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CASE REPORT

A CASE REPORT OF A CASE OF PERFORATING MOLE

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INTRODUCTION: Molar pregnancy is a gestational trophoblastic disease. It is an abnormal condition of the placenta where there are partly degenerative & partly proliferative changes in the young chorionic villi. Incidence varies from country to country. In India incidence is about 1:160[1]. It is common in patient with low dietary intake of animal fat, protein & carotene. In 85% cases karyotype is 46 XX, Molar chromosomes are derived entirely from father.

A patient presented in Gynae OPD on 11.02.13 with complains of pain lower abdomen for 3 months and history of spontaneous abortion of 3 months, 3 months back. Patient had 3 Dilatation & Evacuation done from November, 2012 to February, 2013 in Purulia, West Bengal for irregular bleeding per vaginum. Her Last Menstrual Period was in August, 2012, she did not remember the exact date and she is para 1+2. First abortion was of 2 month 5 years back and then she had one Full Term Normal Delivery 4 years back. Baby is now alive and healthy. Third was again spontaneous abortion of three months, three months back.

On examination: Pallor was mild; Pulse – 98/minute B.P. – 100/60 mm of Hg, Chest – Bilateral vesicular breath sound was heard with no added sound. C.V.S. – S1 and S2 was heard.

On per abdominal examination: Uterus was 20 wks.in size with cystic to firm consistency mobile from side to side. On per Speculum Examination – Cervix was smooth and congested with discharge. Per Vaginal Examination – Cervix was long 50% length was present. External Os was admitting tip to finger.

Report of investigations: Blood group was A+, Hb – 10.6 gm %, TC – 6300 / cumm, Platelets – 1.26 lakhs / ml, USG with color Doppler – Uterus was bulky 15x7 cm, with a large heterogeneous heteroechoic solid cystic lesson of 12x4 cm in endometrial cavity – H. mole. Ovaries – both ovaries cystic, Rt – A cyst of size 2.5 cm diameter, Lt – A cyst of size 3 cm diameter, Serum ßHCG – 4, 20, 300/mIU/ml (11.02.13), SGPT – 11 IU/ Lt, SGOT – 35 IU/ Lt., Serum Bilirubin –0.7 mg / dl. Blood Urea – 14 ml/dl, Serum TSH –0.066 µ IU/ml, FT3 – 1.56 pg/ml, FT4 – 1.31 ng/dl.

Risk scoring was done – Risk score was 7 – which means she was in high risk category.

Patient was referred to oncologist. MAC regime was started. After 1st cycle of chemotherapy ßHCG level – 341950 mIU /ml. After 1st cycle Complete Blood Count, Liver Function Test, Renal Function Test was repeated & 2nd cycle of chemo was started from 02.03.2013.

From 3rd day of 2nd cycle patient started complaining of pain lower abdomen. She became pale & BP became 90/50 mm of Hg. Immediate fast I.V. R.L. drip was started & requisition for blood was sent & Blood Transfusion was started. Urgent USG & CT scan was done. Perforation of uterus by molar tissue was found. Patient was prepared for emergency hysterectomy. On 06.03.13 emergency laparotomy was done. Blood was present in peritoneal cavity. There was fundal perforation of uterus near left cornu by molar tissue. Total abdominal hysterectomy was done. Both-theca lutin cysts were

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left as such2 units of Blood were given. On cutting open the uterus there was molar tissue with fluid filled spaces and old blood clots & necrotic tissue filling the uterine cavity. Molar tissue had invaded myometrium& perforated uterine fundus near left cornu. Post-operative period was uneventful. On Day 8 after surgery ßHCG was repeated. ßHCG was 9800mIU/ml. Stitches were removed on 10th day and patient was discharged on 12th day with advice to report after 1 week. ßHCG was repeated & ßHCG was 56.1mIU/ml. Opinion of oncologist was taken and it was decided to give another cycle of chemo. After chemo patient was discharged with advice to report after 1month.

HPE report showed Chorio Carcinoma and ßHCG on 13.05.13was 11.6mIU/ml. Patient was referred to Oncologist for further management.

DISCUSSION: About 15-20% of complete moles progress to persistent Gestational trophoblastic neoplasia[2], there is a Plateau or re-elevation of HCG level. Post molar Gestational trophoblastic neoplasia may be benign or malignant. Staging of Gestational Trophoblastic neoplasia is[3]

Stage I – Disease confined to uterus.

Stage II – Gestational Trophoblastic neoplasia extending outside uterus but limited to genital structures.

Stage III – Gestational Trophoblastic neoplasia extending to lungs with or without genital tract involvement.

Stage IV – Metastasis to liver, brain, kidney & gastrointestinal tracts.

A scoring system based on prognostic factors has been developed depending on age of patient, interval between end of antecedent pregnancy & start of chemotherapy, Level of HCG, ABO group, size of largest tumor, site of metastasis, number of metastasis & prior chemotherapy. If total score is more than 7 then it is kept in high risk category.

In this patient risk score was 7. As the patient was in high risk category patient was referred to oncologist. Oncologist started combination chemotherapy with Methotrexate, actinomycin- D & cyclophosphamide.

During the course of second cycle of chemotherapy patient developed sudden features of internal hemorrhage e.g. pain abdomen Tachycardia, fall of Blood Pressure, distension of abdomen. Urgent ultrasonography & CT showed perforation of uterus with molar tissue. Emergency laparotomy was done and Total Abdominal hysterectomy with preservation of both theca lutin cyst was done. B-HCG was repeated on 8thpost-operative day. B-HCG was 9800 mIU/ml. Patient was discharged on 12th post-operative day with advice for follow up and patient was referred to oncologist.

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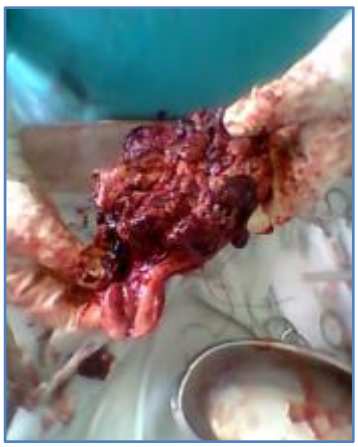
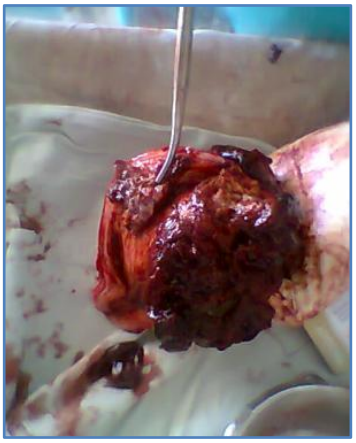


Uterine cavity with molar tissue

Uterine cavity with Molar Tissue



Uterine cavity with Molar Tissue

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