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**Case Report**

# When it's not just menopause: an unexpected hydatidiform mole in a 47-year-old woman

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## ABSTRACT

Hydatidiform mole is a form of gestational trophoblastic disease (GTD) that is usually diagnosed during the reproductive years. Presentation in women of perimenopausal age is uncommon and may be mistaken for other causes of abnormal uterine bleeding. A 47-year-old woman, para 1 living 1, presented with irregular and progressively heavier vaginal bleeding. Initial ultrasonography at a peripheral centre suggested a fibroid uterus with cystic areas. Repeat evaluation demonstrated a markedly elevated serum beta-human chorionic gonadotropin (β-hCG) concentration (1,500,000 mIU/ml) and ultrasonographic features suggestive of a complete hydatidiform mole. In view of her age and completed family, total abdominal hysterectomy was performed after assessment and management of associated biochemical hyperthyroidism. Histopathological examination, supported by negative p57 immunostaining, confirmed a complete hydatidiform mole without myometrial invasion. Serial postoperative β-hCG concentrations declined to the normal range. This case emphasizes the need to include GTD in the differential diagnosis of abnormal uterine bleeding in perimenopausal women, even when initial pregnancy testing is negative.

**Keywords:** Complete hydatidiform mole, Perimenopausal age, Abnormal uterine bleeding, Beta-human chorionic gonadotropin, p57 immunohistochemistry, Gestational trophoblastic disease

## INTRODUCTION

Gestational trophoblastic disease (GTD) comprises a spectrum of disorders arising from abnormal proliferation of placental trophoblastic tissue. Hydatidiform mole is the commonest premalignant form and is classified as complete or partial. Complete hydatidiform mole is typically characterized by diffuse hydropic villous change and trophoblastic proliferation, usually in the absence of fetal tissue. Although molar pregnancy is most often encountered in women of reproductive age, maternal age is an established risk factor, with increased risk reported at the extremes of reproductive age, particularly after 40-45 years.[1] In older women, vaginal bleeding and uterine enlargement may initially be attributed to common gynaecological conditions, potentially delaying diagnosis. Accurate diagnosis requires correlation of clinical findings, quantitative serum β-hCG, ultrasonography and histopathology, with p57 immunohistochemistry aiding distinction of complete mole from other gestations.[2]

## CASE REPORT

A 47-year-old woman, para 1 living 1, with a previous full-term normal vaginal delivery, presented with irregular vaginal bleeding that had been present since December 2024. She described intermittent spotting during January and February, followed by bleeding episodes lasting approximately 5–6 days in March and heavier bleeding in April. Urine pregnancy tests performed in January,

February and March were reported as negative. She also described intermittent abdominal pain and nausea of one month's duration. There was no history of vomiting, a palpable abdominal mass or postcoital bleeding.

An ultrasonographic examination performed at a peripheral hospital had suggested an enlarged fibroid uterus with cystic areas. In view of the persistent bleeding and atypical imaging appearance, she underwent further evaluation at our centre.

***Clinical examination***

The clinical examination findings are summarized in Table 1. The enlarged, soft uterus, measuring approximately 16-week size, prompted further evaluation for pregnancy-related pathology despite the earlier negative urine pregnancy tests.

***Investigations and clinical results***

Urine pregnancy testing was weakly positive at our centre, and the quantitative serum β-hCG concentration was 1,500,000 mIU/ml. Pelvic ultrasonography demonstrated an enlarged uterus containing a heterogeneous hyperechoic intrauterine mass with multiple cystic spaces, producing a snowstorm-like appearance. No fetal parts were identified. A theca-lutein cyst was noted in the left ovary (Figure 1). The combination of a markedly elevated β-hCG concentration, an enlarged uterus and a multicystic intrauterine mass strongly supported the clinical diagnosis of a molar pregnancy.

