

Molar Pregnancy and Insitu Hysterectomy: A Case Report

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ABSTRACT

The gestational trophoblastic disease, with its most frequent representative, the hydatidiform mole, has a particular place in the obstetrical pathology being the only neoplasm linked to the fecundation process and because of its uncommon and sometimes unpredictable gravity. We present two patients with hydatidiform mole case one 50 yrs with molar pregnancy directly gone of total abdominal hysterectomy and second case 40 yrs previously suction evacuation done then gone for total abdominal hysterectomy. Ultrasonography for invaluable for the diagnosis and b hcg was the tools for diagnosis and follow up. Decrease of beta-hCG levels was reassuring in both cases. Contraception completed the follow-up plan for the young, fertile patient.

Key words: molar; hysterectomy; fydatidiform mole; chemotherapy.

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INTRODUCTION

Gestational trophoblastic disease (GTD) represents a spectrum of histologically distinct pathologies including molar pregnancy, invasive mole, placental site trophoblastic tumour and choriocarcinoma. Invasive mole, placental site trophoblastic tumour and choriocarcinoma grouped as gestational trophoblastic tumours (GTT) has been referred to as “God’s first cancer and man’s first cure”.¹ The reported incidence of GTD varies widely worldwide, from a low of 23 per 100,000 pregnancies (Paraguay) to a high of 1,299 per 100,000 pregnancies (Indonesia).² The malignant potential of GTD is also higher in South Asia (10-15%) compared to western countries (2-4%).³ Even if recent progress in imaging and laboratory diagnosis largely improved its management, the treatment of this condition includes quite different options (from conservative approach to hysterectomy) and its prognosis still remains, sometimes, unpredictable and a matter of concern.⁴ We present in this paper two different cases of women with hydatidiform mole. The particularity and interest of these cases is represented by clinical situations, which imposed same specific approach.

CASE REPORT

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Figure 1. Size of Uterus at 28 week



Figure 2. Hysterectomy specimen

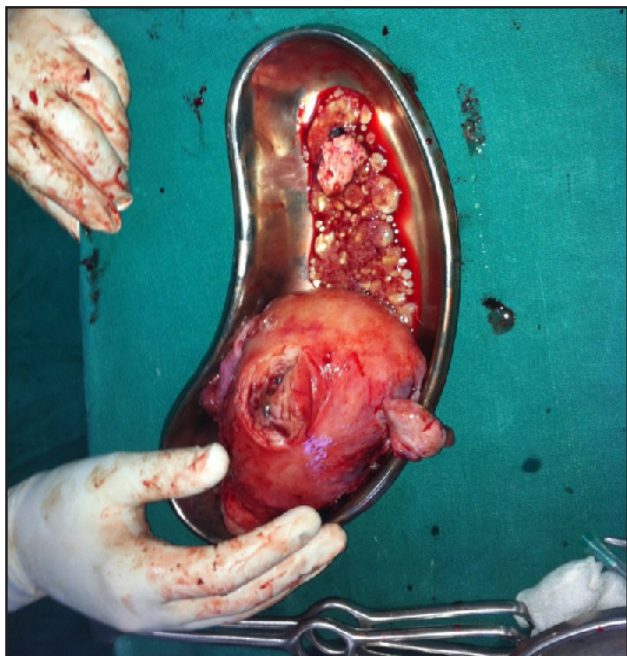


Figure 3. Cut section of previous specimen showing grape like structure

Case 1

Mrs. Renuka Sapkota 50 years P7L5D2 presented in gynecology OPD with complain of Amenorrhoea for 2 months following that felling of mass per abdomen for 20 days and PV bleeding for 14 days, on her medical history she is known case of hypothyroidism for which she was under regular medication, on examination Vitals were stable and chest and CVS no abnormal finding, per abdomen enlarged uterus boggy feeling non tender, per speculum examination healthy cervix slight congested, and dark altered clot bleeding present, per vaginal examination uterus 20 weeks size, boggy feeling, mobile, cervical os close, bilateral Fornices were free, laboratory examination UPT negative, B-hCG >10lakhs Miu/ml, Hb 5.6gm/dl %, rest LFT, RFT, CXR within normal limit, usg show bulky uterus with hyperechoic cystic area containing. Initially patient admitted and 2 pint of whole blood transfused and one stat dose of methotrexate 1mg/kg im given, and TAH with BSO done. Post operative un eventful hemoglobin restored with another 2 pint of whole blood and Bhcg repeated 48 hrs after surgery which shows 227247miu/ml again after 48 hrs repeated which shows 24003miu/ml and patient discharged on 8th post operative day.

