

DOI: <http://dx.doi.org/10.18203/2320-1770.ijrcog20192465>

Case Report

A molar pregnancy detected by following irregular vaginal bleeding after a first trimester evacuation: rare case report

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Received: 16 March 2019

Accepted: 04 May 2019

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ABSTRACT

In this case report summarizes the sequence of events that led to detection of a molar pregnancy missed by ultrasound and initial pathology examination. A 29 years old Asian nulliparous patient came to our clinic with missed period. On beta HCG she was 6 weeks pregnant. After 20 days she was diagnosed with 7 weeks missed abortion on ultrasound. surgical evacuation done for same. After 3 weeks she came with irregular vaginal bleeding. After physical and vaginal examination Beta HCG done, which was very high. On transvaginal ultrasound partial molar pregnancy was detected, so she was immediately admitted and repeat surgical evacuation was done. Histopathology report confirmed partial molar pregnancy which was not detected in previous report. She was regularly followed up with Beta HCG value up to 1 year which declined dramatically. Though molar pregnancy is rare, but it has the potential to develop into invasive mole, so any abnormal bleeding post evacuation should be followed up properly. Beta HCG values and histopathological evaluation is important for correct diagnosis and follow up.

Keywords: Beta HCG, Histopathology, Molar pregnancy, Ultrasound

INTRODUCTION

Gestational trophoblastic disease or gestational trophoblastic neoplasia is a collective term used to describe hydatiform mole, invasive mole, choriocarcinoma and placental site trophoblastic tumours.¹ Hydatiform mole is the commonest gestational trophoblastic disease and the incidence is 0.1% amongst all pregnancies.² The commonest symptom being irregular vaginal bleeding preceded by amenorrhea.³ The diagnosis of both complete (CHM) and partial (PHM) hydatidiform moles in first trimester miscarriages is difficult.⁴ Majority of hydatidiform moles that undergo ultrasound examination are not recognised as molar on scan and are diagnosed as missed miscarriage or early pregnancy failure clinically and sonographically and the initial diagnosis of molar disease being made by the pathologist reporting the routine histopathological

assessment of products of conception from the failed pregnancies.⁵ Author present rare case of molar pregnancy which was missed initially and diagnosed later during post evacuation follow up. Author successfully managed the case with timely diagnosis and intervention. Patient was followed up for 1 year with no complications.

Written informed consent was obtained from the patient for the publication of this case report and accompanying images.

CASE REPORT

A 30-year-old nulliparous Asian woman came to clinic with complaints of missed period. Pregnancy was confirmed on beta HCG about 6 weeks. Previously, she was having regular menstrual cycle. After few weeks an ultrasound examination was performed which revealed 7

weeks missed abortion. Her Beta HCG value was 33,177 mIU/ml. In view of missed abortion pregnancy was terminated by suction evacuation and all extracted samples were sent for histopathological examination (HPE).

After 1 week patient came with slight off and on vaginal bleeding. Her vitals were stable and on per vaginal examination there was mild bleeding. HPE report showed the presence of very few RPOCs. Patient was sent back home and advised to come back in case of more vaginal bleeding or lower abdominal pain. After 2 weeks she came back with history of persistent vaginal bleeding with off and on and lower abdominal pain since 10 days with nausea and vomiting since 2-3 days. On examination she was dehydrated and hypotensive. Per abdominal examination revealed enlargement of uterus up to 14 weeks with mild lower abdominal tenderness. Per speculum examination showed mild to moderate bleeding.

