

**CHORIOCARCINOMA REVEALED BY VAGINAL AND PULMONARY METASTASIS:
A CASE REPORT*****Abdelali Kallali, Oumaima Sarhdaoui S. Boujjida, N. Zeraiidi, A. Lakhdar and A. Baidada**Gynaecology-Obstetrics and Endoscopy Department, Maternity SOUISSI, University Hospital Center IBN SINA,
University Mohammed V, Rabat, Morocco.***Corresponding Author: Abdelali Kallali**Gynaecology-Obstetrics and Endoscopy Department, Maternity SOUISSI, University Hospital Center IBN SINA, University Mohammed V,
Rabat, Morocco.

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INTRODUCTION

choriocarcinoma is a rare malignant tumor with high metastatic potential, which fits into an entity called gestational trophoblastic diseases; These include benign entities called hydatidiform moles, complete or partial and which are not tumors and malignant entities called Gestational Trophoblastic Neoplasia, which include, among others, choriocarcinomas. We will report the case of a choriocarcinoma revealed by vaginal and pulmonary metastasis.

CLINICAL CASE

39 years old, presented for 3 months post coital metrorrhagia, of low abundance, associated with intermittent pelvic pain, without urinary or digestive signs, complicated by progressive dyspnea on exertion, hemoptysis, and chest pain. the whole evolving in an apyretic context. Furthermore, the patient reports moderate abundance of menometrorrhagia 10 months after a vaginal delivery.

The clinical examination finds an alteration of the general condition with anorexia and a weight loss of 20 kg in 8 months, slightly discolored conjunctiva, supple and insensitive abdomen, the speculum examination finds a budding tumor at the level of the external opening of the cervix, bleeding on contact, measuring 2cm / 2cm. (figure 1).

**Figure 1: Vaginal Tumor During Speculum Examination.**

Digital rectal examination is normal. pulmonary auscultation shows a pulmonary condensation syndrome with abolition of vesicular murmur, and reduction of vocal vibrations.

Histopathological examination returning in favor of a trophoblastic tumor.

Chest x-ray revealed bilateral interstitial syndrome with reticulomicronodular opacities. figure 2.



Figure 2: Bilateral interstitial syndrome on chest x-ray

In view of these results, a BHcg assay was requested, which came back strongly positive at 380,000 mIU / ml.

