CASE REPORT

Non Gestational Cervical Choriocarcinoma With Urinary Bladder Metastases: An Unusual Case Report

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Abstract

Primary cervical choriocarcinoma in a woman of child-bearing age with local infiltration into the urinary bladder wall in a 32 year old woman admitted to our hospital with haematuria and vaginal bleeding since 3 months. Ultrasound examination revealed echogenic mass in urinary bladder lumen. Cystectomy with hysterectomy was done. Postoperative pathological examination of surgical specimen showed that case was of primary choriocarcinoma of cervix with local infiltration into the urinary bladder wall.

Key Words

Choriocarcinoma, Urinary Bladder, Extrauterine

Introduction

Primary extrauterine choriocarcinoma is a rare entity seen in clinical practice and is mostly found in genital tract in patients with coexisting or antecedent pregnancy. Most of the extrauterine cases reported are gestational choriocarcinomas located in uterine cervix. (1-2). Saito etal described diagnostic criteria for this entity as (a) absence of disease in uterine cavity (b) pathologic confirmation of the disease (c) exclusion of molar pregnancy and coexistence of normal intrauterine pregnancy (3). Choriocarcinomas which originate from genital regions outside uterus are reported in ovary (4), tube(5), and vulva(6). Extragenital sites include gastrointestinal tract (7), brain (8), urinary bladder (9) and heart (10). Gestational trophoblastic diseases have a varying potential for local invasion and metastases and they generally respond to chemotherapy (11). We hereby, report a unique case of extrauterine cervical choriocarcinoma in a woman of child-bearing age with local infiltration into the urinary bladder wall.

Case Report

A 32 year old woman (Gravida 3, Para 3) was admitted to our hospital in surgery ward with complaints of abdominal pain, haematuria and vaginal bleeding since 3 months. She had last pregnancy five years back which ended with a normal term delivery. She had undergone tubectomy two years back. A per-abdominal non tender mass was found while she was being clinically evaluated. On ultrasound, it was reported as complex right adenexal mass with right obstructive uropathy with suspicion of subserous posterior wall fibroid. Urinary bladder showed mobile echogenic mass in lumen (? Blood clots). Patients was anaemic (Hb 5.4gm %) and there was no pathologic finding in other routine blood tests. She was given six units of blood transfusion. Cinically impression was primary urinary bladder tumor with involvement of uterus. E ight days after admittance of patient, cystectomy with hysterectomy with ileosigmoidostomy were done. Pathologic evaluation of surgical specimen revealed tumour composed of sheets of cytotrophoblast and syncytiotrophoblast . Tumour involved entire posterior lip more towards right lateral border where it is infiltrating through right parametrial tissue and bladder wall. Rest of the bladder wall showed normal transitional epithelium without any evidence of dysplasia or malignant transformation. Ectocervical mucosa, vaginal vault, both ovaries, left parametrial tissue , urethral and ureteric opening were free from tumour tissue. Endomyometrium was also free from tumour tissue, however, exfoliative tumour tissue was adherent to endometrial surface. After the pathologic specimen was reported as Choriocarcinoma, Serum beta-HCG levels were done and result was a high value of 23,462.7 m IU/ ml . Post operative period was excellent and patient began to receive multiagent chemotherapy against choriocarcinoma. Patient came for follow up one month later and was recovering well.

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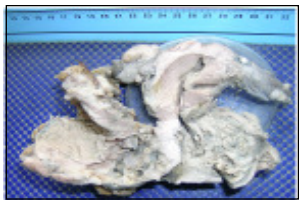

Fig 1. Bulky Uterus with Hypertrophied Cervix. Cut Surface Shows Necrotic Friable Tumor Tissue Diffusely Involving Whole of Posterior Lip. Tumor is Extending to Right Lateral Lip and Adherent Urinary Bladder Wall

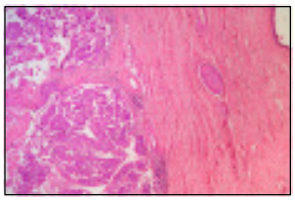

Fig 2. Tumor is extending upto Isthmus , Parmetrium & Urinary Blader Wall. Endomyometrial is free from Tumor

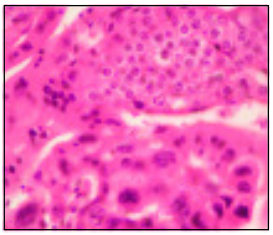

Fig.3 Posterior Lip of Cervix Shows areas of Infiltrating Tumor Tissue Composed of Cytotrophoblast and Syncitiotrophoblast

Discussion

Choriocarcinoma is a highly malignant tumour with metastatic potential. Down regulation of caspases 8 and 10 might contribute to its pathogenesis (12). IGF II regulates the metastatic properties of choriocarcinoma cells through activation of insulin receptors. Pathogenesis of nongestational choriocarcinoma may have a dedifferentiation of the tumour from another histologic type (13). It is also possible to arise from germ cells that had failed to complete their migration to the gonads. Choriocarcinoma may be one of the several elements in a germ cell tumour or it may be a sole component. The latter is termed as pure and is pathologically indistinguishable from gestational choriocarcinoma.

Primary Choriocarcinoma of uterine cervix is a very rare entity. The diagnosis of uterine cervical choriocarcinoma is very difficult. In our case, patient of child-bearing age presented with abdominal pain, haematuria and vaginal bleeding since 3 months. Our case is very unusual example because of its non gestational, extrauterine origin and local infiltration into the urinary bladder wall through right parametrial tissue. As most of the primary cervical choriocarcinoma cases reported are gestational choriocarcinomas, non-gestational origin of our choriocarcinoma case makes it more unusual.Malhotra etal have reported one case of metastasis of an invasive mole to the urinary bladder after evacuation of molar pregnancy (14).Although primary Choriocarcinoma of bladder has been reported, local infiltration from primary choriocarcinoma to bladder wall is also a rare entity. The prognosis is extremely poor in comparison to transitional cell carcinoma. (15). Diagnosis of such kind of locally infiltrative choriocarcinomatous tumour is very difficult for pathologist both in biopsy and in specimen. Surgery can be very helpful in the management of the patient with both gestational and non gestational carcinomas. Because it is chemosensitive tumour type, choriocarcinoma has a very good prognosis even in advanced stages. Immunohistochemical evaluation is the mainstay of the diagnosis in cases that are suspicious of histological type.Pelvic examination, Serum beta-HCG levels and transvaginal color Doppler USG are mainstay for diagnosis.

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