

An Interesting Case of a Vesicular Mole

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Abstract

Molar gestations are increased in older and very young females of reproductive age. We had an unusually large vesicular mole in a multipara without any classical symptoms.

Introduction

Gestational trophoblastic disease encompasses following spectrum: Complete vesicular mole, partial vesicular mole, invasive mole, placental-site trophoblastic tumour to choriocarcinoma.¹

Patients with a complete molar pregnancy usually present with the classical symptoms of vaginal bleeding, hyperemesis, passage of grape like vesicles per vagina and a uterus larger than dates. A few patients may show evidence of preeclampsia and features of hyperthyroidism.²

Case Report

Mrs XYZ, P8L7D1, 40 years, Muslim housewife hailing from Ajamgarh was admitted with complaints of distension of abdomen, pain in abdomen and amenorrhoea since 2 months.

Her periods were normal before.

Patient was apparently asymptomatic two months ago; when she noticed some distension of abdomen which increased to the present size. She also complained of pain in lower abdomen, which was dull aching, non radiating and did not subside with analgesics. She did not avail of any medical treatment. There were no bowel / bladder complaints. She gave no other significant past history. There was no history of any breast/abdominal malignancy in the patient or family member.

At the time of admission patient was anaemic. There was no evidence of goitre. Pulse rate- 100/min;

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BP- 140/90 mmHg. Respiratory and cardiovascular systems were WNL (within normal limits).

On abdominal examination there was a globular mass arising from pelvis corresponding to 36 weeks uterine size, non ballotable and doughy in consistency. No foetal parts were palpable.

Per vaginally uterus could not be felt separately from the mass. Os was closed.

There was no evidence of bleeding.

Patient was investigated. Her haemoglobin was 7.5 g%, Urine pregnancy test was positive. S beta hCG- 1,75,000 mIU/ml. Thyroid profile showed mild thyrotoxicosis with TSH-0.1 microu/ml (suppressed). Renal and liver function tests were normal. USG abdomen and pelvis- suggestive of complete vesicular mole. Mild hepatosplenomegaly. X-ray chest was normal.

Double valve manual vacuum aspiration technique was used to evacuate the uterine contents. Around 3 litres of the vesicles and blood clots were evacuated uneventfully. Uterus involuted from 36 weeks to 18 weeks. She was transfused with 4 units of packed cells.

Post evacuation there was a reduction in uterine size and beta hCG values fell to 22,264.mIU/ml on 6th day (post evacuation) and on day 11 it was 8,837 mIU/ml.

Chemotherapy would be the choice of treatment of this patient. She was counselled for this.

But she was very keen to return to Ajamgarh.

Also considering various risk factors like her age, high parity, large size of mole and high serum Beta hCG levels inclined us to counsel her for hysterectomy.

She was taken up for total abdominal hysterectomy.

During operation uterus was found enlarged upto



Fig. 1 : Patient with uterine size 36 weeks.



Fig. 2 : During evacuation with MVA grape like structures can be seen.

15 x 13 cm with smooth surface.

Both the ovaries were normal. On cut section there was a rough area in fundal region but no evidence of myometrial invasion.

Post operative course of patient in ward was uneventful. She was discharged on day 15 post surgery and her S beta hCG was 200 mIU/ml at the time of discharge.

Histopathology report suggested intact basal endometrium layer with no invasion of myometrium. Exaggerated placental implantation with areas of necrosis. No evidence of choriocarcinoma.

Cervix showed chronic cervicitis.

After great persuasion she followed up 1 month later. There was no evidence of persistent disease or metastasis on chest X-ray, ultrasonography of abdomen. Her beta hCG values were nil.

Discussion

The diagnosis of molar pregnancy can



Fig. 3 : During evacuation with MVA grape like structures can be seen.

nearly always be made by ultrasound, because the chorionic villi of a typical complete mole proliferate with vacuolar swelling and produce a characteristic vesicular sonographic pattern. The classical 'snowstorm' pattern of the uterus is not commonly seen now.³ Benson et al reported that the majority of first trimester complete moles demonstrated a typical sonographic appearance of a complex and echogenic intrauterine mass containing many small cystic spaces {which correspond to the hydropic villi on gross pathology}.^{4,5} Studies have shown colour Doppler to be useful in the evaluation and follow up of gestational trophoblastic tumours.⁶

Differential Diagnosis

1. **Leiomyoma:** Leiomyomas have a characteristic whorling and lack the cystic appearance of a mole.

2. **Ovarian tumors:** They may be diagnosed when a normal uterus is demonstrated.

3. **Hydropic placental degeneration:** It can be confused with a mole accompanying a live foetus. Vesicles, cysts, foetal remains, and an abnormal placenta can be seen.

Serum quantitative beta hCG levels are usually very high for the given gestational

period, although early stages may have normal levels.

Failure of these levels to return to a normal value, post treatment, is a prognostic indicator of retained molar tissue.

Treatment for recurrent molar pregnancy, called gestational trophoblastic neoplasia, or GTN, usually consists of a chemotherapy with methotrexate. Fortunately, methotrexate is safe on the system, and can be given as a single intramuscular dose. In other cases like cases with little or no reduction in beta hCG, metastatic disease multiple doses or even the addition of other chemotherapeutic agents like adriamycin, etoposide may be necessary.

Also, when GTN is suspected, the patient usually gets a CT scan of the brain, lungs, and abdomen, and a battery of blood tests. Again, weekly hCG tests are obtained until they fall to zero, then careful follow-up is undertaken for a year. Patients can expect an almost 100% cure rate using chemotherapy.

Surgical procedures, especially hysterectomy is found to be of use removing known foci of disease in selected high-risk patients with gestational trophoblastic neoplasia or trophoblastic tumour with evidence of perforation. Patients with evidence of uterine disease but nil or very little extra-uterine disease show benefit from hysterectomy. Mutch *et al* reported curing 10 (71%) of 14 patients who had hysterectomy as part of their treatment. At the Brewer Centre, surgeries like hysterectomy have shown good results in most patients treated.

Future Pregnancy

Fortunately, the risk of having another molar pregnancy is about 1% (1 in 100). It is

necessary to perform an early ultrasound to make sure the pregnancy is normal when a patient has had a prior molar pregnancy. It is also advisable to send the placenta to the pathologist after the delivery just to make sure there are no abnormal areas.

Prognosis

More than 80% of hydatidiform moles are benign. The outcome after treatment is usually excellent. Close follow-up is essential. In 10 to 15% of cases, hydatidiform moles may develop into invasive moles. In 2 to 3% of cases, hydatidiform moles may develop into choriocarcinoma, which is a malignant, rapidly-growing, and metastatic (spreading) form of cancer. Despite these factors which normally indicate a poor prognosis, the rate of cure after treatment is high.

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