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Case Report

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Molar Pregnancy Presents as Tubal Ectopic Pregnancy

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Key words: hydatiform mole; ectopic pregnancy; choriocarcinoma; choriohormon; gestational sac.

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Abstract

Gestational trophoblastic disease is a spectrum of trophoblastic diseases that includes: Complete molar pregnancy (CMP), partial molar pregnancies (PMP), invasive mole (IM), chorioncarcinoma (CHC), and placental site trophoblastic tumors (PSTT). Hydatidiform moles are abnormal gestations characterized by the presence of hydropic changes affecting some or all of the placental villi. Hydatidiform moles arise as a result of an abnormal fertilization. In this report, the patient was a 28 year old Albanian woman who had induction of ovulation with Clomid. The majority of molar gestations arise within the uterine cavity.

The occurrence of a hydatidiform mole within ectopic gestational tissue is rare. It is important to differentiate a hydatidiform mole from an ectopic pregnancy, particularly in infertile women who have a history of ovulation induction.

Introduction

Gestational trophoblastic disease is a spectrum of trophoblastic diseases that includes: Complete molar pregnancy (CMP), partial molar pregnancies (PMP), invasive mole (IM), chorioncarcinoma (CHC) and placental site trophoblastic tumors (PSTT).

Hydatidiform moles are abnormal gestation characterized by the presence of hydropic changes affecting some or all of the placental villi. Hydatidiform moles arise as a result of an abnormal fertilization. The occurrence of a hydatidiform mole as ectopic gestational tissue is rare [1].

Case report

The patient was a 28 year old Albanian woman who came to Alushani Private Clinic in October 2012 due to a missed period (gestational age: six weeks) and elevated human chorionic gonadotropin β (β-hCG) titer (50 000 units/ml). Her gynecologic history was unremarkable except for primary infertility of 2 year's duration due to polycyctic ovary syndrome. The patient's pregnancy occurred with the use of Clomid 100mg per day for 5 days. She was having hyperemesis, breast tenederness vaginal brown secretion since 2 days prior to presenting to the clinic. The patient didn't have previous medical and surgical histories.

She had smoked 5-10 cigarettes /day and had no histories of previous missed abortion. The patient underwent a physical examination. She was paile, blood pressure was 100/60 mmHg, pulse 110 beats/min and a temperature of 36.8°C. The chest was clear and the electrocardiography (ECG) was normal. The patient had right lower quadrant tenderness by abdominal palpation. There was brown blood in the vagina.

Internal examination revealed a anteverted uterus with right adnexal masse. Tenderness in the right adnexa and cervical motion tenderness were

present.

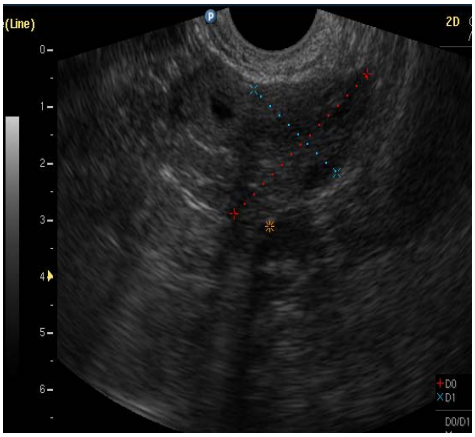

Figure 1: Transvaginal ultrasonography of ectopic pregnancy, right ovary.

We performed transvaginal ultrasonography. There was no gestational sac within the uterus cavity; the endometrial thickness was 9 mm, a right adenexal mass that consisted of a suspicious echofree area gestational sac (GS) of 18.7 *16.3 mm and no free fluid in the cul-de-sac were noted (Fig. 1, 2).

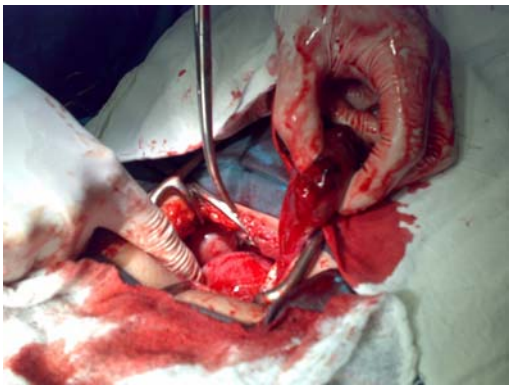

Figure 2: Laparotomy for ectopic pregnancy.

It was recomanded the mesaurment of β (β-hCG) after 48 hours and to revaluate the situation. After 48 hours it was 85.000 IU/ml. With TVUS it was seen that adnexal mass was 20*22 mm, and no gestational sac in the uterine cavity was seen.

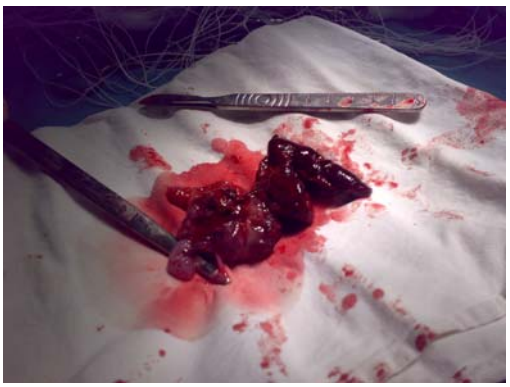

Figure 3: Fallopian tube removal. The embryo around 10 mm, 6-7 weeks of pregnancy.

