Original Research Paper

Volume - 13 | Issue - 08 | August - 2023 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Obstetrics & Gynaecology

"CASE REPORT- COMPLETE HYDATIFORM MOLE IN A 47 YEAR OLD WOMAN"

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ABSTRACT Gestational trophoblastic disease (GTD) represents a spectrum of lesions characterised by an abnormal proliferation of trophoblast, including complete hydatidiform mole, partial hydatidiform mole, invasive hydatidiform mole, choriocarcinoma, placental site trophoblastic tumour, epithelioid trophoblastic tumour, placental site nodule and plaque, and exaggerated placental site reaction.[1] Complete mole is characterised by gross hydropic villous swelling with some degree of circumferential and haphazard trophoblast proliferation microscopically.[2] The incidence of pregnancy in perimenopausal women is extremely low. Most pregnancies that occur will end in spontaneous abortion. In the remaining pregnancies the incidence of GTD is greatly increased.[3] Benign gestational trophoblastic diseases generally occur in younger women of reproductive age and is extremely rare in peri and post menopausal women. Only isolated cases of hydatidiform mole in elderly women have been reported in the literature[3,4]. We report on a patient aged 47 years with a complete hydatidiform mole to emphasise that this diagnosis should still be considered at an older age.

KEYWORDS : hydatiform mole

INTRODUCTION:

Amenorrhea is the cardinal presenting symptom of early pregnancy. Clinical suspicion of pregnancy is increased if a women also reports sexual activity without using contraception [5]. Cessation of menses can be a difficult symptom to evaluate because some women have irregular menstrual cycles. Also, vaginal bleeding/spotting is relatively common in early normal pregnancy and often occurs at or near the time that a menstrual period would be expected [6,7].

The most common signs and symptoms of early pregnancy are: amenorrhea, nausea with or without vomiting, breast enlargement and tenderness, increased frequency of urination without dysuria, and fatigue. Laboratory findings of pregnancy include detection of human chorionic gonadotropin (hCG) in blood or urine. hCG is secreted into the maternal circulation after implantation, which may occur as early as 6 days after ovulation but typically occurs eight to ten days after ovulation [8-11]. This is the earliest that hCG can be detected with a standard serum hCG test. The hCG concentration doubles every 29 to 53 hours during the first 30 days after implantation of a viable, intrauterine pregnancy [5].

The diagnosis of pregnancy is based on the following diagnostic criteria: detection of hCG in blood or urine, identification of pregnancy by ultrasound examination, identification of fetal cardiac activity by ultrasound [5].

Hydatidiform mole (HM) is part of a group of diseases classified as gestational trophoblastic disease (GTD), which originate in the placenta and have the potential to locally invade the uterus and metastasize [12]. Molar pregnancies, although benign, are considered to be premalignant because they have the potential to develop into a malignancy. Malignant disease is referred to as gestational trophoblastic neoplasia (GTN); the histologic entities included in this group are: invasive mole, choriocarcinoma, placental site trophoblastic tumor (PSTT), epithelioid trophoblastic tumor (ETT) [12].

Case Report

A 47-year-old woman, gravida 3, para 2, presented to our hospital with a history of amenorrhea for last 8 months associated with vaginal bleeding, nausea and breast pain since 1 month. Because of her age she assumed that she may be perimenopausal as she had irregular cycles prior to this amenorrhea for few months and hence did not get herself checked. She has had previously two normal deliveries. She was not using any form of contraception. Patient was referred for an ultrasound scan, which was suggestive of a molar pregnancy. On examination patient had uterine size corresponding to 20 weeks. The serum quantitative β-human chorionic gonadotropin (β-hCG) level was measured and was found to be 391123.5IU/l. Preoperative chest X ray, ECG & blood tests were normal. A suction and evacuation was performed and histological examination revealed chorionic villi with marked hydropic changes, cistern formation and moderate trophoblastic proliferation compatible with a complete hydatidiform mole. Follow-up showed a steady downward trend in the level of β-hCG, which was 5.1 IU/l within 2 months. Repeat ultrasound after 2 months showed a normal sized uterus with adenomyotic foci with endometrial thickness of 4.5mm and both ovaries normal. Beta-hCG levels remain undetectable 3months after initial diagnosis.

DISCUSSION

This case highlights the fact that Gestational trophoblastic disease can occur in older patients and should be included in the differential diagnosis of perimenopausal haemorrhage to prevent a delay in diagnosis and treatment.

Patients with HM typically present to their obstetric clinician with missed menstrual periods, a positive pregnancy test, and signs and symptoms consistent with early pregnancy or early pregnancy complications (bleeding, pelvic discomfort, hyperemesis gravidarum). Molar pregnancy may be suspected based on unusually high hCG levels or only after evaluation of a failed pregnancy [5, 13-16].

Common early presenting symptoms of HM are: vaginal bleeding, pelvic pressure or pain, an enlarged uterus, and hyperemesis gravidarum. However, these are also common in early "normal" pregnancy, and thus, clinicians most often initially do not suspect an abnormal pregnancy complication. A diagnosis of spontaneous abortion (miscarriage) or ectopic pregnancy is much more likely, rather than HM [12].

The possibility of HM, however, should also be considered in any reproductive-age female with abnormal vaginal bleeding. A quantitative serum hCG level should be obtained and, if elevated, an ultrasound examination should be performed to correlate hCG levels with gestational age. If the clinical presentation suggests HM and the ultrasound exam confirms it, malignant gestational trophoblastic neoplasia (GTN), must be excluded. Patients should be asked about symptoms of metastatic disease and appropriate diagnostic studies (chest X-ray) should be done. The lungs (symptoms include dyspnea or chest pain) and vagina (vaginal bleeding) are the most common metastatic sites, but other potential sites include the central nervous system or liver [12].

The shared symptoms between pregnancy and hydatidiform mole and the overlap in clinical and laboratory findings may make it arduous for a clinician to differentiate between the two diagnoses. This is why it is important for any clinician to keep an open mind when seeing patients who present with high levels of hCG, as well as the shared symptoms previously mentioned.

The primary concern of molar pregnancy is that this premalignancy

may evolve into a metastatic malignancy that can affect the lungs, vagina, central nervous system and liver. Because of this, symptoms related to these respective organs must be obtained from the patient's history. In developed countries, the incidence of complete hydatidiform mole is approximately 1-3 per 1000 pregnancies and those of the partial hydatidiform mole about 3 per 1000 pregnancies [17].

It is also important to note that ova from older patients may be more susceptible to abnormal fertilizations that result in this phenomenon. In fact, the risk for a complete mole was increased two fold for patients >35 years and 7.5-fold for patients >40 years [18]. Patients aged 40 or older with hydatidiform mole formation may also have a higher rate of severe complications.

Additionally, given the above case presentation, it is interesting to note that benign gestational trophoblastic disease generally occurs in women of reproductive age and is extremely rare in perimenopausal women [19]. Because of this, the rare occurrence of hydatidiform mole in this perimenopausal patient is of the utmost interest. Furthermore, in this specific case even though this molar pregnancy was non-viable, this 48-year-old perimenopausal female is now classified as Gravida 3 Para 2.

CONCLUSION:

Ultimately, in this case study, we present a 47-year-old perimenopausal female patient that presented to the clinic with signs and symptoms of a normal pregnancy. Upon further workup of the patient, it was determined that the patient had a complete hydatidiform mole. This disease has a rare chance of occurrence in pregnancies, which makes this case quite unique.

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