

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

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Abstract

Summary: Postpartum choriocarcinoma is an uncommon but extremely aggressive gestational trophoblastic neoplasia (GTN) is postpartum choriocarcinoma. Its clinical manifestations frequently resemble those of typical subsequent postpartum haemorrhage sources, which can impede identification and increase maternal morbidity.

Case Presentation:

A woman with a history of three prior caesarean sections presented with recurring severe vaginal bleeding. Conservative management was initiated 12 days after an emergency caesarean delivery when an initial examination revealed retained products of conception. However, hypovolemic shock worsened the patient's condition. 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 performed because 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), a spectrum of malignant trophoblastic diseases.¹ Due to its rarity, postpartum choriocarcinoma may initially resemble more frequent causes of subsequent postpartum haemorrhage (PPH), delaying its identification.² This case emphasises the importance of raising suspicion as soon as possible when postpartum bleeding is unusual or prolonged.

Case Presentation

Twelve days following an emergency caesarean section, a 30-year-old woman, P3+0, who had three prior caesarean 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 15 postoperative days.

She visited her treating physician on the twentieth postoperative day because she was still bleeding. She was actively bleeding but was haemodynamically stable at the time of the initial assessment. She was administered tranexamic acid both orally and intravenously. She was prescribed misoprostol 200 μ g TDS for seven days after a transabdominal ultrasound revealed the possibility of retained products of conception (RPOCs). She started taking misoprostol, but instead of getting better, her bleeding worsened. She subsequently presented to her obstetrician in hypovolemic shock, and prompt resuscitation was performed. A transvaginal ultrasound revealed a large postpartum uterus, raising the possibility of RPOCs. Doppler ultrasonography, conducted by a skilled radiologist, revealed no aberrant vascularity and no distinct endomyometrial junction.

Additional testing revealed a significantly higher β -hCG level of 115,897 mIU/mL. Pelvic MRI revealed a fluid-filled, enlarged endocervical canal with an ill-defined lobulated lesion affecting the anterior uterine wall. The findings suggestive of an invasive mole or GTN included subtle enhancement, myometrial invasion, 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 admission. The patient was taken to the operating room for an urgent surgical procedure.

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

Histopathology:

A highly mitotic trophoblastic tumour composed of cytotrophoblasts, syncytiotrophoblasts, and intermediate trophoblasts with myometrial invasion, lymphovascular invasion, necrosis, and bleeding was observed under a microscope. No tumours were observed in the omentum, ovaries, tubes, or cervix. The final diagnosis was uterine-confined gestational trophoblastic neoplasia, also known as choriocarcinoma.

Follow-up: Beta HCG on 18th July 2024 was 830 mIU/ml. Chronic carcinoma of Figo stage I with a score 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

All authors approved the final version to be published & agreed to be accountable for all aspects of the work.

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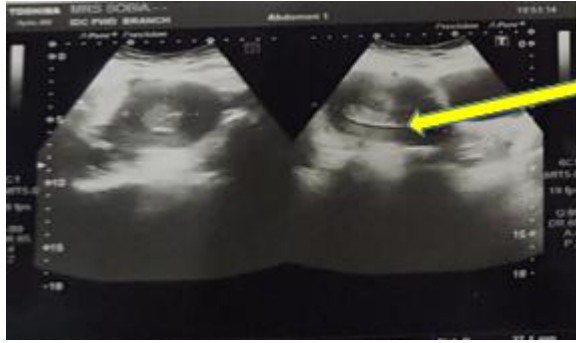


Figure 1: Heterogeneous lesion predominantly hyperechoic measuring 37x 31 mm

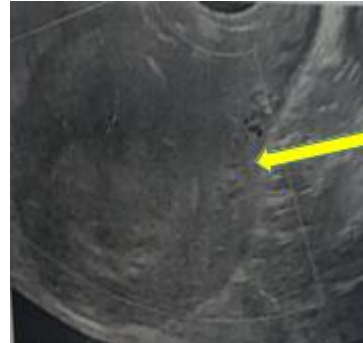


Figure 2: Cystic solid mass in endolumen

Discussion

Rare as it is, postpartum choriocarcinoma sometimes mimics common causes of secondary PPH, delaying diagnosis.^{2,3} Since GTN can occur after any pregnancy event, including term birth or caesarean section, early β -hCG testing should be performed if bleeding persists or worsens despite treatment for suspected RPOCs. Although the 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, failure to detect GTN may result in catastrophic bleeding.⁵

Conclusion

This case highlights that GTN should be to suspect GTN in cases of chronic postpartum bleeding that do not respond to conventional treatment. Sophisticated imaging and β -hCG are essential for early assessment. In this instance, prompt diagnosis and surgical intervention saved the patient's life. Although uncommon, postpartum choriocarcinoma should be considered in the differential diagnosis of subsequent PPH.

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