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Case Report

Metastatic Vulvo-Vaginal Choriocarcinoma Mimicking a Vulvar Hematoma: A Case Report

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Introduction

Choriocarcinoma, included in gestational trophoblastic neoplasms, is a tumor with high malignant potential [1]. Next to the lung, vulvo-vaginal metastasis comprises 30% of all metastatic incidences in choriocarcinoma. Metastasis in this region is often misleading in its initial appearance. Recent onset vulvo-vaginal swelling may be the sole clinical presentation, as sometimes-antecedent pregnancy remains uninformative [2]. We report a case of metastatic choriocarcinoma who presented as a case of vulvar hematoma.

Case Presentation

A 16 years-old abortion-I lady presented with a history of vulvar swelling of one week duration following a fall down accident-she fall down on the left side of her body. She had abortion three months back and she had history of intermittent vaginal bleeding of two months duration. Up on evaluation at presentation, she had tachycardia of 120 beats per minute and she was clinically pale otherwise her blood pressure was normal. Up on pelvic physical examination, there was 4 by 4 centimeters tender vulvar mass on the right side. Her CBC profile showed a hemoglobin of 5.5g/dl.

With the assessment of vulvar hematoma secondary to trauma, she was admitted to gynecology ward and transfused with two units of whole blood. The plan was to evacuate hematoma if there was further expansion. Meanwhile, her serum beta hCG was determined and it was 156,000 and a diagnosis of metastatic gestational neoplasia was considered. She was transfused with two more units of blood. She was put on follow up to start chemotherapy. Unfortunately, patient was lost from her follow appointment to start chemotherapy for unknown reason and never came back again.

Discussion

Approximately 30% cases of CC have metastatic disease at the time of diagnosis. Lungs (80%) are the most common site of metastasis, followed by vagina (30%) and liver (10%). Metastatic CC involves the brain in 3e28% of patients [3].

The clinical presentation of Choriocarcinoma (CC) is so much varied that every case may be one of its kinds and thus can be a diagnostic challenge. Early diagnosis and prompt initiation of chemotherapy is a well-known determinant of prognosis of CC. A knowledge regarding the variations from its classic clinical presentation is, therefore, a must to any practicing clinician [4]. Our case presented as a case of vulvar hematoma following a fall-down accident. Vulvo-vaginal metastasis of trophoblastic tumour may occur even after first trimester loss. Gary L Goldberg in omit similar study showed that, out of five cases of vulvo-vaginal metastasis, two developed following spontaneous abortion [5].

As choriocarcinoma metastatic sites are hypervascular in nature, any local surgical intervention may precipitate life-threatening hemorrhage. Essentially, diagnosis of metastatic choriocarcinoma is based on history, clinical presentation and allied elevated serum β-HCG titer. Biopsy from the local metastatic sites is not mandatory for the diagnosis [6]. Biopsy was not taken in our case. The friable and hypervascular nature of a metastatic lesion places the patient at risk for significant hemorrhage. The chief treatment for vaginal metastasis is still chemotherapy. Moreover, local infusion of 5-Fu, gauze packing, and selected angiographic embolization developed in recent years have been adopted as successful methods for treating vaginal metastasis [7].

Conclusion

In any vulvar hematoma presentation, in the absence of a recent vaginal delivery or instrumental delivery or a straddle type of fall-down accident, the possibility of vulvo-vaginal metastatic GTN should be considered. Care should be taken not to attempt to evacuate hematoma unless the diagnosis of CC is ruled out.

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