CHORIONEPITHELIOMA OF THE JEJUNUM

A. L. SORESE, M.D.

(From the Greenpoint Hospital, Brooklyn, N. Y.)

Chorionepitheliomas have been reported in patients from seven to seventy years of age. Primary ectopic chorionepithelioma has been described in the broad ligament, fallopian tubes, and vagina. In other recorded cases lesions have been found in the liver, lungs, ovaries, and brain, without the presence of a primary uterine tumor. Primary chorionepithelioma of the jejunum is rare, only one case having been discovered in the literature, that of Sears (1933).1

Sears suggests four possible explanations for the tumor in his case. (1) It may have originated as part of a teratoma of the ovary or liver, metastasizing to the jejunum. (2) It may have originated in connection with an ovarian pregnancy. (3) It may have arisen from malignant degeneration of trophoblastic emboli. (4) It may have been that a uterine chorionepithelioma was the primary lesion and that this healed spontaneously or disappeared as the result of expulsion or curettage, while the metastatic lesion ultimately killed the patient. This last explanation he believed was the most probable.

For the case reported below we are inclined to accept Sears' third explanation as the correct one, i.e., that the tumor was due to a deposit of trophoblastic emboli which had undergone malignant change, penetrated the maternal vessels, and lodged in the jejunum.

CASE REPORT

M. S., a forty-nine-year-old Russian housewife, was admitted to the Gynecological Service of Greenpoint Hospital on Sept. 1, 1934. Her complaints upon admission were irregularity of menstruation of two years' duration and continuous profuse vaginal bleeding, with the passage of clots, for the past two weeks.

The family history and past personal history were negative. Menstruation had begun at thirteen years of age, and had been regular until two years prior to admission. Since that time it had occurred every three, four, or five months instead of monthly. The patient had had eight normal pregnancies, remaining in bed five to six days post partum in each case. She had had one miscarriage about five years before admission, following the birth of the eight children. The cause of this miscarriage and the month of gestation could not be ascertained.

The patient was obese and did not appear acutely or chronically ill. Vaginal examination revealed a parous outlet and a relaxed pelvic floor. The fundus was enlarged to the size of a three months' pregnancy, was freely movable and irregular in outline. The cervix was open and a bloody vaginal discharge was present. A diagnosis of fibromyoma uteri was made and a curettage advised.

Pathological examination of the specimen obtained by curettage revealed several small, irregular friable fragments of tissue with no gross organ morphology. Microscopic examination showed shreds of endometrium and blood clot. There was no conclusive evidence of glandular hyperplasia or malignancy. The stroma contained numerous plasma cells and was loose and edematous. One small shred showed a scraping from the cervical area with hyper-

1 Ann. Surg. 97: 910, 1933. Sears includes a bibliography of ectopic chorionepithelioma.
plastic glands but no evidence of malignancy. No tissue of pregnancy was identified, nor was there any direct evidence of fibromyomatous tissue.

The pathological diagnosis was chronic interstitial endometritis and chronic cervicitis. The patient was re-admitted on April 8, 1935, complaining of vaginal bleeding. She stated that she had a period of amenorrhea following her discharge from the hospital, which lasted until ten days prior to this admission. Since that time bleeding had been continuous. Three days after it began frequency of urination developed and bleeding was associated with voiding. No clots were noticed. The patient complained of a sense of weakness, but there was no abdominal pain nor were any other symptoms present.

The red blood count was 4,650,000; hemoglobin 90 per cent (Sahli); white blood count 5800, with 78 per cent polymorphonuclears and 22 per cent lymphocytes. The urine showed a slight trace of albumin with 1 to 2 blood cells per high-power field. The sedimentation time was seventy-five minutes; the blood urea was 45 mg. per 100 c.c. of blood. The Wassermann and Kahn reactions were negative.

Vaginal examination revealed a parous outlet. The cervix was in the axis of the vagina, the uterus much enlarged and irregular in outline. No masses were palpable in either fornix and there was a moderate bloody vaginal discharge. The clinical diagnosis was adenomyosis uteri, and removal of the uterus was advised.