Case 2

Mrs. Goma sapkota 40 years female P4L4A2 presented with complain of pv bleeding for 24 days following suction evacuation for partial hydatidiform mole in local hospital following evacuation she had >1500miu/ml b-hcg, in 1st week she had B hcg 34474 miu/ml and in second week repeat b-hcg 49578miu/ml so patient is being reffered to our hospital, she does not have chest pain, cough, she had normal bowel and bladder habbit, on examination vitals were stable, chest, CVS, P/A normal, per speculum examination reveals cervix healthy, parous, dark altered clot blood present, per vaginal examination uterus 10 weeks size bilateral Fornices were free, mobile nontender, hemoglobin 9.4gm/dl %, ultrasonography shows finding suggestive of invasive mole and other LFT, RFT, TFT were with in normal limit initially patient again gone through suction evacuation histopathology of which shows complete hydatidiform mole, then serial b-hcg monitored 1st week 42256.5miu/ml and nest 48 hrs bhcg 68996.15miu/ml so patient was decided for total abdominal hysterectomy and bilateral salphingoophorecotmy, post operative period was uneventful on 7th day b-hcg done which was 3871.5miu/ml which was decreased by log and discharged.

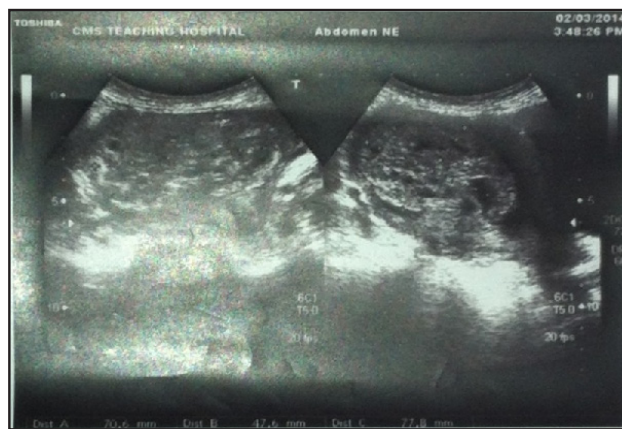


Figure 4. USG showing molar pregnancy

DISCUSSION

The most common form of gestational trophoblastic disease is represented by the hydatidiform mole. Known from the antiquity (Hippocrates described it), mola was first used as a term by Smellie in the

17th century. However, real progress was made only later: pathological description (19th century-Velpeau and Boivin), possibility of progression to choriocarcinoma (1885-Marchand) or presence of high level of urinary gonadotropin (Zondek).⁴ Hydatidiform mole, complete or partial, represents a placenta characterized by marked villous enlargement due to central edema of the stroma, variable hyperplasia of the villous trophoblast and edema. Most molar pregnancies are complete, and 25% to 43% are partial.⁵ The reported incidence of GTD varies widely worldwide, from a low of 23 per 100,000 pregnancies (Paraguay) to a high of 1,299 per 100,000 pregnancies (Indonesia).² The malignant potential of GTD is also higher in South Asia (10-15%) compared to western countries (2-4%).³ Hydatidiform moles and malignant gestational trophoblastic neoplasia (GTN) are recognized as relatively uncommon, but potentially devastating, diseases occurring in women of reproductive age. Primary management of hydatidiform moles includes surgical evacuation coupled with close monitoring of serial human chorionic gonadotropin (hCG) values. In patients with malignant GTN, surgery was initially recognized as effective only in the treatment of a few women with nonmetastatic choriocarcinoma or postmolar GTN. Teenagers and perimenopausal women are most at risk.⁶ Characteristically, women older than 35 years of age have a relative risk of 2.0, and women over 40 years of age have a 5- to 10-fold increase.⁷ as

in our case in some literature shown positive result to women who have completed their families and have risk factors for postmolar GTN, hysterectomy offers the advantage of simultaneous evacuation and sterilization.⁸ similar management plan was given in next literature Because malignant sequelae are more prone to occur in older age groups-37.5% of patients aged ≥ 50 years versus 27.5% of patients aged 40–49 years versus 13.9% of patients aged ≤ 15 years after molar evacuation.⁹ hysterectomy plays a crucial role in the management of these patients and offers a lower risk for malignant sequelae than with suction D&E.¹⁰ Hysterectomy decreases the overall risk for postmolar GTN to approximately 3.5% from the anticipated 20% following suction D&E.¹¹ Because most women with hydatidiform moles are aged < 40 years, the adnexa should not be removed unless the patient has obvious adnexal metastases, is perimenopausal, or has complications related to theca lutein cysts.⁸ All patients should be chemically monitored after hysterectomy because it does not completely eliminate the potential for postmolar GTN.^{11,12}

CONCLUSIONS

Although the treatment protocol of GTD initially a suction evacuation for H. mole and chemotherapy but in some instances, there is a role of hysterectomy with bilateral salpingoopherectomy to whom who are in perimenopausal age and completed child bearing to lead to the complete remission.

Conflict of Interest: None

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