International Journal of Gynaecology and Obstetrics Research
www.gynaecologyjournal.in
E-ISSN: 2663-3612, P-ISSN: 2663-3604
Received: 02-09-2022, Accepted: 18-09-2022, Published: 06-10-2022
Volume 4, Issue 1, 2022, Page No. 13-15

Intense lumbar pain revealing metastatic gestational choriocarcinoma

Razafindrahova Patricia Alice[1*], Randriamarolahy Anja Holinoro[2], Rakotoniaina Irène[3], Randriamalala Ruffin[4], Fenomanana Sonia[5], Ahmad Ahmad[6]

[1] Medical Radiologist, University Hospital Center, Mitsinjo Betaanimena, Toliary, Madagascar
[2] Medical Radiologist, Hospital Center, Mitsinjo Betanimena University, Toliary, Madagascar
[3] Medical Biologist, Mitsinjo University Hospital Center, Betanimena, Toliary, Madagascar
[4] Medical Oncologist, University Hospital Center, Tanambao, Toliary, Madagascar
[5] Associate Professor in Obstetrics Gynecology, Hospital Center Tanambao University, Toliary, Madagascar
[6] Professor, Department of Radiology, University Hospital Center, Joseph Ravoahangy Andrianavalona, Antananarivo, Madagascar

Abstract

Uterine choriocarcinoma is a trophoblastic tumor characterized by its high metastatic potential. It most often results from the degeneration of a hydatidiform mole. Renal and pulmonary metastases can rarely reveal this pathology. Our objective is to report a new observation in a young nulliparous woman aged 27 with a history of spontaneous miscarriage 6 months ago and minimal menometrorrhagia for 2 months. She was admitted urgently to a private hospital center for intense lumbar pain simulating renal colic. She presents with dyspnea on exertion and omucous skin pallor with severe anemia at 4g/dl of hemoglobin. The paraclinical examinations discovered pulmonary and renal metastases from a gestational choriocarcinoma. The delay in diagnosis associated with a lack of regular clinical, biological and ultrasound follow-up of a spontaneous miscarriage can jeopardize the vital prognosis of a patient.

Keywords: choriocarcinoma, dyspnea, lower back pain, metastases

Introduction

Choriocarcinoma is a rare malignant tumor with a high metastatic potential. If not diagnosed early and without treatment, the prognosis is fatal. It fits into gestational trophoblastic diseases [1]. The objective of this work is to report a case of metastatic choriocarcinoma of late diagnosis in a very young nulliparous woman.

Observation

We report the case of a 27-year-old woman admitted to a private hospital in the city for intense lumbar pain. An ultrasound of the urinary tract carried out in search of a possible urolithiasis came back normal. The patient's symptomatology was treated as renal colic, without improvement despite treatment with analgesics-antispasmodics. In her history, 6 months earlier, the patient had a notion of spontaneous miscarriage without follow-up and for 2 months she had presented minimal menometrorrhagia for which a pelvic ultrasound was performed and mentioned the presence of an intrauterine clot. and she had undergone uterine curettage at the time. During her hospitalization, the patient presented dyspnea on exertion which was treated as severe anemia with a hemoglobin level of 4 g/dl from which she had received 3 blood transfusion bags. A few days later, the patient was referred to our department for an emergency imaging examination following the intensification of lumbar pain associated with dyspnea with ambient air desaturation. We performed a thoracic and abdomino-pelvic CT scan without injection of contrast product following the patient's hypercreatinineemia at 975 mmol/l. This examination revealed multiple bilateral pulmonary parenchymal nodules in balloon release (figure 1), spontaneous hypodensities at the level of the bilateral superior renal poles (figure 2) and a heterogeneous globose uterus (figure 3). The diagnosis of choriocarcinoma was confirmed by an anatomopathological examination of the debris brought back by the uterine curettage performed despite the low plasma level of ß human chorionic gonadotrophin (ß HCG) at 200IU/ml. The cerebral computed tomography performed as part of an extension assessment was normal. The patient died after 2 courses of chemotherapy by intense genital bleeding despite the emergency hysterectomy for hemostasis.

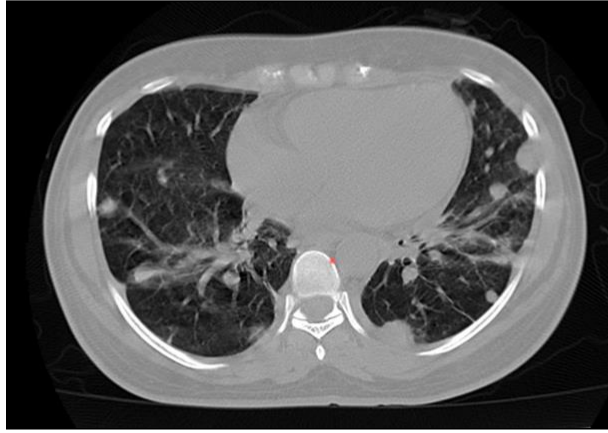

Fig 1: Axial CT section, showing lung nodules

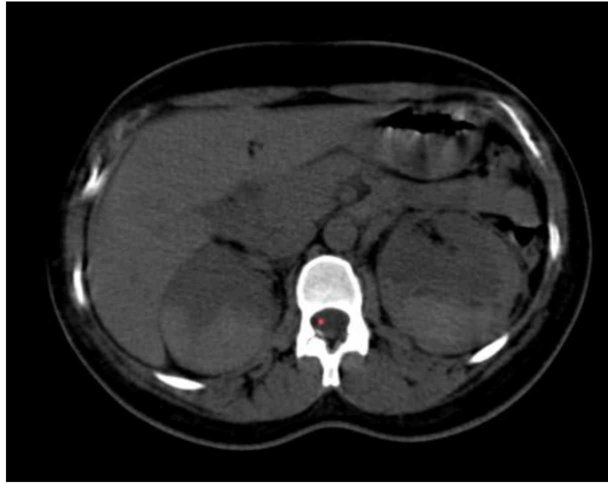

Fig 2: Axial CT section passing through the abdomen, showing hypodense lesions at the level of the upper poles of the bilateral kidneys

