

MOLAR ECTOPIC PREGNANCY;

AN UNUSAL PRESENTATION. A CASE REPORT

Dr. Shama Chaudhry, Dr. Iqra Jangda, Dr. Rubina Hussain.

ABSTRACT.....Ectopic molar pregnancy is a rare occurrence. Clinical diagnosis of a molar pregnancy is difficult but histopathology is the gold standard for diagnosis. The management of ectopic molar pregnancies consists of surgically removing the conceptus, follow up & chemotherapy, if required. We are reporting a case report of a 35-year-old married, nulliparous woman, admitted in emergency with a 6-week history of amenorrhea, severe abdominal pain & an episode of fainting at home. Per abdominal examination revealed tenderness over the right iliac fossa, with guarding & rigidity. Diagnosis of ruptured ectopic pregnancy was made. Emergency laparotomy was done. Histopathological examination, showed tubal ectopic pregnancy with partial hydatidiform mole & a separate corpus luteal cyst. She was followed up with serial beta hCG which became normal within 1 month. Although ectopic molar pregnancy is a rare entity but all ectopic pregnancies should be examined histologically to rule out presence of gestational trophoblastic disease to plan follow-up accordingly in order to avoid persistent gestational trophoblastic disease which has a chance of malignant conversion. The prognosis of ectopic molar pregnancies is the same as for other forms of gestational trophoblastic disease.

Key words: Ectopic molar pregnancy, partial hydatidiform mole, persistent gestational trophoblastic disease.

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INTRODUCTION

Hydatidiform moles (HMs) are a type of gestational trophoblastic disease that results from abnormal fertilization and subsequent trophoblastic proliferation.

The incidence of hydatidiform moles is 1 per 1,000 pregnancies¹. Ectopic pregnancy occurs in 20 per 1,000 pregnancies². Thus, the incidence of ectopic molar gestation is very rare.

CASE REPORT

A 35-year-old married, nulliparous, without notable medical history, conceived after 3 courses of clomiphene citrate, was admitted in emergency with a 6-week history of amenorrhea, severe abdominal pain & an episode of fainting at home. She also had right sided lower abdominal pain & bleeding for which she was given oral progesterone by a GP two week prior to the presentation. On examination, her pulse was 105b/min & B.P was 100/60mmHg & was looking pale & distressed. Per abdominal examination revealed tenderness over the right iliac fossa, with guarding & rigidity. Per vaginal examination showed closed cervix,

positive cervical excitation & normal sized uterus. Her serum beta hCG was 25318 iu/ml. Transvaginal ultrasound showed right sided viable ectopic pregnancy, right ovarian cyst measuring 4X3cm & moderate amount of free fluid in pouch of douglas.

Emergency laparotomy was done. During the operation, swollen fusiform right fallopian tube containing gestational sac, with bleeding from fimbrial end, right ovarian cyst & hemoperitoneum of 300ml was seen. A normal sized uterus, an intact left-sided fallopian tube & cystic left ovary was found. Consequently, right-sided salpingectomy, enucleation of right ovarian cyst with reconstruction of right ovary, ovarian drilling of left ovary & peritoneal lavage was performed.

Histopathological examination, showed tubal ectopic pregnancy with partial hydatidiform mole & a separate corpus luteal cyst. She was followed up with serial beta HCG which became normal within 1 month.

DISCUSSION

The gestational trophoblastic disease consists of two

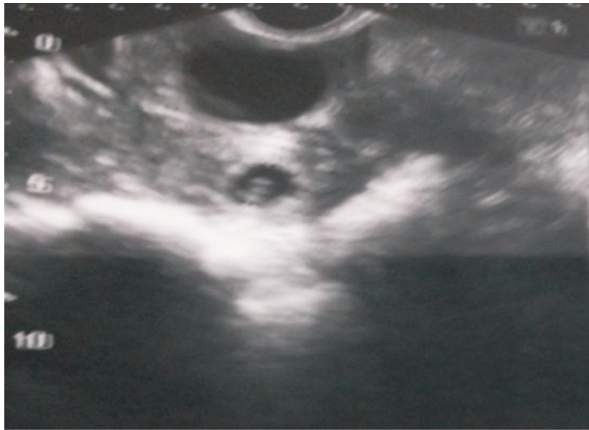


Fig. 1: Molar tubal ectopic pregnancy & corpus luteal cyst on transvaginal scan.

