

INVASIVE MOLE AT 22 WEEK GESTATION WITH PERFORATION OF UTERUS

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INTRODUCTION

The Gestational trophoblastic diseases (GTD) are a group of pregnancy related disorders arising from abnormal placental trophoblastic cells. It comprises two premalignant conditions: partial and complete hydatidiform mole and, Malignant Gestational Trophoblastic Neoplasia (GTN). Histologically GTNs are classified into 3 subgroups: choriocarcinoma destruens (invasive mole, IM), choriocarcinoma (CC) and a rare placental site trophoblastic tumour (PSTT)¹.

IM is characterized by trophoblastic proliferation invading the myometrium with edematous chorionic villi⁵. These trophoblastic villi differentiate IM from CC.

CASE REPORT

A 31 year old un-booked lady, resident of Swabi presented to outpatient department of Obstetrics and Gynaecology at 22 weeks of gestation. She had history of lower abdominal pain along with mild per vaginal bleeding. Her previous antenatal record at Swabi was uneventful with ultrasound report of single alive fetus at 22 weeks gestation with type-I placenta praevia. She was 7th gravida with 3 full term normal deliveries and 3 abortions. Last abortion was intrauterine death at 5 months about 1 year ago in her native village.

On examination, she was severely pale looking with 22 weeks fundal height as per abdomen. Bleeding per vaginum was mild. Her hemoglobin was 6.8 grams per deciliter (gm/dl), blood group AB positive with normal coagulation profile. While under observation she fainted in the ward after short history of acute abdominal pain. She was shifted to intensive care unit and transfused 2 pints of blood. Next morning she complained of increase in severity of pain. On examined her

abdomen was found distended, tense and tender with absent fetal heart sounds. Provisional diagnosis of abruption placenta was made.

On ultrasound and guided aspiration haemoperitoneum was found. Urgent laparotomy was done with arrangement of blood. About 1500 ml blood was found in peritoneal cavity. Uterus was soft, intact and 22 week's size.

Small fetus with normal looking placenta was delivered through transverse incision on uterus.

On exploration a small, 1 cm rent on posterior uterine wall was found which was bleeding but not communicating with uterine cavity. It was confined to myometrium and serosa, while endometrium was intact. Bleeding continued even after stitching. Decision for subtotal hysterectomy was taken. After hysterectomy peritoneal cavity washed with normal saline and drain placed. In post operative period, her vitals maintained normal but output in drain was 2000 ml in next 10 hours. She was transfused 3 more pints of blood.

Next morning her hemoglobin was 8.2 g/dl and coagulation profile was normal. In next few hours' additional 1500 ml blood collected in drain. She was re-opened and a small bleeder in one of stump was found which was ligated and haemostasis secured. But she went into cardiac arrest in immediate post-operative period, leading to her death after 2nd surgery. Histopathological examination of uterus revealed myometrial invasion by trophoblastic tissue.

Post-Op metastatic workup was not possible in our case because of fatal outcome.

DISCUSSION

GTN constitutes less than 0.05-0.1 % of all gynecological malignancies. These tumours arise when the normal regulatory mechanism controlling the proliferation and invasiveness of

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trophoblastic tissue is lost. They have distinct tumour markers and varying tendency towards local invasion and distant metastasis.³

Invasive mole may perforate through the myometrium resulting in uterine perforation and intra peritoneal haemorrhage⁴. Intraperitoneal haemorrhage and severe vaginal bleeding are life threatening complication, so emergency hysterectomy is required in majority of case.²

Direct vascular invasion and distant metastases rarely occur in invasive mole, the most common site reported is lungs^{5,6}.

Pelvic ultrasound and uterine curetting are not reliable to detect myometrial invasion unless there is sufficient myometrial sample to demonstrate invasion.⁷

In acute presentation of invasive mole intra operative management options are limited. Evacuation of uterus is treatment of choice but use of oxytocin to attain haemostasis is controversial. Mitane et al recommended partial resection of uterus if invasive mole presented with internal haemorrhage in young women.⁷

Goldstein et al used local uterine resection along with bilateral internal iliac artery ligation to achieve haemostasis.⁸

In our patient we performed subtotal hysterectomy to attain haemostasis after uterine evacuation.

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