In this situation it was recommended Metotexate for ectopic pregnancy although the BHCG was higher than 5000 IU/ml but the adnexial mass was smaller than 4 cm, so it was decided to prove with Methotrexate. 48 hours after the admission of Metotrexate, she felt lower pelvic pain, lipotimia. Blood exam: eritrocytes 3200 mm^3, Hb 9.2 g/L, Ht 27m. TVUS free fluid in Douglas.

In this condition the patient underwent in Laparotomia. The fallopian tube was resected due to a rupture that extended to the subserosal surface. Pathologic report was right fallopian tube ectopic pregnancy with features of a partial hydatidiform mole (Fig. 3, 4).

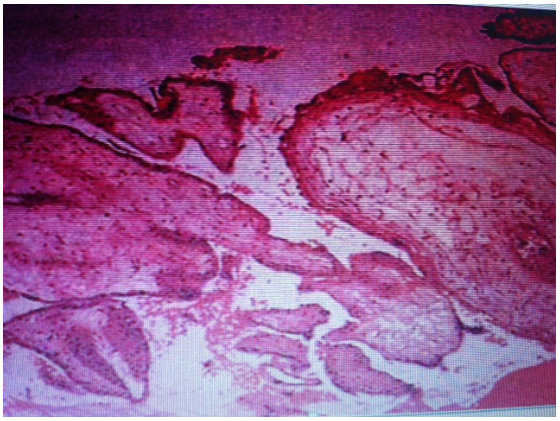

Figure 4: Histology of partial hydatiform mole.

Based on the pathologic report, a workup for hydatidiform mole was begun, followed by serum β-hCG titer.

Discussion

The incidence of a partial or complete hydatidiform mole in pregnancies is 1 in 1,000 pregnancies in UK [1, 2] or 1 in 40 Missed Abortions and 1 in 35 Missed abortions in Albania.

Theoretically, the same proportion of ectopic pregnancies should also be affected by molar change since the main etiologic factor preceding both partial and complete hydatidiform moles is an abnormal androgenetic chromosomal constitution of the conceptus that is present before implantation regardless of the site [2]. Tubal ectopic hydatidiform moles are rare occurrences and only 133 cases have been reported in the literature [2].

All patients who present with a hydatidiform mole complain of abdominal pain; some also have vaginal bleeding. The condition can mimic the usual symptoms of ectopic pregnancy particularly when a hemo peritoneum is present however it is actually an ectopic molar pregnancy [3].

Immunohistochemicalmarkers such as P57KIP2, which has been recently described, can also be useful for early diagnoses of Hydatiform moles even on the basis of minimal tissue since this protein is not expressed in the villus trophoblast or the stroma

of complete hydatidiform moles,but it is not avaible here in our country [4].

Because trophoblastic tissue has an invasive nature when located in the early gestational sac, an ectopic pregnancy may be associated with apparent local invasion of surrounding tissues by the trophoblast [5].

The lesions of gestational trophoblastic tumor (GTT) misdiagnosed as an ectopic pregnancy can be seen in the fallopian tube, horn of the uterus, peritoneal cavity, greater omentum and recto -uterine pouch [2]. Misdiagnosis leads to delay in therapy with resultant increased morbidity of GTT [6]. However, none of the cases in one series developed persistent gestational trophoblastic disease, and hCG concentrations spontaneously returned to normal levels during surveillance in all cases that had a confirmed diagnosis of hydatidiform mole [5].

However, cases described previously did not develop persistent gestational trophoblastic disease (GTD) clinically or require chemotherapy.

Consequently, the risk for persistent GTD after an extra-uterine molar gestation is approximately 0.5% for partial and 15% for complete hydatidiform moles. The diagnosis of apparently primary tubal choriocarcinoma with no confirmed previous ectopic hydatidiform mole is now wellreported but poses no specific histopathologic diagnostic problems; the features are identical to choriocarcinoma at other sites [5]. In many cases metastatic disease may be present at diagnosis, but it remains unclear in what proportion of cases the choriocarcinoma may have developed from a previous unrecognized tubal molar conceptus or whether some cases may represent seeding from a uterine primary conception [6].

Patients who have received methotrexate for ectopic pregnancy are managed nonsurgically because no tissue diagnosis is available.Monitoring of hCG is important till it returns in normal level.

A tubal ectopic hydatidiform mole is a rare condition. The mean gestational age at admission is six weeks. It is important that after induction of ovulation for infertility treatment, the clinician considers the possibility of a hydatidiform mole in the extra-uterine cavity of which special attention and treatment is needed, rather than simply treating an ectopic pregnancy. In patients with histories of infertility and induction of ovulation, ectopic pregnancy is more common and always should be consider a molar ectopic pregnancy.

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