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Case Report

A case report of 26 weeks of complete molar pregnancy with posterior uterine fibroid

Manju Prabhakar*, Maryam Ali

Department of Obstetrics and Gynecology, Muzaffarnagar Medical College, Muzaffarnagar, Uttar Pradesh, India

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***Correspondence:**
Dr. Manju Prabhakar,
E-mail: manju.prabhakar2863@gmail.com

ABSTRACT

Molar pregnancy is one of the classifications of GTD and sometimes can be associated with hyperthyroidism. The classic features are irregular vaginal bleeding, hyper emesis and large uterus for gestational age. Though incidence of uterine fibroid with pregnancy is 1% to 10% but encountered with molar pregnancy is rare. Here we reported a case of complete molar pregnancy with posterior uterine fibroid who initially presented with 3-month amenorrhea and had a complaint of spotting per vagina occasionally with ultrasonography report suggestive of molar pregnancy and post uterine fibroid with raised beta-hCG with low TSH suggestive of hyperthyroidism.

Keywords: Molar pregnancy, Hyperthyroidism, Raised beta-hCG

INTRODUCTION

Gestational trophoblastic disease (GTD) is a rare complication of pregnancy that may be associated with hyperthyroidism. The incidence in the United States is about 1 in 1500 live births. Complete moles have the highest incidence of thyrotoxicosis and predominantly affect younger women and present with vaginal bleeding most of the time.[1] It is a group of disorders that arises from placental trophoblastic tissue. They include benign lesions which comprise of complete and partial hydatidiform mole and also malignant lesions consisting of invasive mole, choriocarcinoma, epithelioid trophoblastic tumor and placental site trophoblastic tumor.[1,2] In general complete moles are 46XX or 46XY karyotype and chromosomes are entirely of paternal origin. Partial moles have triploid karyotype (69XXY OR 69XYY) with one maternal and usually two paternal haploid chromosomes.[3]

CASE REPORT

A 35-year-old G3P1L2A1 came to obstetrics and gynaecology department OPD at Muzaffarnagar Medical College and Hospital with a history of three months of amenorrhea and UPT positive with complaints of spotting per vagina for 20 days. She carried a USG report depicting enlarge uterus with a hydatidiform mole and posterior fibroid of size 6×3 cm and serum beta hCG which was 8,19000 mIU/ml. On examination the patient was stable. The patient's vitals showed BP-130/80 mmHg, PR-78 /min and respiratory rate of 18 /min. On per abdomen examination uterus was 26 weeks in size, on per speculum examination-slight bleeding was present, and on per vagina examination-uterus was 26 in size, soft to firm, os entering tip of the finger, bilateral adnexa were free and non-tender. Here below were the investigations with reports.

USG

The endometrial cavity is distended (143×110×50 mm) showing evidence of hyperechoic and cystic areas giving snowstorm appearance likely a complete mole with well defined hypoechoic lesion of 46.9×36.6 mm along the posterior uterine wall s/o fibroid.

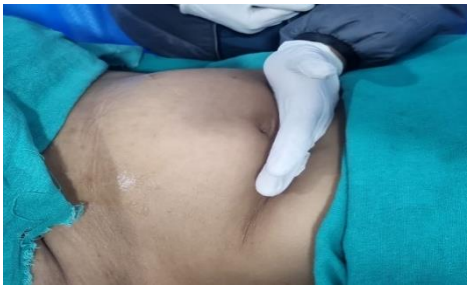

Figure 1: Preop fundus height corresponding to 26 weeks.

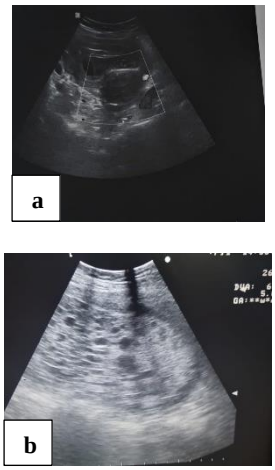

Figure 2 (a and b): USG films.

MRI report

Bulky uterus with heterogeneous signal intensity areas with multiple small innumerable cystic areas within and uterine fibroid.

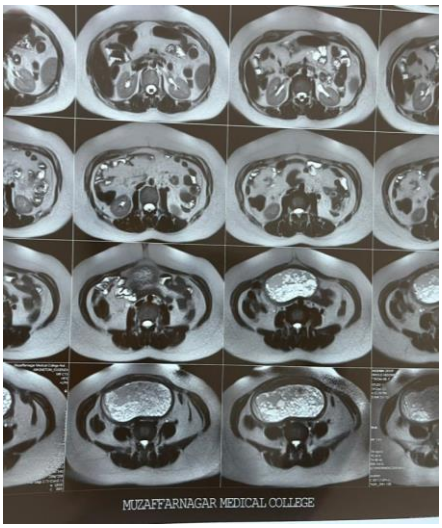

Figure 3: MRI report.

Her lab investigation was all within normal levels except for serum TSH which was low (<0.03 uIU/m) and serum beta hCG which was 819000 mIU/ml.

