



CASE REPORT

Invasive mole presenting as acute abdomen- a case report

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Abstract

Gestational trophoblastic neoplasms include the tumour spectrum of hydatidiform mole (complete and partial), invasive mole, (chorioadenoma destruens), placental site trophoblastic tumour and choriocarcinoma. Here a case is reported as invasive hydatidiform mole presenting as an acute haemoperitoneum. The patient presented with acute abdominal pain and signs of haemoperitoneum. Emergency laparotomy revealed a perforating molar pregnancy, resulting in massive haemoperitoneum. Total hysterectomy was done, 5 units blood were transfused. Serum β HCG levels regress quickly and spontaneously.

Key words: Molar pregnancy, invasive mole, acute abdomen.

Introduction

Gestational trophoblastic neoplasms (GTN) are proliferative as well as degenerative disorders of placental elements. Invasive mole follows approximately 10 to 15 percent of complete hydatidiform moles.¹ They are characterized by persistence of edematous chorionic villi with trophoblastic proliferation invading into the myometrium. The presence of villi the trophoblastic tissue differentiates an invasive mole from choriocarcinoma. Here a case is described which is an invasive molar pregnancy perforating the uterus causing massive haemoperitoneum.

Case report

A 31 years old woman from middle socio-economic class presented at Gazi Medical College Hospital, Khulna, at 12:30 am on 14th April 2016 with the complaints of severe lower abdominal pain for 6 hours and slight pervaginal bleeding for 8 hours. She was married for 16 years, had 1 living child and history of two induced abortion. She has history of dilatation and evacuation and curettage (D&E&C) for two due to incomplete abortion at a Upazilla level

hospital. On examination, she was severely anaemic, hypotensive and abdomen was tensed and tender. Emergency ultrasonography was done which revealed massive haemoperitoneum with bulky uterus with loss of contour of uterus. Serum β hCG was sent before operation. Emergency resuscitative measures were taken and urgent laparotomy was done under general anesthesia. About 3L of fresh and clotted blood was found which was evacuated. A perforation was found on fundus and signs of impending perforation near the cervix on anterior wall of uterus (Fig. 1 and 2). Size of uterus was about 14 weeks. Emergency total hysterectomy was done. Intraoperatively 3 units of blood were transfused. During postoperative period, another 2 units of blood transfusion was given. Her postoperative period was uneventful. Specimen was sent for histopathology which revealed invasive molar pregnancy and complete form with infiltration into the myometrium. Postoperative follow-up for metastasis done including serial quantitative β hCG, chest X-ray, upper abdominal ultrasound did not show any sign of



Fig.1. Uterus with site of perforation



Fig. 2. Uterus with invasive mole

metastasis. Pre-operative β hCG was 9056 mIU/ml, 1 week after operation was 122 mIU/ml, 2 weeks after operation was 69 and then gradually decreasing became negative after 5 weeks. Subsequent β hCG levels were negative on regular follow-up visits.

Discussion

Hydatidiform mole is an abnormal pregnancy which should be evacuated as soon as possible and follow-up is most important.² Invasive mole is a form of complete molar pregnancy evolution.³ Complete hydatidiform mole is recognized to have a potential for developing uterine invasion or distant metastasis. Invasive mole may perforate through the myometrium resulting in uterine perforation and intraperitoneal haemorrhage.⁴ Direct vascular invasion and metastasis rarely occurs in invasive moles, the most common site reported is the lung.^{5,6} The more dreaded complication of lung infiltration by the trophoblastic tissue was however not seen in this patient but there was a 15-20% chance of lung involvement, which either regress completely after evacuation or responds to chemotherapy single or multiple agents.⁷

Conclusion

The clinical presentations as an acute abdomen in patients with molar pregnancy may be usually due to invasive mole on choriocarcinoma. Emergency laparotomy helps in saving the life of the patient presenting with perforating mole. Use of chemotherapy in the

management of invasive mole is datable, with the evidence of spontaneous regression of metastatic mole. In this case chemotherapy was not considered as there was no evidence of metastasis and the β hCG levels were low and thereafter declined rapidly and became negative.

References

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