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Clinical Case Reports

Postpartum Secondary PPH Leading to Diagnosis of Choriocarcinoma: A Case Report

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Abstract

Summary: One uncommon but extremely aggressive kind of gestational trophoblastic neoplasia (GTN) is postpartum choriocarcinoma. Its clinical manifestation frequently resembles typical subsequent postpartum hemorrhage sources, which could impede identification and raise maternal morbidity.

Case Presentation:

A woman with a history of three prior cesarean sections appeared with recurring severe vaginal bleeding. Twelve days after an emergency cesarean delivery, Conservative management was started after an initial examination revealed retained products of conception. However, hypovolemic shock caused the patient's condition to worsen. Suspicion of GTN was raised by significantly high levels of β-human chorionic gonadotropin (β- hCG) in the serum and pelvic magnetic resonance imaging. An urgent surgical procedure was carried out since the bleeding was potentially fatal.

Keywords: Postpartum Hemorrhage, beta-Human Chorionic Gonadotropin, Cesarean Section, Choriocarcinoma, Gestational Trophoblastic Neoplasia

Introduction

Choriocarcinoma is one of the most aggressive types of gestational trophoblastic neoplasia (GTN), which is a spectrum of malignant trophoblastic diseases.[1] Due to its rarity, postpartum choriocarcinoma may initially resemble more frequent causes of subsequent postpartum hemorrhage (PPH), delaying identification.[2] This case emphasizes how crucial it is to raise suspicions as soon as possible when postpartum bleeding is unusual or prolonged.

Case Presentation

Twelve days following an emergency caesarean section, a 30-year-old lady, P3+0, who had three prior cesarean sections, began experiencing significant vaginal bleeding. Before experiencing two to three episodes of severe bleeding with clot passage during the next five days, she was well for the first fifteen postoperative days. She saw her treating physician on the twentieth postoperative day because she was still bleeding. She was actively bleeding but hemodynamically stable at the time of the initial assessment. She was given transaminic acid both orally and intravenously. She was prescribed misoprostol 200 µg TDS for seven days after a trans-abdominal ultrasound revealed the possibility of retained products of conception (RPOCs). She started taking misoprostol, but instead of getting better, her bleeding got much worse.

After that, she went to her obstetrician in hypovolemic shock, and prompt resuscitation was performed. Once more, a transvaginal ultrasound revealed a large postpartum uterus that raised the possibility of RPOCs. Doppler ultrasonography, conducted by a skilled radiologist, revealed no aberrant vascularity but did not reveal a distinct endomyometrial junction.

A significantly higher β-hCG level of 115,897 mIU/mL was found after additional testing. An MRI of the pelvis revealed a fluid-filled, enlarged endocervical canal with an ill-defined lobulated lesion affecting the anterior uterine wall. The findings were suggestive of an invasive mole or GTN and included subtle enhancement, invasion of the myometrium, loss of the junctional zone, and adjacent neovascularization. The patient experienced dizziness, sweating, pallor, hypotension (BP 90/60 mmHg), a weak pulse (110 bpm), chilly, clammy extremities, and sudden, profuse vaginal bleeding with clots on the third day of stay. For an urgent surgical procedure, she was taken to the operating room.

Hemoperitoneum was found to be between 100 and 200 mL. Both tubes and ovaries looked normal, and the uterus was the size of a 12-week gestation. Peritoneal washings were performed together with a complete abdominal hysterectomy, bilateral salpingo-oophorectomy (TAH+BSO), and infracolic omentectomy.

Histopathology:

A highly mitotic trophoblastic tumor made up of cytotrophoblasts, syncytiotrophoblasts, and intermediate trophoblasts with myometrial invasion, lymphovascular invasion, necrosis, and bleeding was visible under a microscope. There were no tumors in the omentum, ovaries, tubes, or cervix. The final diagnosis was uterine-confined gestational trophoblastic neoplasia, sometimes known as choriocarcinoma.

Follow-up: Beta HCG on 18th July 2024 came out to be 830miu/ml. Chronic carcinoma of Figo stage I with a scoring of 4 (low risk) was diagnosed, and the patient was referred to the oncology clinic for chemotherapy (methotrexate and folinic acid).

Contributions:
TF SE TK - Conception, Design
ZM SNM HB - Acquisition, Analysis, Interpretation
ZM SE TK SNM HB - Drafting
TF - Critical Review

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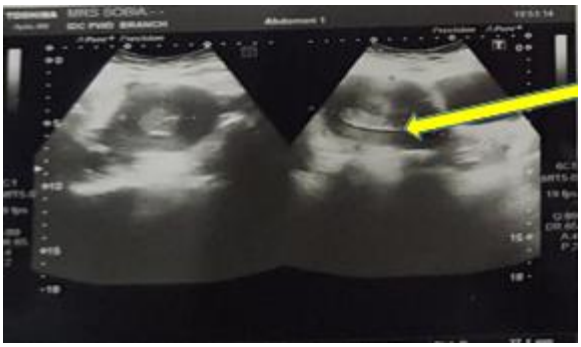

Figure 1: Heterogeneous lesion predominantly hyperechoic measuring 37x 31 mm

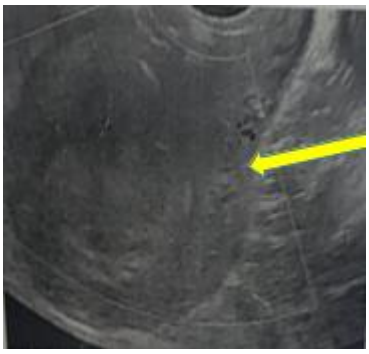

Figure 2: Cystic solid mass in endolumen

Discussion

Rare as it is, postpartum choriocarcinoma sometimes mimics common causes of secondary PPH, delaying diagnosis.[2,3] Since GTN can happen after any pregnancy event, including term birth or caesarean section, early β-hCG testing should be prompted if bleeding persists or gets worse despite treatment for suspected RPOCs. Although results may be nonspecific, imaging modalities such as Doppler ultrasound and MRI are essential for distinguishing RPOCs from GTN.[4] Since choriocarcinoma is extremely chemosensitive and has excellent results when treated promptly, early detection is essential. As demonstrated in this instance, where surgical intervention proved to be life-saving, failing to detect GTN may result in catastrophic bleeding.[5]

Conclusion

This case shows that GTN should be suspected in cases of chronic postpartum bleeding that do not respond to conventional treatment. It is essential to use sophisticated imaging and β-hCG for early assessment. In this instance, prompt diagnosis and surgical intervention saved lives. Even though it is uncommon, postpartum choriocarcinoma needs to be considered when making a differential diagnosis for subsequent PPH.

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