

PRIMARY NON-GESTATIONAL UTERINE CHORIOCARCINOMA MIMICKING LEIOMYOMA IN A POSTMENOPAUSAL WOMAN: AN UNUSUAL CASE REPORTHaruna Usman¹ Abdullahi Muhammad Ahamad² Usman Abba³¹Department of Obstetrics and Gynecology Rasheed Shekoni Federal University Teaching Hospital Dutse- Nigeria²Department of pathology, Bayero University Kano/Aminu kano Teaching Hospital, Kano-Nigeria³Department of Obstetrics and Gynecology, Yobe State University Damaturu-Nigeria**Corresponding Author:** *Usman Abba*, Email: usmanabbagdm@gmail.com

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Abstract**Background:** Gestational trophoblastic neoplasia (GTN) is a rare cause of postmenopausal bleeding that can be easily missed, leading to delayed treatment.**Case report:** We report a 50-year-old postmenopausal woman, 9 years after menopause and last delivery, who presented with 7 months of recurrent vaginal bleeding and anemia requiring 5 units of blood transfusion. Intraoperative findings revealed a bulky uterus with necrotic bleeding lesions and hemoperitoneum. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed, and histopathology confirmed GTN.**Conclusion:** This case underscores the need for a high index of suspicion for GTN in women with abnormal uterine bleeding regardless of menopausal status. Early use of beta-hCG testing can reduce diagnostic delays and enable prompt treatment, especially in resource-limited settings.**Cite this article:** Haruna Usman¹ Abdullahi Muhammad Ahamad² Usman Abba³. Primary non-gestational uterine choriocarcinoma mimicking leiomyoma in a postmenopausal woman: an unusual case report. Yob Med J.2025;2(1):66-69

Introduction

Gestational trophoblastic neoplasia encompasses a diverse group of interrelated but distinct tumors that include choriocarcinomas, placental-site trophoblastic tumors, and epithelioid trophoblastic tumors¹

Choriocarcinoma is classified into two types depending on the pathogenetic mechanisms underlying it. Gestational Choriocarcinoma (GC) has an antecedent history of pregnancy, abortion or a hydatidiform mole, and therefore has both paternal and maternal DNA. Non-gestational Choriocarcinoma (NGC) is much rare compared to gestational Choriocarcinoma. NGC is not linked to any form of pregnancy and is the rarer subtype, originates from trophoblastic differentiation of germ cell tumors in the gonads or as a somatic component of another histologically different tumor such as teratoma, yolk sac tumor, embryonal carcinoma, and endometrioid adenocarcinoma hence, non-gestational choriocarcinoma contains only the patient's genetic material^{2 3}.

The occurrence of NGC in the ovary has been well documented. However, its occurrence in postmenopausal uterus is rare.⁴

The clinical features and prognosis of gestational and NG Choriocarcinoma are very different. Therefore, it is imperative to be able to make the distinction.

In this case report, we document a case of post-menopausal woman who presented with abnormal vaginal bleeding, that was subsequently diagnosed as NGC.

Case Report

We present a 50-year-old postmenopausal woman whose last menstrual period was 9 years ago that presented with an abnormal vaginal bleeding of 7 months. Her last childbirth was also 9 years ago. The vaginal bleeding was recurrent with passage of clots, but there was no history of passage of vesicles. She has been transfused with five pints of blood over the past seven months. There was history of abdominal pain and dizziness, but no history of syncopal attacks. Abdominal examination revealed uterine size of 24 weeks gestation, nodular and firm in

consistency. Pelvic examination revealed blood-Smeared female external genitalia. There were vaginal and suburethral haemorrhagic deposits measuring about 1.5x1.5cm, 1 x 1cm and 0.5cm x 0.5cm. Abdominopelvic ultrasound scan revealed a bulky uterus with anteroposterior diameter of 64mm. There were fairly oval shaped mixed echogenic masses in the posterior uterine wall measuring 65 x 43mm and similar mass measuring 39mm x35mm in the cervical region all consistent with huge solitary uterine and cervical fibroids. Colposcopy revealed type II transformation zone with atypical vascular pattern. No aceto-whitening, but poor iodine uptake.

A provisional clinical diagnosis of Uterine leiomyoma was made.

She underwent a total abdominal hysterectomy with bilateral salpingoophorectomy. Intraoperatively, there was 1 liter of hemoperitoneum with a bulky uterus to the size of a 24-week pregnancy, doughy in consistency with multiple cystic nodules and large necrotic area on the fundus oozing blood with bowel attached to it. No obvious metastatic deposit seen in the peritoneal cavity, both ovaries were atrophied. The specimen was sent to the Pathology department for histopathologic analysis.

