A Rare Case- Placental Site Trophophoblastic Tumour

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Background : Gestational trophoblastic disease is an umbrella term for a group of pregnancy related disorders arising from abnormal placental trophoblast cells. It may follow either molar pregnancy, non-molar term pregnancy or first-trimester non-molar miscarriage. Persistent gestational trophoblastic disease is potentially fatal, but majority of patients are cured with chemotherapy.

Case : 25 year old G4P2L2A1 with 8 months amenorrhea , irregular spotting PV since 5 months. UPT positive. USG suggestive of placenta accreta and intrauterine pregnancy of 7 weeks 3 days with increased vascularity on doppler. She was started on tab. methotraxate 5 mg per day for 4 days by private practitioner and asked to follow up for serial βHCG. βHCG was 16,041 mIU/ml intially, which gradually decreased to 2015 mIU/ml over 4 months. She came to us with 2015 mIU/ml value, where a repeat USG suggestive of the same. Her vitals were stable, systemic examination normal. PS : Cx soft hyperemic, PV : uterus 10 weeks ,AV. Investigations- CBC, LFT, KFT, Chest x ray - normal. Patient was started on chemotherapy. Injection methotrexate 50 ml was given in alteration with injection leucovorin intramuscular for 4 doses. USG was done after 7 days which showed reduced vascularity on Doppler. βHCG was repeated- 527 mIU/ml .She underwent suction and evacuation with 2 blood reserved.

Intraoperatively, copious amount of product was obtained the sample was sent for histopathology examination . Intraoperative bleeding managed with intrauterine packing. βHCG was repeated 48 HRS after evacuation which came to be 17 mIU/ml

Discussion : Gestational Trophoblastic Neoplasia (GTN) is a rare disease with varied presentation, and clinicians are still faced with many challenges in management. It includes both benign and malignant forms. Early diagnosis by ultrasound, availability of sensitive β-HCG assays, and introduction of effective chemotherapy regimens have made this once fatal malignancy curable. GTN is common at extremes of age, less than 15 years and more than 45 years [1]. The placental site trophoblastic disease show benign to malignant presentation.It differs from choriocarinoma with little amount of β-HCG.[2] Curettage can lead to uterine perforation because the tumour invades deeply in the myometrium [3]. Tumor best treated with hysterectomy[4].Suction and evacuation done in sporadic cases where fertility is desired. Repeat or second uterine evacuation has a role in selected cases of persistent gestational trophoblastic disease where β-HCG is less than 1500 IU/litre, and ultrasound shows significant retained molar tissue. Third evacuation is no longer recommended.[5,6]

Histopathological Result :

Histopathological Report suggestive of persistent gestational trophoblastic disease.

Patient is asked to come for follow up ,monthly for 6month.

Conclusion : Risk factors for post molar GTN are Advanced maternal age, Uterine size more than period of gestation, Bilateral theca lutein cyst, Post evacuation uterine haemorrhage / subinvolution.Role of chemotherapy and weekly β-HCG levels. Appropriate diagnosis of PTD with serial β-HCG levels[7] and treatment leads to near 100% cureand prevention of neoplastic changes .Anticipating and aggravated approach with patient's compliance played a vital role in saving her of hysterectomy. Multidrug chemotherapy can also be used in case of single drug resistance.[8]

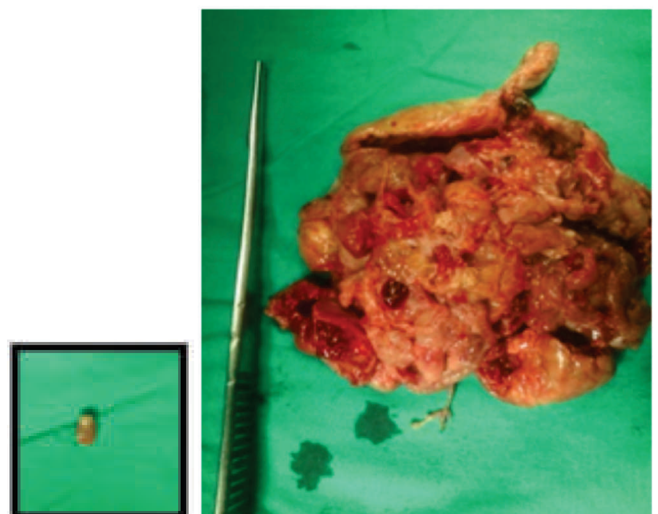

Fig. -1 Trophoblastic tissue with fetal pole(in box)

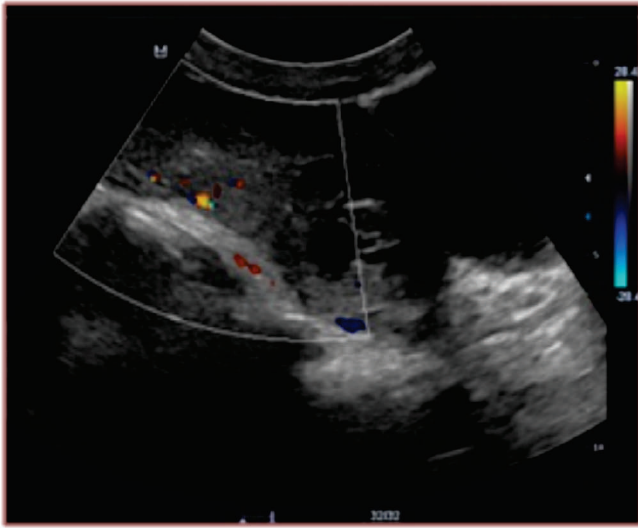

Fig. -2 USG image showing increased vascularity on doppler

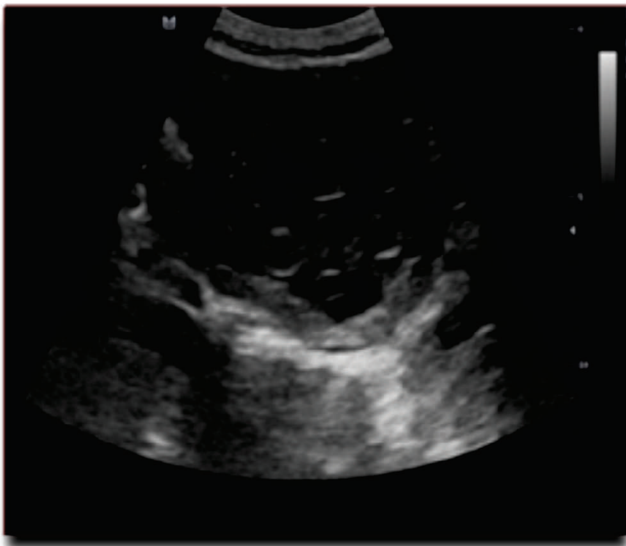

Fig. - 3 Pre Suction and evacuation scan

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