INTRODUCTION

Choriocarcinoma is a highly vascular and highly metastatic tumour of chorionic epithelium (1). Vaginal metastasis complicates about 30% of patients with choriocarcinoma. Other common sites of metastasis include the lungs, vulva, kidneys and the brain. In spite of choriocarcinoma being a very aggressive malignancy, appropriate and timely chemotherapy result in favorable response and quick recovery. Cases of surgical intervention in vaginal and vulvar metastasis have been reported especially with excessive bleeding and poor compliance to treatment (1). Radiotherapy can also be employed as a modality for management of acute profuse bleeding from vaginal metastasis. Vaginal metastasis of choriocarcinoma can be misleading at the time of presentation resulting in misdiagnosis and delay in initiation of life saving treatment.

The case is presented of a 30-year-old, para 1+1 with history of a slow growing, painful and easily bleeding vaginal mass that was initially thought to be uterine prolapse or a prolapsed leiomyoma.

Key words: Choriocarcinoma, metastasis, uterine prolapse.

CASE PRESENTATION

We present the case of a 30-year-old para 1+1 who presented with a one-day history of heavy vaginal bleeding which had started insidiously 5 months earlier from a slow growing vaginal mass. The painful, vaginal mass bled on touch. She had an unclear history of manual vacuum aspiration for an incomplete abortion 3 months prior to presentation in a private facility. Her last normal menstrual period was in September 2019. Her last delivery was in 2015 to a live male infant, 3200 grams born via spontaneous vertex delivery, alive and well. Her past medical and gynecological history were unremarkable. At admission she was in fair general condition and mild pallor. The abdominal examination was unremarkable. On vaginal examination, there was a necrotic, foul smelling, para urethral mass, friable, very tender, extending downwards towards the vulvar opening. Digital vaginal examination was not possible due to marked tenderness. The initial impression was uterine prolapse and right hydrosalpinx. Full blood count revealed a Hmoglobin of 10.4g/dl, B- HCG levels done were 500,000 mIU/l.

The initial pelvic ultrasound showed prolapsed uterus with right hydrosalpinx but a repeat scan ruled out a prolapsed uterus and showed heterogeneous and hyper vascular myometrial lesions with multiple internal cystic regions. A chest X ray done showed normal findings with no evidence of metastasis to the lungs. An examination under anaesthesia was done. On inspection, a periurethral mass extending to the proximal part of the anterior vaginal wall, about 6 cm by 4 cm in size with made of placenta like tissue.
On digital examination at EUA, there was foul smelling, hemorrhagic discharge, the cervix was closed and felt grossly normal, the uterus was about 8 weeks and retroverted on bimanual palpation and there were no adnexal masses. Very guarded and minimal debridement of the necrotic tissues was done, bleeders were ligated, hemostasis was achieved and the rest of the mass was left intact. WHO scoring was computed to 9 \{(Age less than 40 (1), Previous pregnancy – abortion (1), Months since last pregnancy - 4-6 (1), Pretreatment B-HCG 500,000 (4), largest tumour size including uterus – 5cm or more (2), no of tumour spread (1)\}. This was a high-risk score with FIGO staging II as the mass was outside the uterus but within the genital tract.

The patient was then started on chemotherapy on the EMACO regimen. At the time of writing up this case, she had completed 6 cycles and was responding very well. The vaginal mass has cleared completely and B-HCG levels had dropped to 13.55 mIU/ml. The goal was to get three negative readings before stopping chemotherapy. She is on contraception for the next one year and counselling has been done regarding her condition and the need for compliance to treatment.

**DISCUSSION**

Choriocarcinoma is part of a histologically distinct, malignant lesions called Gestational trophoblastic neoplasia. This is a group of heterogenous interrelated lesions that arise from abnormal proliferation of placental trophoblasts. They include invasive hydatidiform mole, choriocarcinoma, placental site trophoblastic tumour (PSTT) and epithelioid trophoblastic tumour (ETT). (3)

The incidence of vaginal metastasis in choriocarcinoma ranges from 8.6 to 30% (4,5). The commonest site for vaginal metastasis has been the lower part of the vulvar with the lesions mimicking Bartholin cysts and vulvar hematomas(4). In the case presented above, the mass was initially thought to be uterine prolapse or a prolapsed uterine or cervical fibroid. There was also an unclear history of uterine evacuation. The other common sites of metastasis include the lungs, the kidneys and the brain. Choriocarcinoma commonly responds very well to chemotherapy depending on the risk scoring. Large sized metastasis of more than 3 cm should be considered high risk and treated aggressively (5). Patients with stage II and III gestational trophoblastic neoplasia and a FIGO score of more than 7 have high risk disease and should be managed with combination therapy.

EMACO (Etoposide, Methotrexate, Actinomycin D, Cyclophosphamide and Vincristine) is commonly used for the moderate and high risk cases (5). The chemotherapy is administered at 2 – 3 weeks interval and timely administration is paramount (3). Other regimens for combination therapy include MFA (MTX, folinic acid, ACT-D), MAC, CHAMOCA (cyclophosphamide, hydroxycarbamide, doxorubicin, ACT-D, MTX, mephalan, and vincristine). For patients with resistance to these EMACO then the combination is use EMAEP which substitutes cyclophosphamide and Vincristine with Cisplatin and Etoposide on Day 8 of each cycle (3).

Other modalities of treatment may include vaginal hysterectomy in chemo resistant cases or in persistent life-threatening hemorrhage despite chemotherapy. Radiotherapy is commonly used for treatment of choriocarcinoma with metastasis to the brain (3).

**CONCLUSION**

Metastatic choriocarcinoma of the vagina requires a high index of suspicion as the presentation can mimic other benign gynecological conditions. This is necessary for timely intervention. The lesions tend to respond well to chemotherapy with 100% cure rate for low risk lesions and 80-90% cure rate for moderate to high risk lesions.
Conflict of interest: None

Consent: Written informed consent was obtained from the patient for publication of this case report and the accompanying images.

REFERENCES


****