The specimen received was an enlarged and distorted uterus with salpingo-oophorectomy measuring 17 x 16x 9 cm and weighed 820g. There was a rupture at the apex 10cm across. Cut section shows a huge submucous mass with ulcerated surfaces protruding into the endometrial cavity. The tumor has necrotic to grayish white hemorrhagic surfaces which were extensively sampled. Histological sections showed a predominantly hemorrhagic areas with sheets of syncytiotrophoblasts and cytotrophoblast cells having pleomorphic and hyperchromatic nuclei. Several areas of infiltration into the myometrium were also seen. (Figures 1 and 2) Given the histologic features as well as the increased beta human chorionic gonadotrophin (beta- HCG) level of 346,231mIU/ml, a diagnosis of Non

gestational Choriocarcinoma was made. The patient was being optimized for commencement of chemotherapy, when her condition deteriorated and she started having irrational talks and became delirious. She passed away on the fourteenth post-operative day.

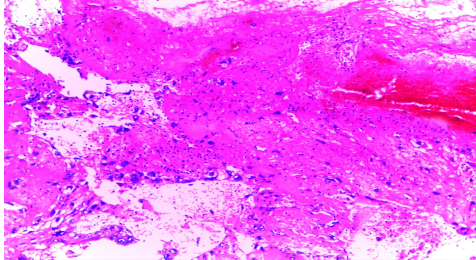


Figure 1 Section shows predominantly areas of hemorrhage and necrosis (Hematoxylin and Eosin X100)

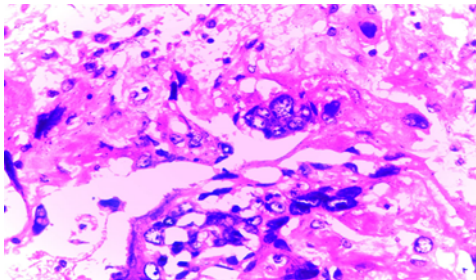


Figure 2 Clusters of malignant cells disposed singly and in a syncytium. The cells have pleomorphic and occasional hyperchromatic nuclei with moderate to abundant cytoplasm (A), Similar malignant cells are seen infiltrating into the myometrial fibers. (B) (Hematoxylin and Eosin X400)

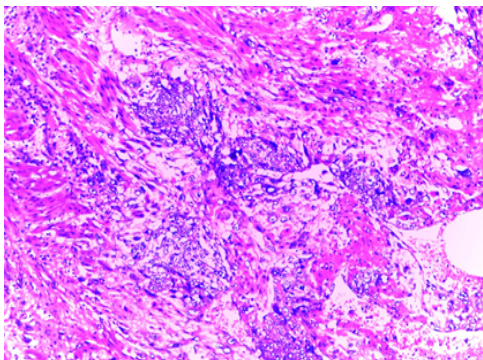


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Discussion

In this case report, the presentation of the postmenopausal woman with abnormal vaginal bleeding and the finding a uterine mass led to the presumptive diagnosis of uterine leiomyoma. This is not unusual given the fact that most patients with uterine leiomyoma have similar presentation. The other possible differential diagnosis of an endometrial cancer was not considered due to absence of endometrial thickening on the ultrasound scan. The diagnosis of a choriocarcinoma was only considered after the specimen was sent for histopathological analysis and histologic features consistent with choriocarcinoma were observed. It was this initial observation that prompted the request to review the presumptive clinical diagnosis by assaying serum beta HCG level. However, being a postmenopausal woman this finding was consistent with that of Wang and Hirata but contrary to the findings by Sano where the reported case was that of a premenopausal woman^{1,6,7}. GCC arises from chorionic cells from a previous pregnancy. NGCC, however, arises from pluripotent germ cells or originates from poorly differentiated somatic carcinomas⁷. Primary uterine non gestational choriocarcinoma is characterized by abnormal uterine bleeding, suprapubic swelling and pain this was corroborated by another researcher⁶. This presentation made the diagnosis very difficult and diagnosis of leiomyoma was entertained. Patient later deteriorated exhibiting some neuropsychiatric symptoms, this may not be unconnected to likely brain metastasis. This presentation was the reason why serum beta HCG level was not requested for until after the histopathological diagnosis. The diagnostic dilemma was the reason why chemotherapy was not commenced till the demise of the patient. Had the serum level of beta HCG was determined earlier this index case would have salvaged however, there was no justification to have assayed the Serum beta HCG prior to histopathological finding. Similar case was reported by Sano et. al but that case was in a premenopausal woman.

There were few case reports of primary non gestational choriocarcinoma exhibiting myoma symptomatology^{1,6,7}.

Conclusively it was a difficult experience managing such a patient with diagnostic dilemma leading to delays in commencing appropriate treatment for the patient especially in resource constraint setting. Therefore, high index of suspicion can go a long way in assisting the managing physician to request for appropriate investigations and commence appropriate treatment promptly.

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