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Case Report

Large Symptomatic Chorioangioma of Placenta; A Rare Complication of Pregnancy in Enugu, South East Nigeria

Abstract

Chorioangioma is the most common non trophoblastic tumour of the placenta which can result to severe pregnancy complications with attendant maternal and fetal morbidity and mortality [1]. Most cases of chorioangiomas are small, microscopic and of no clinical important [2,3]. We present the very first case of large symptomatic chorioangioma managed successfully in University of Nigeria Teaching Hospital Enugu.

The patient was referred to the University of Nigeria Teaching Hospital Enugu on account of suspected symptomatic chorioangioma, at a gestational age of 32 weeks. She was managed conservatively and had elective caesarean section at 36 weeks' gestation with good outcome. There was a large solid and cystic lesion on the placenta measuring 8cm x10cm. Histological diagnosis of chorioangioma of capillary type was made.

Case Report

This was a case of a 29 year old multigravida who was referred from a private specialist hospital to University of Nigeria Teaching Hospital Enugu on account of abdominal distension and ultrasound diagnosis of polyhydramnios and chorioangioma at gestational age of 32 weeks. She booked for antenatal care in the specialist hospital. At gestational age of 32 weeks, she complained of abdominal distention. An obstetric ultrasound done reported a large chorioangioma with co-existing polyhydramnios. She was subsequently referred to University of Nigeria Teaching Hospital Enugu for expect management. She was seen in antenatal clinic of University of Nigeria teaching hospital at gestational age of 32 weeks and 4 days. She was re-evaluated. The fundal height was not compatible with the gestational age. Fasting blood sugar and two hours post prandial done were normal. Neither structural abnormalities nor fetal hydrop was reported in the scan. The amniotic fluid index was 38.8cm and a well defined heterogenic mass measuring 11cm by 6 cm in the placenta was seen. She was counselled on her condition and commenced on daily fetal kick chart and twice weekly cardiotocograph. She had elective caesarean section at 36 weeks and was delivered of a live female baby that weighed 3.0kilogrammes with Apgar score of 9 in first minute and 10 in fifth minute. The placenta was sent for histological examination. Macroscopically, the placenta measured 23x13cm and weighed 1000g. There was a large solid and cystic lesion on the placenta measuring 8x10cm. Histological diagnosis of chorioangioma of capillary type was made. Baby was certified by the neonatologist to be normal and was discharged same day to the mother. Patient was discharged on 5th post operative day with good outcome (Figures 1-4).

Discussionss

Chorioangiomas are rare benign tumor of placenta [4]. It

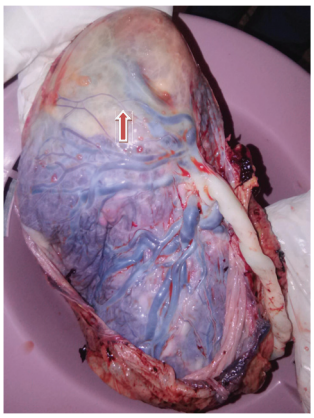

Figure 1: Showing solid and cystic components of the placenta.

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has variable presentations and can result to severe pregnancy complications with attendant maternal and fetal morbidity and mortality. However, most of the cases are asymptomatic and are usually diagnosed postnatally following routine histological examination of placenta. Its risk factors include Diabetes mellitus, maternal age, primigravida, multiple pregnancies, female sex of newborn and hypertension. The maternal complications include polyhydramnios and preeclampsia while the fetal complications are intrauterine growth restriction, thrombocytopenia, fetal hydrops, congestive heart failure, prematurity, preterm birth, abruptio placenta, sudden fetal death, microangiopathic hemolytic anemia and neonatal death [5]. Our patient presented with polyhydramnois but the baby was clinically normal.

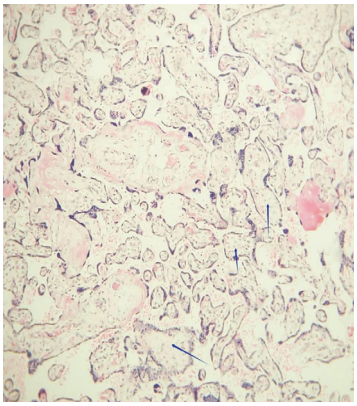

Figure 2: Showing histology slides of placenta with the arrows pointing to the chorionic villi.

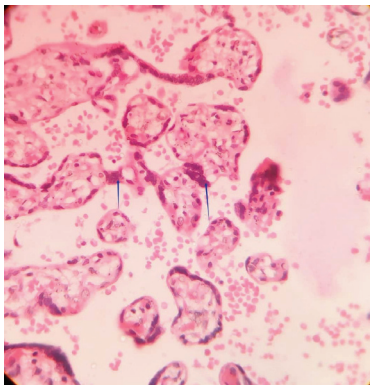

Figure 3: Showing histology slides of placenta with the arrows pointing to trophoblastic proliferation.

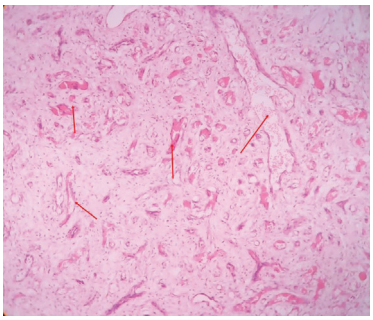

Figure 4: Showing histology slides of the placenta with the arrows pointing to blood vessels of varying sizes, some are dilated.

Doppler ultrasound is the gold standard for diagnosis of chorioangioma. Abnormality like increased liquor volume, alpha-fetoprotein and beta HCG may arouse suspicion [6]. Intense vascularity on Doppler ultrasound is a pointer towards increased fetal complication. In the case presented, the placental tumour was diagnosed sonographically during searches for causes of polyhydramnios in a patient with abdominal distension.

Management of chorioangioma is usually conservative in mild to moderate type as was done for this case under review. For severe cases, prenatal treatment by ultrasound guided interstitial laser therapy and in-utero endoscopic devascularization may be done. In-utero blood transfusion to correct fetal anemia has also be done with good outcome. Also alcohol injection, or microcoil embolization of feeding vessels can be done in cases with fetal complication such as hydrops. Maternal indomethacin therapy or amniocentesis is useful in management of polyhydramnios. Steroid administration for fetal lung maturity before 34 weeks is indicated. If complications appear late in pregnancy delivery is the option of management [7].

Conclusion

Large chorioangioma with polyhydramnios is a rare complication of pregnancy in our environment that causes increased maternal and fetal morbidity and mortality. High index of suspicion, fetal surveillance and delivery after fetal maturity are associated with good outcome.

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