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 persistant GTN showing no response to chemotherapy. Transvaginal sonography revealed trophoblastic tissue in the uterus. Metastatic work up was negative. Tumor was resected by hysteroresectoscopy, and there was no need for subsequent chemotherapy, BHCG remained negative after 26 months of follow up.

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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 fetal 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 pragnant and complaining of vaginal bleeding along with the passage of vesicles. Ultrasound confirmed molar pregnancy.

A curetage was performed and BHCG was measured through weekly basis. It was negative for 2 months but then there was a rise in BHCG (15700 mlu/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 recieved metotrexate 50 mg/m^2 weekly (6,7). After 10 weeks of chemothrapy BHCG became negative (8.7 mlu/ml). She received 6 more weekly courses of metothrexate to consolidate the treatment unitil February 1997.

Eleven months later in January 1998; there was a slight rise in BHCG (12 mlU) so we treated her with 4 more courses of MTX/C. F; two months later there was another rise in BHCG (13 mlU/ml). Transvaginal ultrasound showed a localised area of echogenic mass with a diameter of 10 mm in the endometrium. A diagnostic hystroscopy showed a localised mass in the posterior and inferior parts of endometrium, and thus we started MAC (Methotrexate, Actinomycin-D Cyclophosfamide) in July 1998. She received 2 courses of MAC but BHCG continued to rise and reached 68 mlU/ml; so we performed a hystrocopic resection and ablated all trophoblastic tissue, base of tumor was cautherised 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 persistant 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 chmoresistant foci of GTN, when no other tumor has been detected elswehre, renders the patiçnt 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 pulmunary nodules.

Complete reevaluation 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, hysteroscopic resection of tumor will save fertility.

REFERENCES

1. Berkowitz RS, Goldstein DP. The management of molar pregnancy and gestational trophoblastic tumor In: Knapp RC, Berkowitz RS Gynecologic Oncology 2nd ed. New York McGraw-Hill 1993: 328-38.

2. Bagshawe KD, Risks and prognostic factors in trophoblastic neoplsia. Cancer: 38: 1373-85; 1978.

3. Williams Obstetrics 20th edition by Appleton & Lange company P: 684.

4. Sober J.T. Surgical therapy for gestational trophoblastic disease J. Reprod Med: 39: 168-74: 1994.

5. Clarke - Peterson D.L. Huteau J.A. Chemotherapy of gynecologic malignancies In : Te lind's operative gynecology 8th ed. Lippincott - Rawen 1997: 1631-1634.

6. Ross S. Berkowitz & Donald P. Goldstein : GTN in Practical Gynecology chapter 13. page 474: 1994.

7. Ross S. Berkowitz & Donald P. Goldstein : GTN in Novak's Gynecology chapter 35. page 1267: 1996.