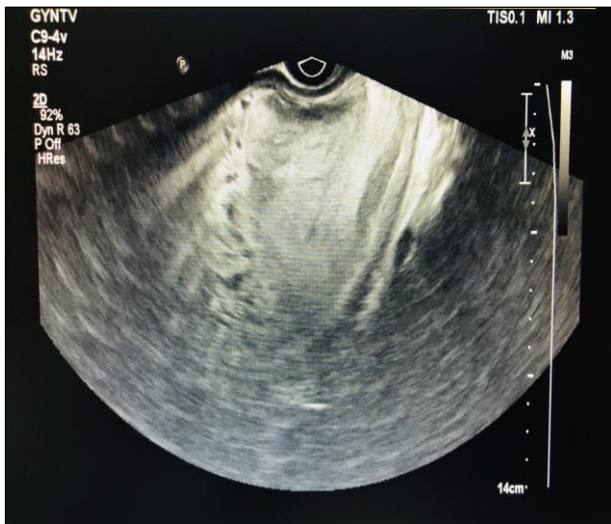


Figure 1: Ultrasound (TVS) examination of the uterus.



Figure 2: Ultrasound (TVS) examination of the uterus.

An Ultrasound (TVS) was done immediately which showed enlarged uterus with heterogenous echotexture lesion measuring 13.5x7.8 cm within the endometrium showing multiple tiny cystic space resulting snowstorm appearance along with solid areas extending up to the uterine cervix with no obvious foetal parts visualized suggestive of molar pregnancy (Figure 1).



Figure 3: Ultrasound (TAS) examination of the uterus.

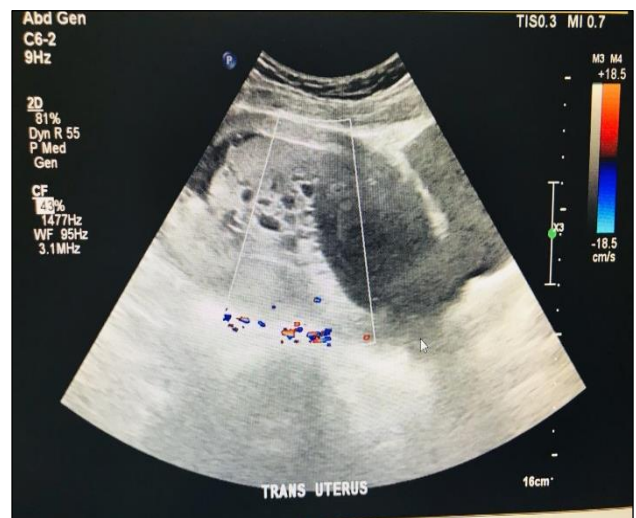


Figure 4: Ultrasound (TAS) examination of the uterus.

Beta HCG done which showed significantly high values of 2,98,827 mIU/ml. Patient was immediately admitted to the hospital. Laboratory studies showed Hb 8.4 gm% so preoperative one unit blood transfusion was done. TSH, liver and renal function tests, clotting profile and other blood tests were normal. Her chest X-ray was normal. The gestational trophoblastic disease and related risks were explained and after informed consent suction curettage was performed under general anaesthesia. Vesicles were observed in curettage material and sent for HPE. After curettage 20 units oxytocin was given. Postoperative Hb was 8.8 gm%, so one more unit of

blood transfusion was done. Prophylactically 50 mg I.M. inj. methotrexate was given.

Patient was discharged after 1 day. Uterus was well contracted and reached up to 6-8 weeks size. She was advised for regular follow up visits. Contraception with OC pills was advised for 1 year. HPE report revealed this time vesicles with partial molar pregnancy. Beta HCG done postoperatively day 5, which showed decreased value of 14,479 mIU/ml. She was advised for weekly follow up till 3 months. The weekly values of beta HCG were 2128, 406, 49, 12.35, 9, 3.3, 2.39 mIU/ml respectively which was significantly decreasing. After this monthly beta HCG done up to 1 year which was constantly showing negative 2.39 values. General condition and physical examination of the patient was normal during follow up. Follow up findings suggestive of complete resolution of partial molar pregnancy without development into malignant disease.

