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Case Report

A rare case of cornual molar ectopic pregnancy

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ABSTRACT

Gestational trophoblastic disease (GTD) comprises a heterogeneous group of placental disorders characterized by abnormal trophoblastic proliferation. The reported incidence of GTD ranges from 0.2 to 5.8 per 1,000 pregnancies, while ectopic pregnancies account for approximately 0.64% of all pregnancies. The coexistence of ectopic pregnancy with molar pathology is exceptionally uncommon. Hydatidiform mole occurs in about 1 in 2,000 pregnancies, with most cases arising within the uterine cavity.

Keywords: Cornual ectopic, Molar pregnancy, Colour Doppler, Interstitial pregnancy

INTRODUCTION

Molar ectopic pregnancy is an extremely rare condition that often clinically resembles a typical tubal ectopic pregnancy. A definitive diagnosis is usually established only after histopathological evaluation. Reported locations of ectopic molar pregnancies include the fallopian tube, ovary, cervix, and cornual region.[1] Transvaginal ultrasonography combined with color Doppler imaging plays an important role in preoperative assessment, although histopathology remains the gold standard for diagnosis.

CASE REPORT

A 29-year-old female (G2P1L1) was referred to our department with complaints of per-vaginal bleeding. She had a history of one previous lower-segment cesarean section and had a 3-year-old male child. On clinical examination, left adnexal tenderness and vaginal bleeding were noted.

Ultrasonography revealed a heterogeneous lesion with multiple cystic spaces and marked vascularity adjacent to the left cornu, measuring approximately 3.5 × 3 cm, raising a strong suspicion of molar pregnancy. The endometrial thickness was 6.8 mm, and the serum β-hCG level was 35,645 IU/l.

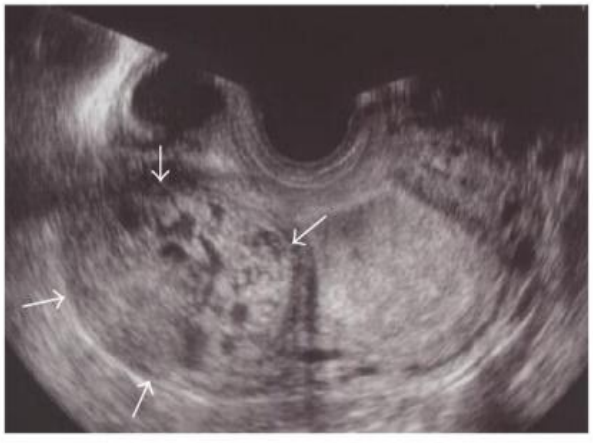

Figure 1: Cornual ectopic pregnancy with molar changes.

Based on these findings, a diagnosis of cornual pregnancy was made, and the patient underwent laparoscopic surgery.

Intraoperatively, a 3 × 4 cm ectopic gestation was identified in the left cornual region. Excision of the cornual ectopic pregnancy along with left salpingectomy was performed, followed by reconstruction of the cornual area.

Histopathological examination of the specimen confirmed a partial hydatidiform mole. One week postoperatively, the β-hCG level had declined to 1,019 IU/l.

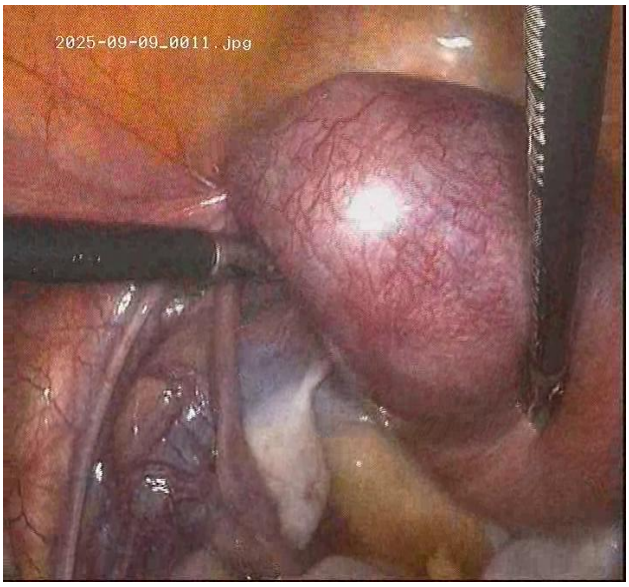

Figure 2: Left cornual ectopic pregnancy.

