

CASE REPORT

Interesting case of invasive mole with hemoperitoneum

Savita Kamble, Tejaswini Kale (Pingle)

Correspondence: Dr Savita Kamble, Associate Professor in Obstetrics and Gynaecology, B J Government Medical College, Pune, Maharashtra, India; Email - savik05@yahoo.in

Distributed under Creative Commons Attribution-Share Alike 4.0 International.

ABSTRACT

Trophoblastic diseases comprise a variety of biologically interrelated conditions which form a clinical spectrum from benign partial hydatidiform mole at the one end to the highly malignant choriocarcinoma at the other without any precise line of demarcation. A case of invasive hydatidiform mole also called as Chorioadenoma destruens presenting as an acute primary haemoperitoneum. The patient presented in shock with acute abdominal pain and signs of haemoperitoneum. Emergency laparotomy revealed a molar pregnancy perforating through the uterine fundus, resulting in massive haemoperitoneum. Hysterectomy was done as a life saving procedure considering the patient in shock, massive hemoperitoneum and irreparable damage to the uterus.

Keywords: Molar pregnancy, invasive mole, haemoperitoneum, trophoblastic embolisation.

Gestational trophoblastic neoplasms (GTN) are proliferative as well as degenerative disorders of placental elements and include complete or partial mole (90%), invasive mole (5- 8%), choriocarcinoma (1-2%) and placental site tumor (1- 2%). Fifteen percent of complete mole can develop into invasive mole. But only 2-4% of the partial mole transform into this variety of trophoblastic tumor [1]. The incidence of GTN varies in different regions from 0.6-1.1 per 1000 pregnancies in Europe and north America to 2 per 1000 in Japan and 1 in 160 in India and middle east [2]. Invasive mole follows approximately 10 to 15 percent of complete hydatidiform moles [3]. They are characterized by the persistence of edematous chorionic villi with trophoblastic proliferation invading into the myometrium. The presence of villi in the

trophoblastic tissue differentiates an invasive mole from choriocarcinoma.

Case report

Twenty year old female married since 8 months was brought in casualty of Sassoon general hospital, tertiary hospital Pune, in a state of shock. Patient came with history of pain in abdomen and vomiting since 1 month, which increased in severity since 2 days. Patient also had per vaginal bleeding and breathlessness since morning on same day. Patient was apparently alright 2 months back. She went to private practitioner for 2 months amenorrhea, underwent dilatation and evacuation. Histopathology report was suggestive of vesicular mole and β - HCG levels were 35,641mIU/ml so patient was advised follow up by private practitioner but she did not go.

Received: 26th July 2016. **Accepted:** 16th November 2016.

Kamble S, Kale T . Interesting case of invasive mole with hemoperitoneum. The New Indian Journal of OBGYN. 2017; 3(2): 114-7

On admission her general condition was poor. She was afebrile, conscious and oriented with pulse rate of 160/min feeble in volume and blood pressure of 70 mm of Hg systolic and respiratory rate of 30/ min. Patient had severe pallor, no cyanosis, clubbing, icterus , oedema, lymphadenopathy. Her respiratory system examination revealed tachypnoea but no crepitations or rhonchi. Her cardiovascular system examination revealed normal heart sounds and tachycardia. On per abdominal examination there was generalised tenderness all over abdomen with distension. There was demonstrable guarding and rigidity and bowel sounds could not be heard. Her per speculum

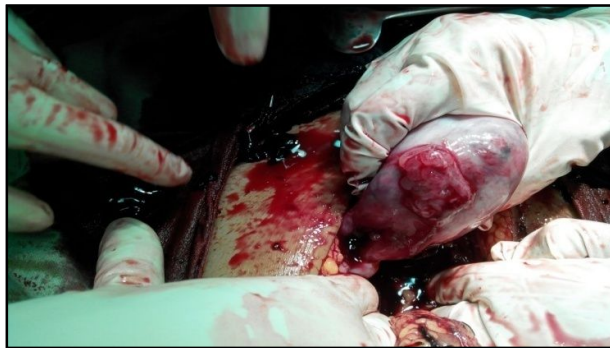


Fig 1: Perforative mole over serosal surface of uterus

examination revealed minimal bleeding. On per vaginal examination cervix was closed with tenderness and boggy present all over fornices but exact uterine size could not be assessed . Patient was immediately resuscitated in view of shock with intravenous colloid support. Her emergency ultrasonography was showing moderate free fluid in abdomen with internal echoes and solid areas along peritoneum suggestive of haemoperitoneum with clots. Uterine size was 12×8.9×8.6 cm. Endometrial echo as well as myometrium was not appreciated, uterus completely replaced by echogenic lesions with cystic contents extending up to cervix and fundal part of uterus. Bilateral ovaries being bulky with multiple theca lutein cyst. On ultrasonography guided tapping there was

frank blood present. Her urine pregnancy test was positive and her haemoglobin concentration was 3 gm% with normal bleeding time and clotting time. Her β HCG on admission report of which was traced postoperatively was 1,27,515 mIU.