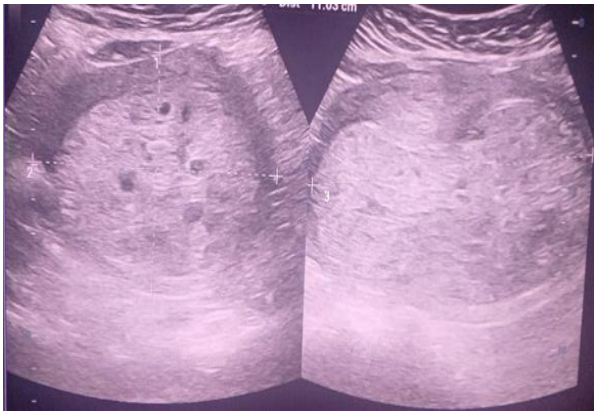


**Figure 1: Pelvic ultrasonography showing an enlarged uterus with a heterogeneous hyperechoic mass and multiple cystic spaces (snowstorm-like appearance), with no identifiable fetal parts; a left theca-lutein cyst was also reported.**

Chest radiography showed no abnormality. Preoperative laboratory evaluation showed a haemoglobin concentration of 10 g/dl. Thyroid function testing revealed a suppressed thyroid-stimulating hormone (TSH) level of <0.008 IU/ml with elevated T3 and T4 concentrations, consistent with biochemical hyperthyroidism.

***Management***

The patient was assessed by the endocrinology team and managed for hyperthyroidism. In view of her age and completed family, total abdominal hysterectomy was performed.

***Intraoperative findings***

As summarized in Table 2 and shown in Figure 2, the uterus was enlarged and soft, while both ovaries appeared normal.

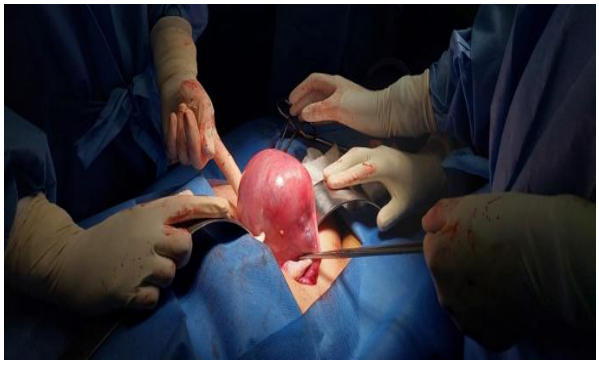


**Figure 2: Intraoperative appearance of the enlarged, soft uterus measuring approximately 16-week size; both ovaries appeared normal.**

***Histopathological examination***

The absence of p57 expression supported the diagnosis of complete hydatidiform mole. No myometrial invasion was identified in the examined specimen.

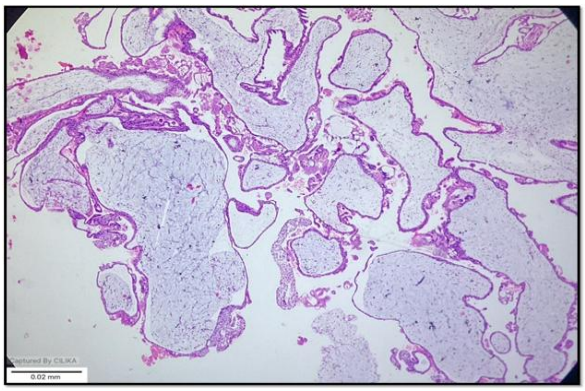


**Figure 3: Histopathological examination demonstrating hydatidiform mole involving the endometrium, without myometrial invasion. The morphology was suggestive of a complete mole, and p57 immunohistochemistry was negative.**

***Postoperative follow-up***

Serial serum β-hCG measurements demonstrated a progressive decline after hysterectomy: 219,411 mIU/ml at 48 hours, 49,457 mIU/ml at one week and 1,274 mIU/ml

at two weeks postoperatively. Subsequent weekly measurements continued to decline until the concentration was below 5 mIU/ml. No biochemical or clinical evidence of persistent trophoblastic disease was reported during the documented follow-up period.

**Table 1: Clinical examination findings.**

| Parameters | Findings |
|---|---|
| **General condition** | Clinically stable |
| **Abdominal examination** | Uterus enlarged to approximately 16-week size; non-tender |
| **Per-speculum examination** | Cervix appeared healthy; bleeding was present |
| **Per-vaginal examination** | Uterus anteverted, soft, approximately 16-week size and non-tender |

**Table 2: Intraoperative findings.**

| Structure | Operative findings |
|---|---|
| **Uterus** | Enlarged, soft; approximately 16-week size |
| **Ovaries** | Both ovaries appeared normal |

## DISCUSSION

This case illustrates an uncommon presentation of complete hydatidiform mole in a 47-year-old woman whose initial symptom was irregular and progressively heavier vaginal bleeding. At this age, abnormal uterine bleeding is frequently evaluated for structural and endometrial causes; however, pregnancy-related pathology should remain in the differential diagnosis whenever the clinical findings are atypical. Maternal age is a recognized epidemiological risk factor for hydatidiform mole, with an increased risk at the extremes of reproductive age. The population-based data reported by Savage and colleagues describe variation in the demographic distribution of molar pregnancies, while contemporary reviews identify advanced maternal age as an important risk factor.[1] The present case is consistent with the need for continued clinical suspicion in women older than 40 years, although a single case cannot establish an age-specific risk.