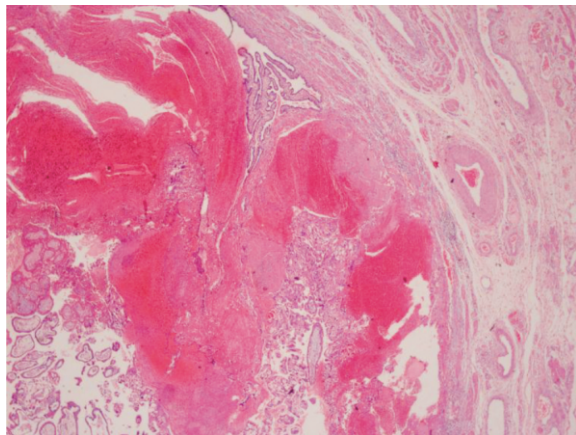


Fig. 2: Hemorrhagic chorionic villi, fallopian tube

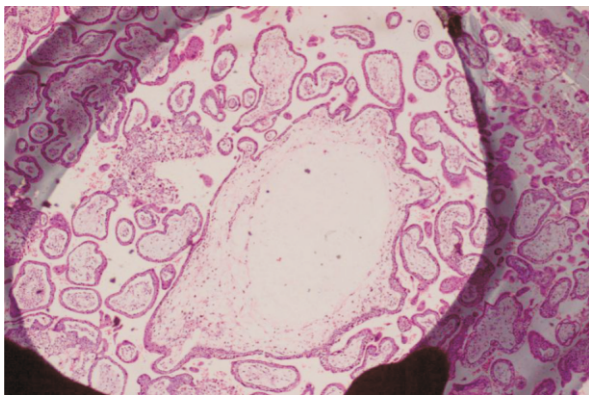


Fig. 3: Hydatidiform mole in the fallopian tube

types of molar pregnancies: complete hydatidiform mole and partial hydatidiform mole. Both have the potential for transformation into gestational trophoblastic neoplasia (GTN). Although most cases of GTN came from molar pregnancy, there are a few cases of choriocarcinoma arising from non-molar pregnancies. The incidence of hydatidiform mole in Asia is 70 to 100 times higher than in Europe or North America, occurring mostly at the extremes of reproductive life³.

Hydatidiform mole is basically an abnormal conceptus, due to abnormal fertilization which can be sub-classified into complete and partial moles based on morphological, pathological, and genetic differences^{1,2}. Partial moles arise from dispermic fertilization of a haploid ovum resulting in a triploid genome whereas in a complete mole, the chromosomal complement is 46,XX with the genome paternal in origin. This is usually caused by fertilization of an empty ovum by a haploid spermatozoon, which subsequently duplicates. Occasionally cases occur by fertilization with two sperm⁴.

Two-dimensional ultrasound is the most frequently used imaging method for the diagnosis of hydatidiform mole. The most common finding in the first trimester of complete mole is the presence of a predominantly echogenic mass with heterogeneous aspect inside the uterine cavity and hypo echoic areas around it, through transvaginal approach. This initial appearance is nonspecific and can be confused with incomplete miscarriage⁵.

Histologically, molar pregnancy is an abnormal gestation characterized by the presence of hydropic change affecting some or all of the placental villi, accompanied by circumferential proliferation of trophoblasts. Non molar hydropic abortions are common; it is clinically important to distinguish molar pregnancies from non molar hydropic changes, because the former has the potential of causing

persistent trophoblastic disease⁶.

Although β -hCG levels are elevated in tubal molar pregnancies, they are generally in the lower range, because implantation in the fallopian tube might preclude adequate vascularization, thereby leading to low levels of hCG. There is no distinctive difference in -hCG levels between molar tubal pregnancies and ectopic pregnancy. Thus, an early ectopic molar pregnancy is not distinguishable from a non trophoblastic tubal pregnancy on the basis of hCG levels⁷.

It is now accepted that patients with ectopic molar pregnancies are clinically indistinguishable from patients with 'traditional' tubal pregnancies, with the possible exception of higher tendency of rupture at the time of presentation^{8,9}. One extensive study on routine pre-evacuation ultrasound diagnosis of hydatidiform mole suggests that ultrasonography identifies less than 50% of hydatidiform moles. Detection rates are, however, higher for complete compared to partial moles, and improve even further after the 14th week of gestation⁵.

The management of ectopic molar pregnancies consists of surgically removing the conceptus with no obvious preference for laparoscopy or laparotomy provided that the whole trophoblast is removed^{8,10}.

The histological examination of the surgically removed conceptus in ectopic pregnancies is essential for appropriate follow-up to be arranged (which includes registration with an appropriate centre). The prognosis of ectopic molar pregnancies is the same as for other forms of gestational trophoblastic disease⁸.

CONCLUSION

Although ectopic molar pregnancy is a rare entity but all ectopic pregnancies should be examined histologically to rule out presence of gestational trophoblastic disease to plan follow-up accordingly in

order to avoid persistent gestational trophoblastic disease which has a chance of malignant conversion.

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*In prosperity our friends know us;
in adversity we know our friends.*

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