

Perforating Hydatidiform Mole at 8 Weeks of Gestation: A Surgical Emergency

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Abstract

Gestational trophoblastic neoplasms include the tumor spectrum of hydatidiform mole (complete and partial), invasive mole (chorioadenoma destruens), placental site trophoblastic tumor, and choriocarcinoma. Hydatidiform mole is the most common, and its incidence varies worldwide from 1 in 125 deliveries in Mexico and Taiwan to 1 in 1500 deliveries in the US. It is common in women under 20 and over 40 of age, belonging to low socio-economic status, and having nutritionally deficient diets. Invasive mole is reported in 10-15% of women who have had primary molar pregnancy. Although considered benign, invasive mole is locally invasive and may produce distant metastases. It may totally invade the myometrium and be associated with uterine rupture and hemoperitoneum. The microscopic findings are the same as in hydatidiform mole. It is common to see a perforating mole when a molar pregnancy has not been detected and evacuated early but perforating mole at 8 weeks of gestation is very rare. As perforating mole leads to rupture of uterus and hemoperitoneum, which is life-threatening to the patient, emergency laparotomy is mandatory as a therapeutic procedure. We report a case of molar pregnancy of 8 weeks gestation in a woman who presented with hemoperitoneum and shock requiring laparotomy.

Keywords: Hemoperitoneum, molar pregnancy, shock

INTRODUCTION

Abnormal uterine bleeding, usually during the first trimester, is the most common symptom, occurring in over 90% of patients with molar pregnancies. Three-fourths of patients with bleeding have this symptom before the end of the 3rd month of pregnancy. Only one third have profuse vaginal bleeding. Excessive nausea and vomiting is reported to occur in 14-32% patients, whereas 10% patients present with hyperemesis gravidarum. Pre eclampsia in the first trimester or early second trimester has been said to be pathognomonic of hydatidiform mole, although it occurs in only 10-12% of these patients. Hyperthyroidism occurs in 10% of patients, whereas almost half of them have an

excessive uterine size for gestational date. Multiple theca lutein cysts causing enlargement of one or both ovaries occurs in 15-30% of women with molar pregnancies. These cysts regress once the mole is evacuated, and regression usually parallels the decline of beta-human chorionic gonadotropins (B-HCG) levels. Operation is indicated only if rupture and hemorrhage occur or if the enlarged ovaries get infected.

The clinical presentation as an acute abdomen in patients with molar pregnancy may be usually due to invasive mole or choriocarcinoma.¹ As uterine perforation leads to hemoperitoneum due to internal hemorrhage leading to irreversible shock and subsequent morbidity and mortality, prompt diagnosis and treatment is needed.^{1,2}

In the present case, the woman presented with acute abdomen, tense abdomen with the loss of contour of uterus on ultrasound and with features of shock but only 8 weeks of amenorrhea. Accurate diagnosis and subsequent emergency management saved the woman from this potentially fatal complication.

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CASE REPORT

A 22-year-old woman was referred from a district hospital on the early morning of July 28, 2012 as a case of hydatidiform mole with pain in the abdomen since the past 2-3 h. She was married for the past 6 years, had 2 pregnancies but has only 1 live child, the first pregnancy, the second pregnancy ended in an infant death. Both were home deliveries with no known complications. This pregnancy was the 3rd which she conceived after 1-year of the last childbirth. The eldest child was 5-year-old whom she conceived within 1-year of her marriage. She had amenorrhea of 2 months (Last menstrual period was on 25-5-2012), it was 9th week of gestation. She had no history of bleeding per vaginum or passage of vesicles. There was no suggestive family or past history. No history of any surgeries in the past including dilatation and curettage. On examination, she had a severe degree of pallor, afebrile, feeble pulse, blood pressure - 100/70 mmHg. Abdominal examination revealed 14 weeks size mass with tense abdomen, size of uterus was confirmed by bimanual examination. Urgent ultrasound in the emergency ward revealed molar pregnancy with ill-defined left lateral wall of the uterus and moderate fluid in the peritoneal cavity, may be ascites or possibility of rupture had to be considered.