The initial ultrasound interpretation at the peripheral centre favoured a fibroid uterus with cystic areas. In this patient, the markedly enlarged uterus, heterogeneous intrauterine mass with multiple cystic spaces and absence of fetal parts were more suggestive of a complete mole when reassessed alongside the serum β-hCG concentration of 1,500,000 mIU/ml. Contemporary guidance emphasizes that ultrasound contributes to the clinical diagnosis, but histopathological examination remains essential for definitive classification.[3] The earlier negative urine pregnancy tests followed by a weakly positive result at presentation are noteworthy. The available case records do not provide the assay type, urine concentration or testing conditions; therefore, the reason for the earlier negative results cannot be determined from this case and should not be attributed to a specific mechanism.

The patient also had biochemical hyperthyroidism, with a markedly suppressed TSH and elevated T3 and T4. Very high circulating hCG concentrations can stimulate the thyroid-stimulating hormone receptor because of structural similarity between hCG and TSH, and clinically significant thyrotoxicosis is a recognized, though less common, complication of molar pregnancy.[4] In this case, the temporal association and extreme β-hCG elevation make hCG-mediated thyroid stimulation.[5] Preoperative endocrinology assessment and treatment were appropriate before proceeding with surgery.

Histopathology demonstrated molar tissue involving the endometrium without myometrial invasion. Negative p57 immunostaining supported complete hydatidiform mole. p57 is maternally expressed; its absence in villous cytotrophoblast and stromal cells is characteristic of a complete mole lacking maternal genomic contribution.[6] As discussed by Ngan and colleagues, p57 immunohistochemistry is useful for distinguishing complete mole from partial mole and non-molar gestations, although it does not distinguish partial mole from non-molar gestations.[7] In the present case, the reported morphology together with negative p57 staining provided concordant evidence for complete mole.

Management of hydatidiform mole depends on the patient's reproductive wishes, clinical condition and disease-related complications. Suction evacuation is generally the preferred approach when fertility preservation is desired. Hysterectomy is an accepted alternative in women who have completed childbearing, and it removes the molar pregnancy while reducing the risk of local uterine persistence; nevertheless, it does not eliminate the possibility of postmolar gestational trophoblastic neoplasia.[2] In this 47-year-old woman with completed family, hysterectomy was selected after counselling. The decision should be understood as an individualized management choice rather than a procedure recommended solely on the basis of age.

The postoperative β-hCG trend in this patient showed a substantial and continuing decline, reaching the reported normal range (<5 mIU/ml). This is reassuring, but serial quantitative β-hCG surveillance remains essential after treatment of a complete mole, including after hysterectomy, because persistent or rising concentrations may indicate postmolar gestational trophoblastic neoplasia. Current FIGO guidance recommends structured follow-up until normalization and for the subsequent period specified for complete mole.[6,8] The exact duration of follow-up in this case was not stated; the final manuscript should include the date of the first normal result and the duration of subsequent surveillance if these data are available.

This report is limited by its single-case design and by the absence of some potentially relevant details, including the exact dates of ultrasound and surgery, the complete thyroid profile and treatment administered, detailed histopathological description, and the duration of β-hCG surveillance after normalization. These details should be added from the medical record where available. Despite these limitations, the case reinforces the importance of measuring serum β-hCG and considering GTD in women presenting with unexplained uterine enlargement and abnormal uterine bleeding, irrespective of age.

## CONCLUSION

Complete hydatidiform mole, although uncommon in perimenopausal women, should be considered in the differential diagnosis of abnormal uterine bleeding and uterine enlargement. Quantitative serum β-hCG, characteristic ultrasonographic findings and histopathological assessment with p57 immunohistochemistry facilitate accurate diagnosis. Hysterectomy may be considered in women who have completed childbearing, but it does not replace postoperative β-hCG surveillance. A high index of suspicion and appropriate follow-up are essential to identify persistent disease early.

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