DISCUSSION

Vaginal bleeding in the first trimester is a common obstetric situation ranging from an insignificant episode to life threatening emergency. The major causes are abortion, ectopic, and molar pregnancy.⁶ The estimated incidence of partial hydatidiform mole (PHM) is 1 in 700 pregnancies whereas the incidence of complete hydatidiform mole (CHM) is around 1 in 1500–2000 pregnancies.^{7,8} Approximately 20% of complete moles and 0 to 3.5% of partial moles lead to persistent gestational trophoblastic disease (GTD).⁹

A molar pregnancy is a rare condition that needs to be detected because of the potential to develop into malignancy and long-term risk to the mother if undiagnosed, delayed or erroneously diagnosed. In the first few months of pregnancy, molar pregnancy is associated with a higher incidence of vaginal bleeding or discharge, abdominal pain and morning sickness. However, as these symptoms are relatively nonspecific, they rarely lead to the diagnosis being made prior to the routine first ultrasound scan.¹⁰ Molar pregnancy can be missed out on USG or sometimes in early pregnancy it may not be detected or represent as missed abortion or anembryonic pregnancy. It has been found that the concordance rate between pathologists for the diagnosis of molar pregnancies (CHM or PHM) ranges from 55% to 75%.¹¹ Thus, following B-hCGs after a normal pathology report is indicated for detecting molar pregnancies.

Hamdani reported diagnostic challenges for partial molar pregnancy as clinical presentations is like normal pregnancy before 12 weeks, HCG levels may be normal or slightly raised, USG is usually confusing specially in first trimester and histology is also not conclusive most of the time. 12 case had all the similar findings so it could not be diagnosed initially. Lee et al, reported a case of a molar pregnancy detected by following beta HCG after a

first trimester loss which was missed by ultrasound and initial pathology examinations. Repeat D and C was done and later histopathology report revealed partial molar pregnancy. As advised patient used contraception and her beta HCG was followed till 1 year which was negative. Lee concluded that following serial quantitative human chorionic gonadotropin (B-hCG) levels after spontaneous, therapeutic, and elective abortions will help detect potentially life-threatening molar and ectopic pregnancies.¹³ Similar to this, in present case also molar pregnancy was missed out initially on USG and histopathology which was later detected by beta hcg during follow up of abnormal vaginal bleeding. Any recurrent and irregular vaginal bleeding after termination of pregnancy should be followed up with high index of suspicion for diagnosis and treatment. Following serial quantitative B-human chorionic gonadotropin (B-hCG) levels after spontaneous, therapeutic, and elective abortions will help detect potentially life-threatening molar and ectopic pregnancies.¹³

ACOG classifies its recommendation that “abnormal bleeding for more than 6 weeks after any pregnancy should be evaluated with hCG testing to exclude a new pregnancy or gestational trophoblastic disease” as a Level C recommendation based primarily on consensus and expert opinion.¹⁴ Fortunately, the majority of cases can be cured by simple surgical intervention and those that require chemotherapy are generally cured with very low toxicity treatment. After evacuation, in the majority of cases the residual trophoblast cells are unable to continue to proliferate for long and the fall in serum hCG levels is a very accurate indication of their declining activity. In most cases, after evacuation of a molar pregnancy the hCG level falls to normal (<4 iu/l) within 2–3 months, after which relapse of the molar pregnancy is extremely rare. Fortunately, a change in hCG level gives a very accurate assessment of the level of disease activity and this forms the basis of the follow-up protocol.¹⁰

CONCLUSION

Molar pregnancies are rare. The diagnosis of both complete and partial hydatiform moles in first trimester miscarriages is difficult. Most cases diagnosed as early pregnancy losses. Post evacuation recurrent and severe vaginal bleeding can occur. Undiagnosed molar can develop into malignant disease. So high index of suspicion is important after any post evacuation abnormal bleeding and this should be followed up with combined approach of TVS USG and beta HCG for correct diagnosis and treatment. After termination of molar pregnancy further follow up is necessary to prevent maternal morbidity and mortality since molar pregnancy may lead to gestational trophoblastic neoplasia.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Salvi MB. A molar pregnancy detected by following irregular vaginal bleeding after a first trimester evacuation: rare case report. *Int J Reprod Contracept Obstet Gynecol* 2019;8:2549-52.