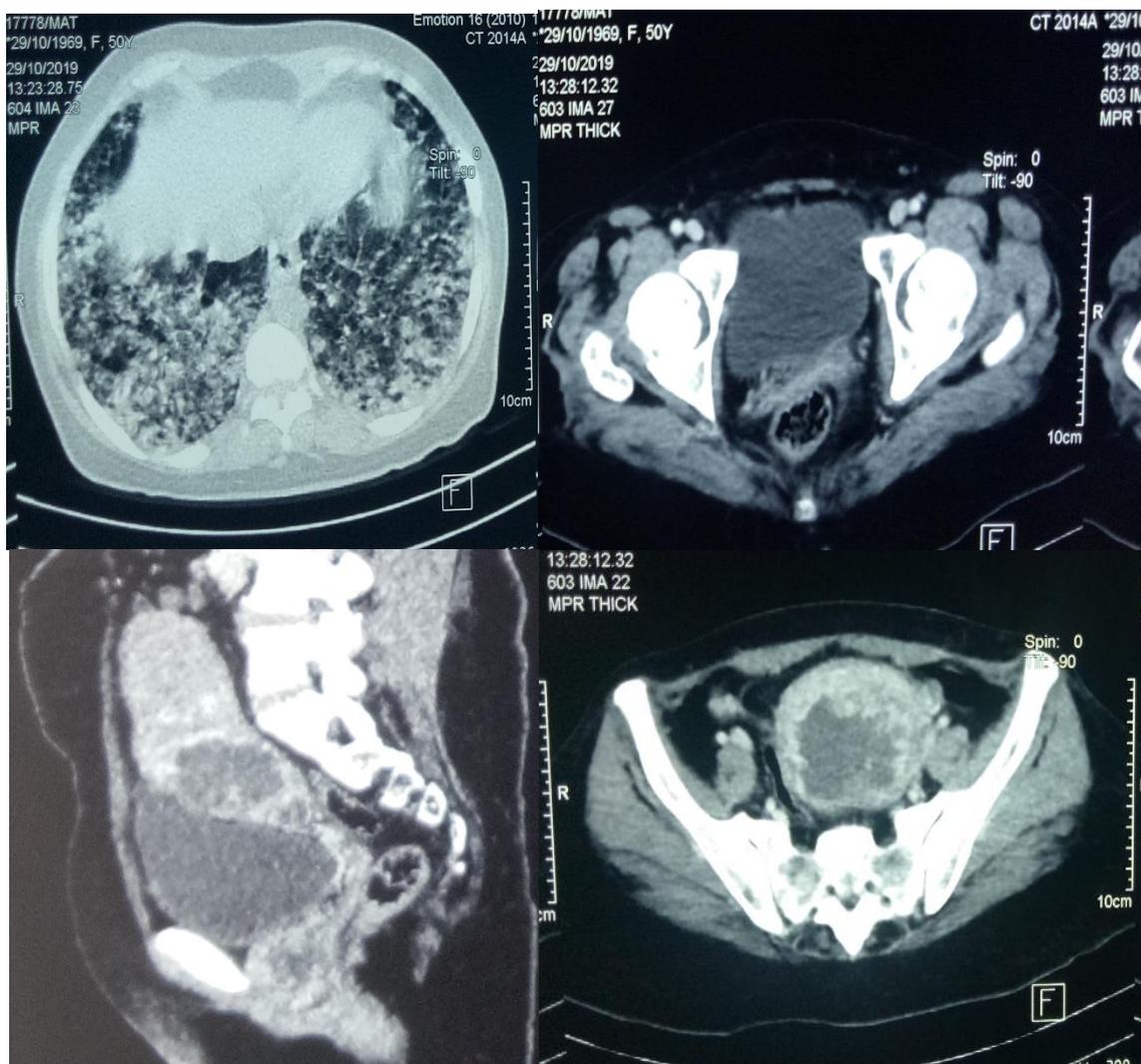


Figure 3: Thoraco-abdominal CT: subpleural nodules, bilateral micronodules, globular uterus closing cystic formations.

The thoraco-abdominal CT shows sub-pleural nodules and bilateral micronodules, heterogeneous globular uterus containing cystic images, infiltrating the myometrium, with a heterogeneous cystic image at the vaginal level. Figure 3 our patient received multiple chemotherapy according to the EMA-CO protocol (etoposide, methotrexate, actinomycin D, cyclophosphamide, vincristine [Oncovin]) with good clinical and biological evolution.

DISCUSSION

Gestational choriocarcinoma is a malignant tumor of the villous trophoblast, without placental villi and molar vesicle.

The frequency of choriocarcinoma is high in Asia, Africa and Latin America, ranging from 23 to 335 per 100,000 pregnancies, but rare in North America, Europe and Australia with rates varying between two and seven per 100,000 pregnancies.^[2,3]

Choriocarcinoma is discovered in this clinical case in a multipara, at 10 months of a vaginal delivery, on a biopsy of a vaginal tumor, the diagnosis of primary tumor of the cervix was in the foreground.

The telltale signs are persistent unexplained bleeding or re-ascend, stagnation, lack of normalization at 6 months of total serum choriogonadotropin (hCG) levels after evacuation of a hydatidiform mole, persistent unexplained bleeding after spontaneous abortion or an abortion, occasionally bleeding unexplained in the weeks or months following a normal delivery or an ectopic pregnancy.

The most frequent metastatic sites are the lungs (80%), the vagina (30%), the brain (10%), the liver (10%) renal localization is very rare, often concomitant with pulmonary localization which would result from systemic dissemination by arterial emboli following pulmonary involvement.

Pelvic ultrasound often shows an irregular, heterogeneous image, with hyperdense areas and involvement of several tunics without respecting their architecture. Choriocarcinoma is a richly vascularized tumor; pulsed or color Doppler reveals hypervascularization of the lesion computed tomography is essential for the extension assessment to search for distant metastases. Pelvic magnetic resonance imaging (MRI) is not a first-line test;

Chemotherapy has radically changed the prognosis of these cancers. Survival went from 19% with surgery to almost 90% with chemotherapy.

Chemotherapy has become the treatment of choice for gestational trophoblastic tumors, with the exception of the tumor at the placental implantation site which is chemoresistant and where surgery remains in place.^[3]

The therapeutic efficacy is confirmed by monitoring the level of plasma β -hCG, which drops by half after each treatment.

Surgery has very specific indications depending on the stage of development and the condition of each patient. It remains indicated in the event of peritonitis, uncontrollable bleeding or drug resistance.^[4]

Post-treatment monitoring must be both clinical and paraclinical, essentially based on regular dosing of β -hCGs. effective contraception should be prescribed for at least one year.^[1,2] Any subsequent pregnancy should be considered at risk of developing a gestational trophoblastic tumor and therefore requires an ultrasound as soon as possible.^[5] recovery is defined by normalization of β -hCG levels for three consecutive weeks.

CONCLUSION

A good knowledge of this group of trophoblastic tumors and their affiliation also makes it possible to propose more coherent and adequate therapeutic protocols. Early management of gestational trophoblastic tumors makes it possible to detect low-risk forms, and therefore to have high efficacy with chemotherapy and to avoid resistance. The relative rarity of the condition and the complexity of treatment protocols make it necessary to create reference centers for the establishment of registers and for the consensual treatment of these tumors.^[4]

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