From history, examination and sonography report invasive perforative vesicular mole with haemoperitoneum was suspected. Patient was immediately shifted to operation theatre for emergency exploratory laparotomy after written informed valid consent in view of invasive mole, uterine perforation, need of multiple blood transfusion, obstetric hysterectomy and Medical Intensive Care Unit (MICU) admission with need of ventilators support if required. General anaesthesia was given. Abdomen opened by midline infra-umbilical incision .There was evidence of haemoperitoneum of 500 ml, which was drained and 800 gm clot present in bilateral paracolic gutters. Evidence of perforative mole over serosal surface of uterus at many sites which were bleeding actively (Fig 1). There was evidence of bilateral theca lutein ovarian cyst around 5×6 cm. The decision of hysterectomy was taken as a life saving procedure considering the patient in shock, massive hemoperitoneum and irreparable damage to the uterus. Total abdominal hysterectomy with preservation of both ovaries was done.

Intraperitoneal drain was kept after peritoneal wash. Abdomen closed in layers after confirmation of hemostasis. Intraoperative 3 units of PCV and



Fig 2: Gross cut section of uterus

evidence of spontaneous regression of metastatic mole in the literature [5, 6]. We did consider chemotherapy in our case as there was evidence of lung trophoblastic embolism and the β -hCG levels were high postoperatively and also patient was symptomatic.

Trophoblastic pulmonary embolisation usually occurs following hysterectomy for invasive mole or evacuation of a molar pregnancy when the uterus is larger than dates and the human chorionic gonadotropin levels are more than 1 lakh. Differential diagnosis is usually pulmonary embolisation, transfusion related acute lung injury and aspiration. It has a dramatic onset with dyspnoea, tachypnoea, bilateral pulmonary infiltrates and low PaO₂ levels. Treatment requires supportive measures only and intubation is rarely required. The clinical course is short lived with gradual improvement after 48 hrs and complete resolution in 72 hrs.

Self limited respiratory distress arises in 3-10% following molar evacuation, with the number rising to 25% when the uterus is larger than dates and the human chorionic gonadotropin levels are more than 1 lakh mIU/ml [9].

Conclusion

Hydatiform mole has a potential for myometrial and vascular invasion, leading to uterine perforation and massive internal hemorrhage which can be life threatening. Therefore, to avoid such adverse consequences it is necessary to identify such cases by early first trimester ultrasound and strict follow up where the diagnosis of persistent gestational trophoblastic disease can be done at the earliest.

Conflict of interest: None. **Disclaimer:** Nil.

References

1. Miller FM, Laing FC. Gestational trophoblastic disease <http://brighamrad.harvard.edu/cases/bwh/hcache/34/full.html>
2. Berkowitz RS, Goldstein DP. In: Berck JS (ed). Gestational trophoblastic neoplasm. Philadelphia. Lippincott Williams and Wilkins. 2002; 1353- 74.
3. Hammond CB. Gestational trophoblastic neoplasms. In: Scott JR, DiSaia PJ, Spellacy WN (eds). Danforth's Obstetrics and Gynecology, 8th edn. Philadelphia: Lippincott Williams and Wilkins. 1999; 927-37.
4. Mackenzie F, Mathers A, Kennedy J. Invasive hydatidiform mole presenting as an acute primary haemoperitoneum. Br J Obstet Gynecol. 1993; 100: 953-54.
5. Wilson RB, Hunter IS, Dockerty MB. Chorioadenoma Destruens. Am J Obstet Gynecol. 1961; 81: 546-59.
6. Ring AM. The concept of benign metastasizing hydatidiform moles. Am J Clin Path. 1972; 58:111-17.
7. Mitani Y et al. Partial resection of the uterus for chorioadenoma destruens. In: Proceedings of the Fifth World Congress on Obstetrics and Gynaecology. 1984.
8. Kumar S, Vimla N, Mittal S. Invasive mole presenting as acute hemoperitoneum. J K science. 2004; 6: 159-60.
9. Twiggs LB, Morrow CP, Schlaeth JB. Acute pulmonary complications of molar pregnancy. Am J Obstet Gynecol. 1979; 135: 189-94.

Savita Kamble¹, Tejaswini Kale(Pingle)²

¹Associate Professor, Department of Obstetrics and Gynaecology, BJ Government Medical College, Pune, Maharashtra, India; ²Assistant Professor, Department of Obstetrics and Gynaecology, BJ Government Medical College, Pune, Maharashtra, India.