Management

The patient had been taken up for suction and evacuation after blood arrangements and total pre-anesthetic check-up under spinal anesthesia.

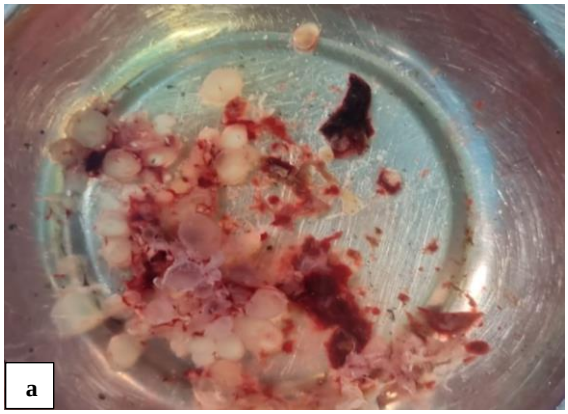

Figure 4: Tissue extracted with blood around 1.5 litre.

Tissue and blood clots with vesicles were seen intraoperatively and sent for histopathological examinations. The below pictures are of vesicles and around 1.5 litre of tissue had been extracted and post suction uterus size drastically reduced to 8-week size on per abdomen examination.

Outcome and follow-up

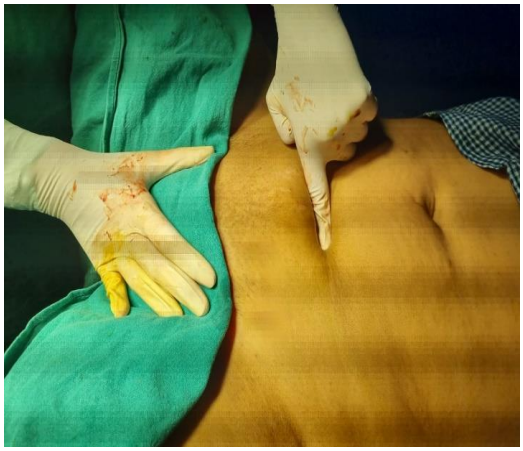

Figure 5: Post-suction size of uterus reduced on per abdomen examination.

The subsequent histopathological features were suggestive of complete hydatidiform mole, we also followed up with the serum beta hCG, which showed decreasing pattern. The table below mentions the blood reports accordingly.

Table 1: Serum beta hCG.

Date	Serum beta hCG
8/12/23	819000mIU/ml ↓
20/12/23	163661mIU/ml ↓
27/12/23	6553.7mIU/ml ↓
2/1/24	893mIU/ml ↓
10/1/24	244Miu/ml ↓

We followed the patient till we got the negative beta hCG report and we also planned for the medical management of fibroid.

DISCUSSION

Hydatidiform mole is principally a disease of chorion. It is best regarded as a benign neoplasia with malignant potential. The most common features are vaginal bleeding with lower abdominal pain and expulsion of grape-like vesicles. This is a rare complication of pregnancy that may be associated with hyperthyroidism. Surgical pathologists often encounter hydropic villi in products of conception at the first trimester and must determine whether the villi represent complete hydatidiform mole (CM), partial hydatidiform mole (PM), or hydropic abortion (HA). The distinction between these is important for determining the appropriate treatment of patients. Fukunaga et al study assessed interobserver and intraobservervariability.[4]

In the last two decades, due to early diagnosis, there has been a change in the clinical picture of HM. Sun et al reported fewer number of patients with CM presenting with vaginal bleeding. This was attributed to the implementation of early routine ultrasound for pregnant women in the region.[5] Complete moles secrete high levels of beta-hCG, much higher than what would be expected of a normal pregnancy, at a given point in time. This proves to have an important role as a tool when trying to diagnose a complete mole. The rapid rise in the beta-hCG level can differentiate this from a normal pregnancy and is responsible for potential complications such as hyperthyroid features, HG, theca lutein cysts, and/or preeclampsia with or without severe features. There is also a 6-32% chance of progression to malignant choriocarcinoma and about a 12-15% chance of progression to persistent GTD.[6]

The American College of Obstetricians and Gynecologists recommends that for patients with HM, beta hCG levels should be measured 48 hours after evacuation and every 1 to 2 weeks until levels are undetectable. After attaining undetectable levels, follow-up measurements are made at monthly intervals for an additional 6 months.

CONCLUSION

Molar pregnancy is an uncommon condition in our region. Women aged older than 35 years and nulliparous are at a higher risk of developing molar pregnancy, with vaginal bleeding as the commonest presenting symptom. Patients with high beta hCG levels (>100,000 mIU/ml) and large for date uterus at diagnosis are at high risk of developing GTD and need a careful follow-up thereafter. Early booking of pregnant women to antenatal care clinics and routine first trimester ultrasounds has made diagnosis easier and earlier before any complications arise. Histological review for all miscarriages is mandatory for the detection and diagnosis of HM.

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