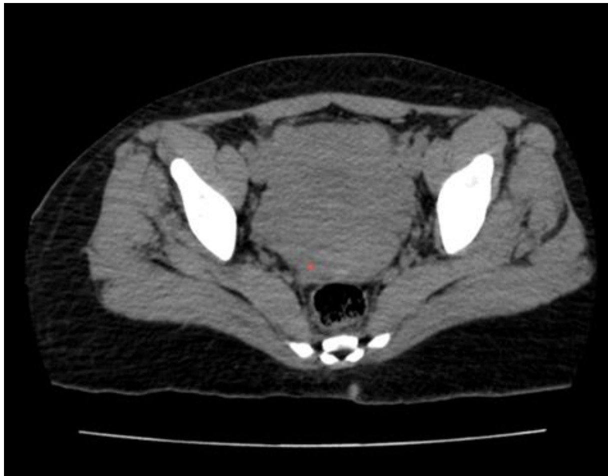

Fig 3: Axial scan section passing through the pelvis, showing a globular uterus

Discussion

Gestational choriocarcinoma is discovered in this clinical case in a nulliparous woman, 6 months after a poorly managed spontaneous miscarriage. The recent unexplained menotrorrhagia with insufficiently interpreted ultrasounds and the absence of BHCG dosage, could have raised suspicion of this fatal pathology earlier. The diagnosis of gestational choriocarcinoma, despite a clinical polymorphism, is based on unexplained metrorrhagia and high levels of BHCG without pregnancy [1, 2]. Gestational trophoblastic diseases can be observed after any pregnancy: normal, molar, ectopic, spontaneous abortion or voluntary termination of pregnancy (IVG) [3]. Typically, there is an absence of normalization or a rise in total serum BHCG levels after the end of pregnancy [4]. The contribution of pelvic ultrasound can be significant. Exceptionally, the diagnosis can be suspected in the face of clinical manifestations related to metastases [3]. Which is our case here. The most frequent metastatic sites

are the lungs (80%), the vagina (30%), the brain (10%), the liver (10%) [3]. Renal localization is found in 1.3 to 14% of metastases. For Soper *et al,* this location is always associated with a pulmonary location [5]. In our case, an image in favor of pulmonary and renal metastases was evoked. It would result from systemic dissemination by arterial emboli following pulmonary involvement. Gestational choriocarcinoma is rarely evoked in the presence of metastatic renal localization [3]. The standard treatment for choriocarcinoma is chemotherapy. Recourse to surgery is rare. Choriocarcinoma is the most common form of trophoblastic tumors. It is still rare, with an incidence of 1/50,000 live births according to Bagshawe. This incidence is higher in Asia, Africa and Latin America (1/8000) [6]. In 50% of cases, which is observed in our observation, the choriocarcinoma develops following a hydatidiform mole, or is secondary to a spontaneous abortion (25%), a normal pregnancy (22.5%) or to an ectopic pregnancy (2.5%). The most common location is the uterine wall [7].

Conclusion

Renal metastases associated with lung metastases from gestational choriocarcinoma are rare. This possibility must be taken into account in patients of childbearing age following a pathological pregnancy. The dosage of BHCG must be systematic in case of unexplained metrorrhagia in a young woman to avoid delay in diagnosis and management of this fatal pathology.

References

1. Regis C, Taieb S, Lesoin A, Baranzelli MC, Blehaut T, Leblanc E. Localisation inhabituelle d’un choriocarcinome gestationnelle. Gynécologie Obstétrique & Fertilité,2006:716:719-34.
2. Benedet JL, Bender H, Jones 3rd H, Nqan HY, Pecorelli S. FIGO staging classifications and clinical practice guidelines in the management of gynecologic cancers. FIGO committee on gynecologic oncology. Int J Gynaecol Obstet,2000:209:262-70.
3. Cohn DE, Herzog TJ. Gestational trophoblastic diseases: new standards for therapy. Curr Opin Oncol,2000:492:496-512.
4. American College of Obstetrics and gynecology. ACOG Practice Bulletin No 53. Diagnosis and treatment of gestational trophoblastic disease,2004:1365:1377-2103.
5. Soper JT. Role of surgery and radiation therapy in the management of gestational trophoblastic disease. Best Pract Res Clin Obstet Gynaecol,2003:943:957-76.
6. Bagshawe KD. Gestational trophoblastic diseases. Report of a WHO scientific Group. World Health Organ Tech Rep Ser.,1983:692:7-81.
7. Kairi-Vassilatou E, Papakonstantinou K, Graspa D, KondiPaphiti A, Hasiakos D. Primary gestational choriocarcinoma of the uterine cervix. Report of a case and review of the literature. Int J Gynecol Cancer,2007:17(4):921-5.