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A Case of Invasive Mole with Uterine Rupture Presenting as a Hemoperitoneum

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ABSTRACT

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. Here is a case which presented with history of evacuation for molar pregnancy. She presented with irregular p/v bleeding on and off and after admission silent perforation with massive haemoperitoneum was detected for which emergency laparotomy with hysterectomy was done (operative photographs enclosed). She was given massive transfusion. She recovered and followed up till her beta hCG levels were within normal limits. As patient presented to us with haemoperitoneum and intraoperative there was invasion into whole of the uterus, it could not be saved and hysterectomy was done. Patient received 6 cycles of Methotrxate chemotherapy and was followed up for 6 months after beta hCG levels were within normal limits.

KEYWORDS : Invasive mole, Molar pregnancy, uterine perforation, hemoperitoneum

Introduction: - An invasive mole is a tumourous growth associated with gestational trophoblastic disease (GTD). Due to their aggressive nature, invasive mole are considered non metastatic but locally invasive neoplasia. We present a case where invasive mole gradually eroded in uterus and local vessels in the uterine tissue which let to sudden rupture of uterus and massive hemoperitoneum.

Case: - A 25 years old patient was admitted for complaint of vaginal bleeding following evacuation of complete mole 02weeks ago. She was on regular follow up for Gestational trophoblastic Disease. Her basal β-hCG levels before evacuation of mole was 13836.14 IU/ml. Her follow up β-hCG on admission after 02 weeks of evacuation of mole was 14352IU/ml. Her ultrasound examination revealed retained molar tissue as snow storm appearance measuring 3X3 cm at upper most part of uterine cavity. Her both ovaries shown theca leutin cysts of 6X5 in right ovary and 9X8 cm in left ovary. She was diagnosed as a case of GTT with low risk group as per WHO classification.

She was treated with single drug chemotherapy with methotrexate . She received four doses of Inj Methotrxate in doses of 1mg/kg intramuscular. Inj Folinic acid 0.1mg/kg was given intramuscular on alternate days. On last dose of folinic acid, she complaint of sudden abdominal pain and fainting attack in the ward. She also developed tachycardia(Pulse 126/min) and sudden hypotension (BP 80/60mmHg). Her Hb dropped to 4gm%. Her USG abdomen confirmed free fluid likely to be hemoperitoneum. She was immediately taken up for laparotomy which confirmed massive hemoperitoneum. 2.5 liter blood was drained. Subtotal Hysterectomy with bilateral salpingo-oophorectmy was performed. On cut section of uterine cavity invasion of mole through the myometrium involving vessels with erosion of vessels extending from myometrium to outer serosal layer was noticed (Diagram 1,2). Her follow up β-hCG repeated weekly for 02 months shown gradual decline from 2405.35 IU/ml immediate 01 week after Hysterectomy and 214IU/ml at 02 weeks and undetectable at 03months after her surgery.

DISCUSSION

Gestational trophoblastic disease (GTD) describes a variety of gynaecological tumours originating in the trophoblast layer, including hydatidiform mole (complete or partial), placental site trophoblastic tumour, choriocarcin oma and gestational trophoblastic neoplasia (GTN)[1] . Complete and partial hydatidiform moles are non invasive and account for 80% of gestational trophoblastic diseases GTD) cases. Invasive moles that have malignant potential for local invasion and distant metastasis cause most cases of localized GTN[2]. Some degree of myometrial trophoblastic invasion is probably present in most moles; indeed, myometrial invasion is not exclusive to molar pregnancies. Hertig and borrowing used the terminology used for myometrial placentation, classified invasive moles into accreta, increta and percreta[3]. Since hysterectomy is rarely performed in current practice in the treatment of moles, the few specimens seen are usually in unmonitored and often unsuspected pregnancies and, sometimes, are paradoxically percreta moles presenting as acute abdomen due to uterine perforation[4].

Spontaneous ovulation followed by defective fertilization may be the inciting event in the development of GTN. The pathogenesis of GTNs in postmenopausal women is controversial. In contrast to moles occurring during the reproductive years, postmenopausal GTNs seem to evolve independently of gestation. A latent GTN that remains dormant for long periods and becomes clinically evident in the postmenopausal period is thought to be another mechanism[5][6]. Invasive mole appears histologically benign having a similar appearance to complete molar pregnancy . Despite this appearance, the clinical course of invasive mole is a malignant one, with predominantly invasion of the trophoblastic tissue into the myometrium and spread of molar tissue through pelvic veins. If left untreated ,invasive mole can result in heavy bleeding, uterine rupture or other symptoms from local invasion[7][8]The presence of villi in the trophoblastic tissue differentiates an invasive mole from choriocarcinoma. The use of chemotherapeutic agents in invasive mole is controversial [9].Although the beta hCG in this case showed a downward trend. Hysterectomy was performed in the present case as life saving measure due to persistent bleeding from invasion site.

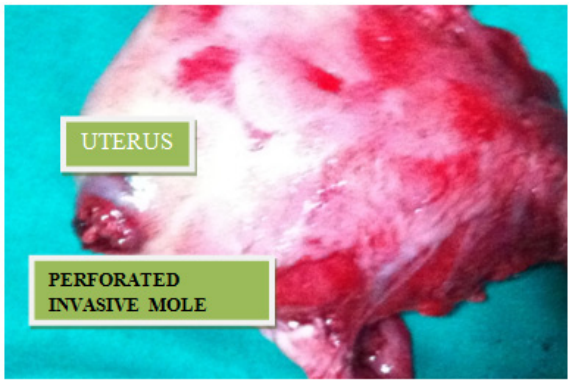


Diagram-1

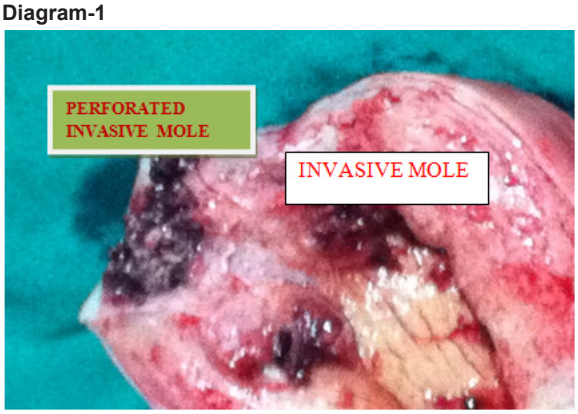


Diagram-2

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