnosis of gestational trophoblastic tumour (GTT), based on non-normalisation of hCG or a histological appearance of choriocarcinoma, medical treatment will be required [2].

## Observation

Mrs G S aged, 30 years mother of 1 children, without

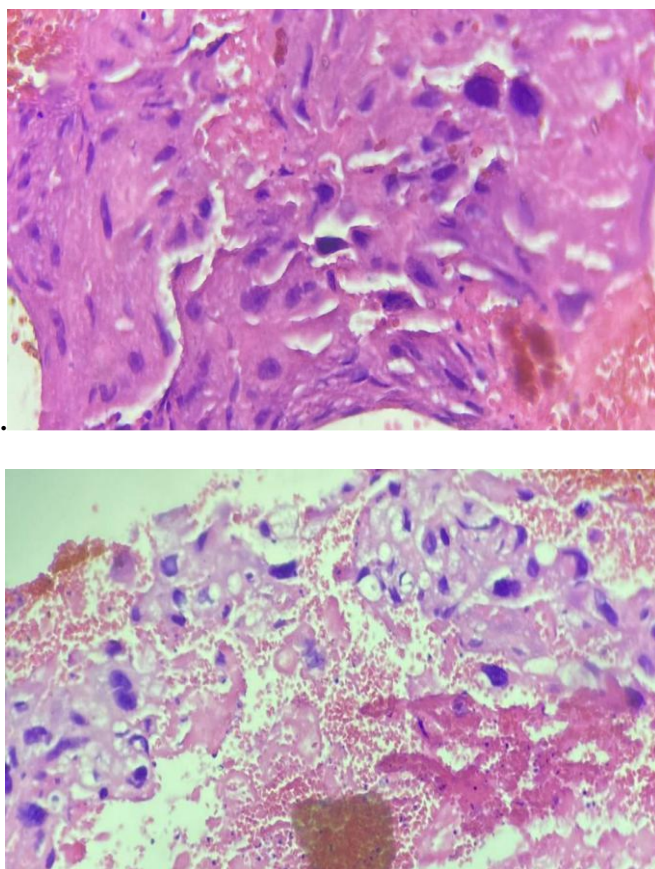
particular pathological antecedents, followed for mole hydatiforme for 2 years; she was aspirated twice with histological examination was in favour of a stopped pregnancy. Given the persistence of metrorrhagia, the patient was referred to us for management. Gynaecological examination revealed minimal bleeding from the endocervix, and the uterus was enlarged halfway to the umbilicus, with infiltrated parameters on rectal examination. Pelvic ultrasound revealed a heterogeneous intrauterine mass measuring 5x4.5 cm. The BHCG was greater than 300,000 IU/L.



**Figure 1:** Ultrasound appearance of a hydatidiform mole

The patient underwent a third aspiration; histological examination revealed a remodelled choriocarcinoma with

extensive necrosis. An extension work-up was carried out, showing no associated secondary lesions.



**Figure 2:** Histological appearance compatible with choriocarcinoma

## Discussion

Choriocarcinoma is a malignant tumour of the placenta, developing at the expense of the epithelium of the ovarian chorion and invading the maternal body. The discovery of antigenic markers in choriocarcinoma that are not present in hydatidiform mole may explain why choriocarcinoma is considered to be a malignant tumour of the placenta. influences the chorial epithelium to proliferate in the manner of a malignant tumour [3]. The mechanism by which an allogeneic graft (the only one of its kind) is not rejected involves consultation with an associated immunodepression. This could explain why no intra-uterine trophoblastic residue is often found in patients with metastatic disease [4].

Traditionally, gestational trophoblastomas have been divided into hydatidiform mole, invasive mole and choriocarcinoma. Such a classification does not currently appear to be very useful, as the histological diagnosis of invasive mole and choriocarcinoma is rarely made, and chemotherapy is often

started without taking account of the results of the pathological examination [5].

As a general rule, choriocarcinoma follows hydatidiform mole. Choriocarcinoma is most often recognised during biological monitoring of the aftermath of a mole in the absence of any clinical signs. Clinical signs, when present, generally characterise an advanced stage [6].

Haemorrhage is the first and most important symptom.

Haemorrhage is the first and most important symptom, either simply prolonging the losses following the molar abortion, or reappearing after a latent period of a few days, weeks or months [7]. Painless, irregular and, above all, repeated, it takes on its full importance because of the history of moles [8].

General signs are delayed: anaemia, weight loss, shortness of breath.

To the touch, the uterus is slightly enlarged, too soft in consistency, with a sometime's open neck. Ovarian cysts, similar to those that accompany mole are seen inconstantly



next to the uterus. Their date of appearance varies. Contemporaneous with mole or following abortion, they may decrease or increase rapidly, without any prognostic argument being drawn from their variations [9].

Apart from haemorrhage, uterine or pelvic infection, torsion of a luteinic cyst, local destruction of the myometrium up to and including uterine perforation and intraperitoneal haemorrhage, all of which are very rare, metastases are the usual complications of choriocarcinoma [10]. Pulmonary metastases are the most common.

Other sites are rarer, but all organs and tissues may be involved: brain, liver, kidney, cervix, intestine, bone marrow, femur, gums, subcutaneous tissue, etc. These sites may require additional investigations: ultrasound, hysteroscopy, CT scan, pelvic arteriography. If left untreated, metastases progress inexorably towards extension and death. They are even particularly terebrating and highly malignant [11].

Medical chemotherapy is the mainstay of treatment for choriocarcinoma because of the particularly good results obtained in these types of malignant tumour. Treatment can only be curative. Treatment is curative [12].

Two drugs are used: methotrexate and actinomycin D. Hysterectomy from the outset is becoming increasingly rare. Hysterectomy is indicated in cases of life-threatening uterine haemorrhage and uterine tumours that have not been eradicated by chemotherapy. Finally, some consider that hysterectomy is still indicated as an initial treatment in the pre-menopausal period, provided that there are no metastases. Chemotherapy should be used if the level of prolanuria is not reversed after excision [13].

Excision of a pulmonary metastasis should be considered when a single pulmonary image persists after long chemotherapy and hormonal excretion does not return to normal. This may result in cure [14].

## Conclusion

Gestational choriocarcinoma is a rare malignancy with high metastatic potential. We report the case of a 31-year-old patient with gestational choriocarcinoma revealed by renal and pulmonary metastases, one year after a normal pregnancy. The diagnosis was made by pathological analysis of the nephrectomy specimen. The outcome was favourable

after appropriate treatment with multidrug therapy. This case highlights the polymorphic symptomatology of choriocarcinoma and emphasises the importance of the  $\beta$ HCG assay for diagnosis [14].

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