HYSTEROSCOPIC ABLATION OF CHORIOCARCINOMA IN A PATIENT RESISTANT TO CHEMOTHERAPY

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Abstract - Gestational Trophoblastic Neoplasia (GTN) is one of the most common gynecologic tumors in our country. Despite development of effective chemotherapy, some cases remain resistant and if there is only one focus of tumor, resection would be indicated.

We present a young woman with stage 1 persistent GTN showing no response to chemotherapy. Transvaginal sonography revealed trophoblastic tissue in the uterus. Metastatic work up was negative. Tumor was resected by hysterectomy and, and there was no need for subsequent chemotherapy, BHCG remained negative after 26 months of follow up.

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Key Words: Trophoblastic tumor, hysteroscopic resection, chemotherapy resistant gestational trophoblastic neoplasia (GTN), Choriovitrosarcoma

INTRODUCTION

Gestational Trophoblastic Neoplasia is among the rarest human tumors that can be cured even in the presence of widespread metastasis (1,2). This tumor is a lethal allograft in maternal tissue.

Choriocarcinoma is the most malignant form of trophoblastic tumor and although it is a choriocarcinoma of the chorionic epithelium, but in its growth and metastasis it often behaves like a sarcoma (3).

In the earlier years of chemotherapy, it was not uncommon to find residual disease in the uterus but this has become infrequent as chemotherapy has improved. Still hysterectomy may be required in patients with metastatic disease to control uterine hemorrhage or sepsis (4).

In this report we describe a young patient who had choriocarcinoma stage 1 with tumor confined to the uterus and unresponsive to chemotherapy. She was treated by hysteroscopic ablation. Since then BHCG has been negative after 26 months of follow up.

Case Summary

A 19 years old primigravida was admitted to our hospital in August 1996. She was 18 weeks pregnant and complaining of vaginal bleeding along with the passage of vesicles. Ultrasound confirmed molar pregnancy.

A curettage was performed and BHCG was measured through weekly basis. It was negative for 2 months but then there was a rise in BHCG (15700 mIU/ml).

CAT scan of brain, chest and abdomen were negative, other metastatic work up such as occult blood and liver and kidney function tests were also negative.

She received methotrexate 50 mg/m² weekly (6,7). After 10 weeks of chemotherapy BHCG became negative (8.7 mIU/ml). She received 6 more weekly courses of methotrexate to consolidate the treatment until February 1997.

Eleven months later in January 1998; there was a slight rise in BHCG (12 mIU) so we treated her with 4 more courses of MTX. F; two months later there was another rise in BHCG (13 mIU/ml). Transvaginal ultrasound showed a localized area of echogenic mass with a diameter of 10 mm in the endometrium. A diagnostic hysterectomy showed a localized mass in the posterior and inferior parts of endometrium, and thus we started MAC (Methotrexate, Actinomycin-D Cyclophosphamide) in July 1998. She received 2 courses of MAC but BHCG continued to rise and reached 68 mIU/ml; so we performed a hysteroscopic resection and ablated all trophoblastic tissue, base of tumor was cauterised by roller ball electrode.

She didn’t received any chemotherapy since then, BHCG soon became negative and after 26 months of follow up, it is still negative. Transvaginal ultrasound showed normal endometrium.

DISCUSSION

The role of surgery in the treatment of persistent trophoblastic disease is somewhat limited because of the advent of effective chemotherapy against trophoblastic tissue (5). However surgical resection may be beneficial in patients with malignant gestational trophoblastic disease who become resistant to chemotherapy. Surgical removal of isolated choriocarcinoma of GTN, when no other tumor has been detected elsewhere, renders the patient free of disease. If the patient is a candidate for resection, it is
important to eliminate the possibility of active disease at other sites including multiple pulmonary nodules.

Complete re-evaluation with CT scan of the brain, thorax and abdomen or pelvis to search for occult metastatic disease should be performed.

This procedure is successful only when a single focus of the disease is identified and no other evidence of systemic spread is suspected. In conclusion, in young patients with chemoresistant GTN confined to uterus, hysterecopic resection of tumor will save fertility.

REFERENCES


