

Case Report

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Invasive mole of the uterus: A description of one case managed by hysterectomy and chemotherapy

Gabkika BM*¹, Saleh A¹, Pazimi T¹, Paching D¹, Rimnaya J¹, Kainba P¹

¹ N'Djamena Mother and Child Hospital, Chad

Abstract

We report a case of invasive mole presenting as an haemoperitoneum. The patient presented with acute abdominal pain, vaginal bleeding, and amenorrhoea of 10 weeks duration. Emergency laparotomy revealed an invasive mole perforating through the uterine isthmus, resulting in an haemoperitoneum. Hysterectomy was performed followed by chemotherapy. She had no side effects of chemotherapy and adhered to the follow up schedule.

Keywords: *invasive mole* N'Djamena Chad.

INTRODUCTION

Invasive mole is a condition where a molar pregnancy, such as a partial hydatidiform mole or complete hydatidiform mole, invades the wall of the uterus, potentially spreading and metastasizing to other parts of the body (such as the vagina or lungs) [1, 2]. Invasive mole follows approximately 10 to 15 percent of complete hydatidiform moles [3]. They are characterised by the persistence of edematous chorionic villi with trophoblastic proliferation invading into the myometrium [1, 3-5]. We describe a case of an invasive hydatidiform mole perforating through the uterus resulting in an haemoperitoneum.

CASE REPORT

A 39-year-old female, presented to the emergency services of N'Djamena Mother and Child hospital with complaints of acute abdominal pain and vaginal bleeding since 2 months. She had amenorrhoea of 10 weeks duration but her previous cycles were regular. Urine test for pregnancy was positive. General physical examination showed moderate pallor and bilateral pitting pedal oedema. Per abdomen examination showed a 15 week size uterus, soft and non-tender. Per vaginal examination showed 15 week uterus, there was vaginal bleeding.

Complete hemogram showed an anemia with Hb 6.7g/dl, blood group being 'A' positive. Beta hCG done 2 days before admission was 66,705.34 mIU/mL. Abdominal ultrasound with doppler done at N'Djamena Mother and Child Hospital showed an moderate haemoperitoneum, a bilateral theca lutein cysts and enlarged uterus measuring 15.6 x 7.5 cms with multiple cystic areas within endometrium (snow storm appearance) and surrounding myometrium was not clearly defined suggesting the presence of molar tissue. Resuscitative measures were taken up for an emergency laparotomy. Abdomen was opened by a midline vertical incision and 1.2 liter of haemoperitoneum was evacuated. There was a profuse haemorrhage from the uterine isthmus and the perforated area resembled trophoblastic tissue. Decision for hysterectomy was taken. Total abdominal hysterectomy with preservation of both ovaries was done. Intraoperatively patient received 3 units of packed cell transfusion. During postoperative period she received 2 more units of blood transfusion and made an uneventful recovery. The pathological diagnosis was invasive mole and microscopy showed the lesion was a complete hydatidiform mole. The post-operative metastatic workup including serum biochemistry, chest X-Ray and upper abdominal ultrasonography did not reveal any evidence of metastasis. Postoperative serum beta HCG levels were high at a level of 2000 mIU/ml so the patient was given chemotherapy with injection Methotrexate and folinic acid for 2 cycles and her beta HCG levels gradually returned back to normal levels after 8 weeks. The monitoring was kept one year after beta HCG normal level. She had no side effects of chemotherapy and adhered to the follow up schedule.

*Corresponding author:

Dr. Gabkika BM

N'Djamena Mother And Child Hospital, Chad

Email: kickbray[at]yahoo.fr

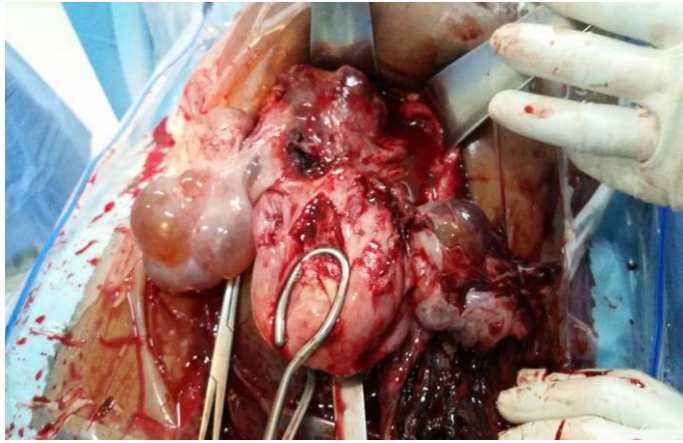


Figure 1: Showing enlarged and perforated uterus, and ovaries cyst



Figure 2: Showing trophoblastic tissue removed from uterus

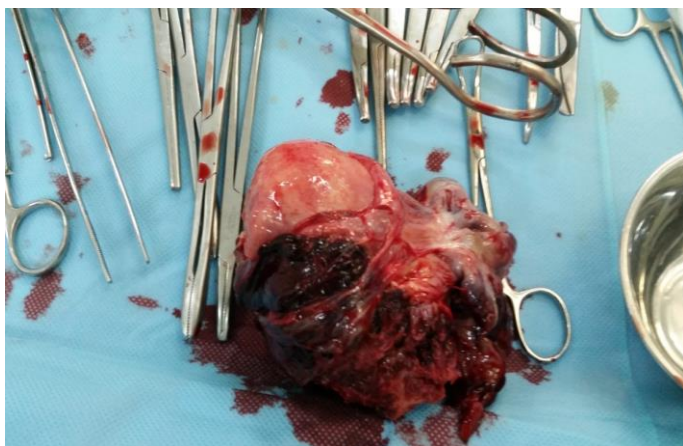


Figure 3: Showing hysterectomy specimen

DISCUSSION

An invasive mole causing uterine perforation is a rare occurrence [6]. Complete hydatidiform moles are recognized to have a potential for developing uterine invasion or distant metastasis. Invasive mole may perforate through the myometrium resulting in uterine perforation and intra-peritoneal bleeding [5, 6, 7]. The clinical presentation of an invasive mole in this case included vaginal bleeding, an enlarged uterus and high serum bHCG level.

The diagnosis of invasive mole rests on the demonstration of complete hydatidiform mole invading the myometrium or the presence of villi in the metastatic lesion. Myometrial invasion is difficult to document on

pelvic ultrasound and also in uterine curettings unless there is a sufficient myometrium to demonstrate the invasion [5, 7-9].

Per operative discovery made of a profuse haemorrhage from the uterine isthmus and the perforated area resembled trophoblastic tissue were determinant to suspect invasive mole. The diagnosis remains pathological. This was confirmed here by the microscopy that had showed the lesion was a complete hydatidiform mole.

Management of an invasive mole includes treatment with chemotherapy as well as continued monitoring of bHCG [9, 10]. Successful treatment of malignant Gestational Trophoblastic Neoplasias (GTN) does not mean that reproductive health can always be preserved. Chemotherapy plus hysterectomy is sometimes the method of choice in advanced malignant GTN treatment [4, 8, 9, 10]. The use of chemotherapeutic agents in invasive mole is controversial [6, 7], the necessity of hysterectomy was reported to control hemorrhage and sepsis but hysterectomy does not protect against distant metastasis. So chemotherapy is still needed [10]. Hysterectomy performed in our case can be justified by the old age, and a completed family size. Methotrexate has been found to achieve complete remission in most non metastatic and low risk GTN. The use of methotrexate in the first intention can be explained by previous finding argued that approximately 8% of patients with complete moles will develop a malignant tumour [7, 10, 10]. Patients with GTN should be followed with weekly quantitative bHCG levels until normal for three consecutive weeks, then monthly for 12 months [6, 7, 9, 10]. In the same way the monitoring was kept one year after beta HCG normal level.

CONCLUSION

Invasive complete mole is a rare occurrence. The clinical presentation of an invasive complete mole can include vaginal bleeding, an perforated uterus, haemoperitoneum and high serum bHCG level. The best management when an old age, and a completed family size remains hysterectomy plus chemotherapy

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Conflict of interest

There are no conflicts of interest.

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Consent

For this work we received the patient's consent and the consent of the director of N'Djamena Mother and Child hospital (Chad).

REFERENCES

1. Hammond CB. Gestational trophoblastic neoplasms. In: Scott JR, DiSaia PJ, Spellacy WN (eds). Danforth's Obstetrics and Gynecology, 8th edn. Philadelphia: Lippincott Williams & Wilkins 1999; 927-37.
2. El-agwany AS. Uterine intramural persistent mole: a case report following molar pregnancy evacuation with arteriovenous mal-formation. Egypt J Radiol Nucl Med 2014; 45(4):1291-4.
3. Smith HO. Gestational trophoblastic disease - Epidemiology and trends. Clin Obstet Gynecol 2003; 46:541-56.
4. Soper JT, Mutch DG, Schink JC. American College of Obstetricians and Gynecologists. Diagnosis and treatment of gestational trophoblastic disease: ACOG Practice Bulletin No. 53. Gynecol Oncol 2004; 93:575-85.
5. Maeda K, Kurjak A, Varga G, Honemeyer U. Trophoblastic diseases. Donald School J Ultrasound Obstet Gynecol 2012; 6:27-42.

6. Sudip S, Biswajit G, Poushali S, *et al*. Invasive mole- a case report. Indian Journal of Medical Case Reports 2015; 4(3):2319-3832.
7. Ahmed SE, Tamer M, AL Abdeldayem. Invasive mole of the uterus: A description of twocases managed by hysterectomy. The Egyptian Journal of Radiology and Nuclear Medicine 2015; 46:1267-1270.
8. Sunesh K, Vimala N, Suneeta M. Invasive Mole Presenting as Acute Haemoperitoneum. JK SCIENCE 2004; 6(3):159-160.
9. Branka N, Jelena L, Snežana R, *et al*. Invasive mole - case report of massive uterine destruction. Bosnian Journal of basic medical sciences 2008; 8(4):373-376.
10. Sahaja K, Venkatesh, Ramlingappa A. A rare case of invasive mole with silent uterine perforation. Int J Reprod Contracept Obstet Gynecol 2013; 2(1):109-110.
11. Kavitha N, Hanaa A. Invasive mole of the uterus – a rare case diagnosed by ultrasound:a case report. Med Ultrason 2014 ; 16(2):175-178.