Serological investigations

Investigations revealed:

Hemoglobin: 5.5 g%

Platelets: 3.2 lakhs

Bleeding time: 2 min 18 sec

Clotting time: 3 min 30 sec

Random blood sugar: 84 mg%

Renal parameters:

Blood urea: 40 mg%

Serum creatinine: 0.9 mg%

Serum electrolytes:

Sodium: 136 mEq/l

Potassium: 3.5 mEq/l

Chloride: 103 mEq/l

HIV: Non-reactive

Laparotomy under general anesthesia was done using sub umbilical midline incision.

Laparotomy findings

Hemoperitoneum of about 2 L, uterus of the size of 18 weeks, 2 sites of perforation on the uterus one anterior surface of uterus below the attachment of round ligaments with vesicles protruding out and another on posterior surface of uterus with vesicles protruding, myometrium was thinned out on the anterior and left lateral side of the fundus of the uterus (Figure 1).

Right ovary was healthy, left ovary was hemorrhagic and cystic. Subtotal hysterectomy with left-sided oophorectomy was done. Total blood loss was estimated to be 4 L, 3 units of cross-matched A +ve blood was transfused pre-operatively, 2 units intraoperatively, and 5 units postoperatively. Totally, 10 units of cross-matched blood were transfused. Her post-operative period was uneventful, and she was discharged on the 21st day, after checking her hemoglobin which was 10 g% and B-HCG, which was 19.8 mIU/mL (Figure 2).

She was followed-up up to December 2013 and had no complications whatsoever.

DISCUSSION

Hydatidiform mole is abnormal pregnancy which should be evacuated as soon as possible, and follow-up is most important.³ Invasive mole may totally penetrate the myometrium and be associated with uterine rupture and



Figure 1: Uterus with perforating mole

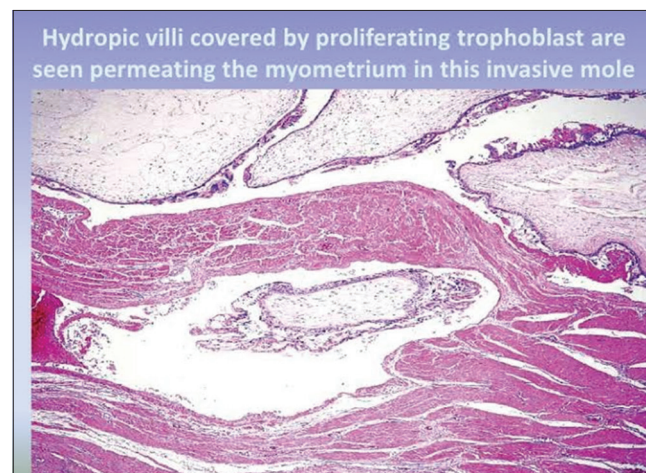


Figure 2: Histopathology of invasive mole

hemoperitoneum.^{1,2,4} Bilateral cystic ovaries are seen in about half of the cases, but surgery is indicated only if there is rupture and hemorrhage. Differential diagnosis of molar is from normal pregnancy which can be confirmed by ultrasound and B-HCG levels. In normal pregnancy, B-HCG values are below 60,000 mIU/ml.

CONCLUSION

Emergency laparotomy helps in saving the life of the patient presenting with perforating mole. If we diagnose it early and evacuate early, we can prevent the patient from landing up in a life-threatening complication. Therefore, I insist that all women should have an early scan almost mandatory at 5-6 weeks of gestation. In this case, the woman had an ultrasound only after she developed symptoms of an abdominal catastrophe. Had she been diagnosed earlier she would not have had

to lose her uterus. The more dreaded complication of lung infiltration by the trophoblastic tissue is however not seen in this patient but there is a 15-20% chance of lung involvement, which either regresses completely after evacuation or responds to chemotherapy single or multiple agent.⁵

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