A supracervical panhysterectomy was performed April 12, under general anesthesia. The uterus was found to be twice the normal size; the walls were thickened and the vessels sclerotic. The endometrium appeared normal, and the tubes were normal and dark in color. The left ovary contained corpus luteum hemorrhages. The ovaries were one quarter the normal size, measuring 1/2 inch in length; both had an oyster shell surface. The report on the operative specimen was as follows:

**Gross examination:** A previously sectioned supracervical mass of uterus and attached adnexa. The uterine mass measured 9 X 7 X 4.5 cm. Further section presents a diffuse interstitial fibrosis showing typical whorls of fibromyoma. The endometrium is not grossly remarkable. Both ovaries show marked stromal fibrosis, and the right ovary shows the remains of follicular cysts. Except for peritubal moderate fibrosis the tubes show nothing grossly remarkable. The left tube shows a small hydatid of Morgagni. There is no conclusive evidence of malignant neoplasia.

**Microscopic Examination:** Sections include fibromyoma of uterus and uterine walls with no evidence of epithelial malignancy. The fallopian tubes show limited edema and focal chronic inflammatory cellular infiltration.

The pathological diagnosis was fibromyoma uteri and chronic salpingitis.

The postoperative course was uneventful and the patient was discharged April 28, in good condition.

The patient was not seen again until Sept. 4, 1935, when she was readmitted to Greenpoint Hospital, this time on the medical service of Dr. J. Steele, complaining of marked weakness of three weeks' duration and the passage of bloody stools for one week.

Nine days before admission she had taken a laxative and then noticed a black bowel movement. Following this all the patient's stools were black in color except on one occasion, when a slight amount of bright red blood was noticed. There were on the average two bowel movements daily. There was no abdominal pain, diarrhea, or vomiting. Prior to this time no bright red blood or black stools had been noticed. The patient had become progressively weaker during the past three weeks and had been confined to bed for a week before entering the hospital.

On examination she appeared acutely ill, with marked pallor of the skin and mucous membranes, and extreme weakness. The heart and lungs were essentially normal.

The red blood count was 1,490,000; hemoglobin 23 per cent; white blood count 13,400, with 90 per cent polymorphonuclears and 10 per cent lymphocytes. The urine was essentially negative. The stool contained occult blood, 4+. Blood urea was 28 mg. per 100 c.c. of blood. The Wassermann and Kline reactions were negative.

In view of the lack of physical findings and history of tarry stools later becoming bright red, the following possibilities were considered: hemorrhage into the gastro-intestinal tract due to malignancy in the sigmoid, a bleeding duodenal ulcer, and bleeding internal hemorrhoids.
FIGS. 1 AND 2. CHORIONEPITHELIOMA OF THE JEJUNUM
Five blood transfusions were given in the period from Sept. 5 to Sept. 13, 1935, the patient receiving 3100 c.c. of whole blood. Following each transfusion she passed a large amount of bright red blood per rectum.

A barium enema, on Sept. 10, showed a filling of the entire colon. No obstructive lesion was demonstrable. There was a small area of irregular filling at the outer aspect of the ascending colon, possibly due to adhesions or to a small neoplasm in that area.

The patient was then transferred to the Surgical Service of Dr. A. L. Soresi, who on Sept. 17, 1935, performed an exploratory laparotomy. The cecum was found to be dilated with old blood; the ileum also showed the presence of blood. A small bluish mass was noticed in the jejunum with a dimple on the serous surface. Adhesions were freed around the cecum, ascending and transverse colon. The portion of the jejunum including the mass was resected and an oblique anastomosis performed.

The pathological report was as follows:

**Gross Examination:** The specimen consists of a contracted segment of small gut measuring 4 cm. in length, with 3 cm. of fatty mesentery attached. The external surface shows some dullness with some thickening of the serosa. The valvulae conniventes are distinct. Projecting from the wall in the region of the submucosa and muscular coat, with complete ulceration, is a small mass measuring 1.7 × 1.5 cm. This mass shows a hemorrhagic surface on section and in the region of the ulceration. The mucosal edges are not elevated. Some opaque tissue occurs toward the base.

**Microscopic Examination:** Sections show wide areas of hemorrhage and numerous areas of small polyhedral almost cuboidal vesicular cells and large irregular hypertrophic cells with basophilic cytoplasm and in some areas resemblance to syncytium. Mitotic figures can be made out in Langerhans' epithelial cell groups. Some of the polyhedral massive cells resemble decidual cell elements.

The pathological diagnosis was chorionepithelioma of the jejunum with metastases.

The postoperative course was stormy and the patient died Sept. 20, 1935.