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Case Report

Invasive molar pregnancy: A case report

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Abstract

Gestational trophoblastic disease encompasses several entities like complete mole, partial mole, invasive mole, gestational trophoblastic carcinoma and trophoblastic carcinoma from implantation site. These entities are different from each other by their origin, morphology, their evolution and their treatment. Invasive mole commonly result from complete hydatidiform mole but may do so from partial hydatidiform mole. It does not often progress to choriocarcinoma. It may metastasize but does exhibit progression to true cancer. 10-15% of complete mole can develop into invasive mole. This is one of the important causative factors of miscarriages. Very rarely (2-4%) partial mole can develop into invasive one presenting with features of incomplete abortion, missed abortion and sometimes as obstetric emergencies like intraperitoneal hemorrhage and torrential vaginal bleeding. So, proper diagnosis and timely intervention can prevent mortality and reduce morbidity of the patients. Here we report a case of invasive molar pregnancy with varied picture.

Key words: Molar pregnancy, Hydatidiform, Gestational trophoblastic neoplasms (GTN).

Introduction

Molar pregnancy is characterized histologically by abnormalities of chorionic villi consisting of varying degrees of trophoblastic proliferation and oedema of villous stroma. It has been classified into complete and partial mole according to the absence or presence of fetal or embryonic elements. Some of these molar pregnancies fail to regress following primary treatment and result in gestational trophoblastic tumors which can be invasive mole, choriocarcinoma, persistent trophoblastic tumor and placental site trophoblastic tumor.[1] Complete hydatidiform mole is less likely than a partial mole transforms into malignant disease after treatment. But 2 to 4% of women with partial molar pregnancies may develop complication like invasive mole or choriocarcinoma.[2,3] Here we report such a rare case of invasive molar pregnancy presenting with long standing amenorrhoea in perimenopausal woman and eventually development of excessive nausia, vomiting for 3 months and mild lower abdominal pain for last 1 week.

Case report

A woman of 45 years old house wife, mother of 4 child reported on 4th Octobar 2016 complaining amenorrhoea for 1 year, exessive nausea and vomiting for 12 weeks and pain in the lower abdomen associated with slight vaginal bleeding for last 1 week. She was regularly menstruating women with average flow and duration for last one year She had no contraceptive practice within 1 year. She got admitted in hospital for amenorrhoea, excessive nausea and vomiting and lower abdominal pain. Her pregnancy test was positive. Vomiting was commonly occur after meal. Vomitus was dark brown in colour. She also complained dull aching pain in lower abdomen

and generalized body weekness for last 7 days. She had no privious history of molar pregnancy. She has no hostory of caugh, breathlessness, headache, blurring of vission. On admission her vital sign and general condition were- moderately anaemic, pulse rate was 90 beats/minute, respiratory rate was 16 breaths/minute, blood pressure was 100/60 mmHg and her respiratory-cardiovuscular system revealed no abnormality. On abdominal examination there was no mass but there was tenderness over hypogastrium. Perspeculum examination- cervix was healthy, no abnormal growth in vulva and vagina. Bimanual examination revealed uterus was 10 week size and a cystic mass felt through the left lateral fornix. Internal os admitted tip of the finger, bleeding was present. Her baseline investigations showed hemoglobin 7gm/dl, blood grouping and Rh typing B positive. Urine for R/M/E was normal, blood sugar, liver function tests, renal function tests all were within normal limit. The striking rise of serum β-HCG was 2,75,000 miu/ml. Left ovary showed corpus luteal cyst on USG. USG of pelvic organs also revealed bulky uterus size about 12X 7.2X 3,8 cm and it contains ecogenic material with intervening cystic space giving rise to snow storm appearance, Hypoechoic mass also found within the myometrium. It suggested the provisional diagnosis contained invasive mole. After anesthetic fitness total abdominal hysterectomy was done on 10.01.2017 and specimen sent for histophatological examination. The gross appearance of bisected uterus showed grapelike mass inside the endometrial cavity and necrotic mass was penetrating the myometrium. Microscopically the wall of the uterus was invaded by large chorionic villi showing hydropic change. Histopathology confirmed the presence of invasive mole. Preoperative, peroperative and postoperatively she received 5 units blood transfusion and other supportive measurements. Recovery was uneventful. Her serum β-HCG level was estimated 24 hours of operation and it was 31,000miu/ml and was planned for chemotherapy with injection (Inj.). Methotrexate 1 mg/kg body weight by intramuscular route weekly for total four doses with folinic acid rescue at 21 days interval. With first course of chemotherapy, she was discharged and followed up with weekly serum β-HCG report and other tumor work ups. She is now advised to continue chemotherapy with the same schedule and be attached with the oncology Department.

Discussion

Gestational trophoblastic neoplasms (GTN) are proliferative as well as degenerative disorders of placental elements and include complete or partial mole (90%), invasive mole (5-8%), choriocarcinoma (1-2%) and placental site tumor (1-2%).[4] 15% of complete mole can develop into invasive mole.[1] But only 2- 4% of the partial mole transform into this variety of trophoblastic tumor.[2,3] Invasive mole usually presents with following symptoms :irregular vaginal bleeding, theca luteine cysts, uterine subinvolution or asymmetric enlargement and persistently elevated serum hCG levels.[1] It can develop both before and after treatment by D&E or S/E.[3] The trophoblastic tumor may perforate the uterine myometrium resulting intraperitoneal bleeding and vaginal bleeding. Treatment may include single or combined chemotherapy according to patient profile and risk status. Histopathology of invasive mole usually shows sheets of anaplastic syncytiotrophoblast and cytotrophoblast without chorionic villi.[1] this case has reported to us with complaining amenorrhoea for 1 year, exessive nausea and vomiting for 12 weeks and pain in the lower abdomen for 1 week. and striking rise of serum β-HCG was 2,75,000 miu/ml. The

histopathology report also documented the presence of invasive mole. Considering the rarity of this case and clinical presentations, I have reported this case. This case emphasize the necessity of doing ultrasonography at and during perimenopausal time and carrying out histopathology examination of tissue for avoiding possibility of missing any case of gestational trophoblastic disease. Thus, early diagnosis can be possible and prompt treatment with proper follow-up can be instituted to have good success rate and to save life.

References

1. Berkowitz RS, Goldstein DP. Gestational Trophoblastic Disease. Berek JS, Reinhart RD Berek and Novak″s Gynecology (14th ed), Philadelphia: Lippincott Williams and Wilkins, 2007:1581- 1604.
2. Danielsson K. Partial Hydatidiform Mole. Updated 3.02.08. About.com:p1-4.
3. Danielsson K. Invasive Mole. Updated 30.01.08. About.com: 1-4.
4. Miller FM, Laing FC. Gestational trophoblatic disease http:// brighamrad. havard.edu/cases /bwh/ hcache/34/full.html.