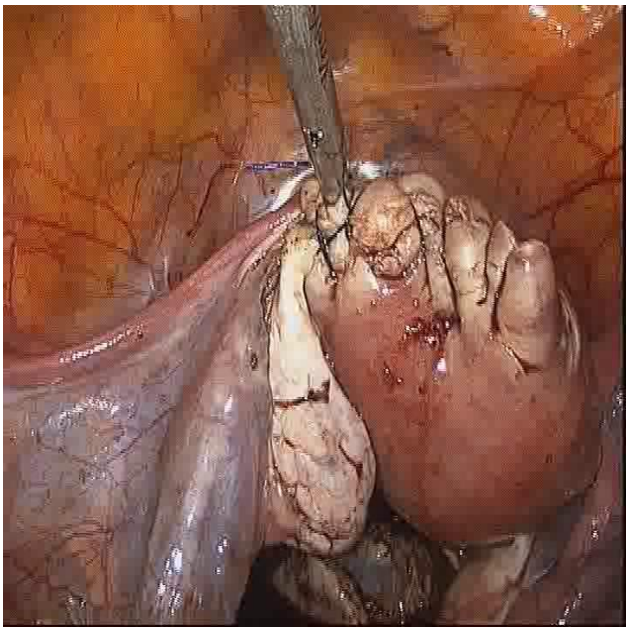

Figure 3: Left salpingectomy with cornual ectopic excision with uterine reconstruction.

Final pathological diagnosis

Ectopic interstitial tubal pregnancy with partial molar changes.

DISCUSSION

Ectopic pregnancy most frequently occurs within the fallopian tube, with an estimated incidence of approximately 20 per 1,000 pregnancies. Cornual or interstitial pregnancies account for only 2–4% of all ectopic gestations.[2] In contrast, molar pregnancies occur in roughly 1 per 1,000–2,000 pregnancies and are predominantly intrauterine. The occurrence of molar changes in an ectopic location is exceedingly rare, with very few cases described in the literature.[3]

The true incidence of ectopic molar pregnancy may be underestimated, particularly in resource-limited settings where routine histopathological examination of salpingectomy specimens is not consistently performed.[4] To the best of our knowledge, this case represents one of the rare reports of a cornual ectopic pregnancy complicated by partial molar changes.

A prior history of molar pregnancy is the most significant risk factor for recurrence, with reported recurrence rates ranging from 1% to 23% in patients with two previous molar gestations.[5] Additional risk factors include extremes of maternal age, nutritional deficiencies (particularly vitamin A), recurrent pregnancy loss, and certain blood groups (A or AB). Risk factors for ectopic pregnancy include pelvic inflammatory disease, prior tubal surgery, and assisted reproductive techniques. None of these risk factors were identified in our patient.

Clinically, invasive ectopic molar pregnancy does not present with distinctive features and often mimics a non-molar ectopic pregnancy, although the risk of rupture may be higher. Symptoms usually manifest during the first trimester and include unilateral pelvic pain and vaginal bleeding.[6] Other associated features may include excessive uterine enlargement, hyperemesis gravidarum, and disproportionately elevated β-hCG levels.

Transvaginal ultrasonography typically demonstrates an empty uterine cavity, while Doppler imaging may reveal a heterogeneous, highly vascular adnexal mass suggestive of trophoblastic disease.[7] However, these findings are not diagnostic, and confirmation relies on histopathological evaluation. Complete hydatidiform moles are characterized by diffuse villous edema, cystic changes, and trophoblastic hyperplasia with minimal vascularization. Invasive moles show similar histological features but with deep myometrial or tubal wall invasion.[8]

Invasive mole must be distinguished from choriocarcinoma, which lacks villous structures and carries a higher risk of metastasis. Imaging studies, including CT scanning, are recommended for staging. No evidence of loco regional or distant metastases was identified in our patient.

Management of invasive ectopic molar pregnancy typically involves surgical removal, most commonly

salpingectomy, followed by close β-hCG surveillance.[9] Chemotherapy may be indicated if β-hCG levels plateau or rise. Post-evacuation monitoring includes weekly β-hCG measurements until normalization, confirmed by three consecutive negative results, followed by monthly monitoring for 6–12 months.[10]

CONCLUSION

Ectopic molar pregnancy is an exceptionally rare clinical entity. This case highlights the importance of considering molar pathology in atypical ectopic pregnancies, particularly those with high β-hCG levels and hypervascular lesions. Long-term β-hCG surveillance for at least six months after normalization is essential to detect early gestational trophoblastic neoplasia and ensure complete remission.

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