Metastatic Choriocarcinoma: An Unusual Cause of Severe Anaemia

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A thirty-year-old married female presented with complaints of generalised weakness, easy fatiguability, giddiness, breathlessness and palpitations for 15 days. There was no fever, jaundice, or bleeding from any site. On examination, it was found that she had severe pallor and was afebrile. Her blood pressure was 130/80 mm Hg. The pulse and respiratory rates were 80 and 22 per minute, respectively. Systemic examination was normal; there was no hepatosplenomegaly or lymphadenopathy. She had two children. She had also had a previous abortion. She mentioned a history of menorrhagia seven months prior to her visit. She had taken treatment and responded to it, but details of the treatment were not available. Her present menstrual pattern was normal.

Haematological investigations revealed haemoglobin of 3.2 gm%; packed cell volume of 12%, total leukocyte count of 6,100/cmm and platelet count of 160,000/cmm. Red blood cell morphology on peripheral smear examination showed a severe degree of hypochromasia and microcytosis and mild macrocytosis, poikilocytosis and anisocytosis. Fasting blood sugar and blood urea nitrogen were found to be normal. The provisional clinical diagnosis of her ailment/condition was severe nutritional anaemia and she was investigated further in that direction. The ultrasonography report of the abdomen was normal. Upper gastrointestinal endoscopy showed normal stomach and duodenum. Three days after admission, she complained of passing dark coloured formed stools. On the fifth day, her condition worsened suddenly and despite all resuscitative measures, she succumbed.

A complete autopsy was performed. Apart from the severe pallor observed externally, in situ examination too showed that all organs were pale. On systemic examination, ileum and descending colon both revealed sessile polyoidal masses measuring 1.5 cm. with haemorrhagic and necrotic cut surface; the serosal aspects were smooth [Figure 1]. The colon contained fresh blood. Sub-pleural haemorrhagic and necrotic nodular masses were present in the basal lobes of both lungs (left, four and right, two). Tracheo-bronchial lymph nodes were enlarged and had similar cut surfaces. Liver, pancreas and right kidney also revealed similar nodules. Uterus and cervix were cut longitudinally and serially at 0.5 cm interval but did not reveal any tumour. The vagina was unremarkable. The ovaries showed four corpus luteal cysts measuring 3 mm to 5 mm. There was no similar nodular lesion. Histopathological examination of all nodules showed sheets of malignant cytotrophoblasts and syncytiotrophoblasts invading surrounding tissue and admixed...
with extensive areas of necrosis and haemorrhage [Figure 2]. Hence the diagnosis of metastatic choriocarcinoma was considered with cause of death being gastrointestinal blood loss.

**Discussion**

Choriocarcinoma is a highly malignant epithelial tumour arising from the trophoblastic tissue of any gestational event, most often a hydatidiform mole. Choriocarcinoma is suspected when there is abnormal uterine bleeding following an abortion or hydatidiform mole. This is one of the most frequent presentations of choriocarcinoma.

Not all patients have a demonstrable lesion in the uterus after an intrauterine gestation or in the gonads, and at times, symptoms related to the metastasis are the first presentation. Metastasis of choriocarcinoma occurs most frequently in the lungs, brain and liver. The gastrointestinal tract can also be affected. To date, there are about 15 reports of metastatic choriocarcinoma affecting the gastrointestinal tract. It can present as in the form of upper gastrointestinal bleeding, intussusception, ileal perforation or rectal bleeding.\(^1\)\(^\text{-}^4\) A survey of literature did not show any report of a metastatic choriocarcinoma presenting as polypoidal masses in the small intestine and colon with complaints of unexplained severe anaemia as it did in the present case. However, there are few reports of testicular choriocarcinoma presenting as polypoidal gastric lesion and occult gastrointestinal blood loss.\(^5\)\(^,\)\(^6\)

We report a case whose chief manifestation at the time of admission was unexplained severe anaemia and there was no complaint of bleeding from any site.

**References**

1. Shroff CP, Roy S, Nanivadekar SA, Deodhar KP. Choriocarcinoma presenting as acute abdomen. Indian J Gastroenterol 1985;4:103-4