TWO DIFFERENT (CASE-ADAPTED) MANAGEMENT STRATEGIES FOR MOLAR PREGNANCY

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INTRODUCTION

Hydatidiform mole is a relatively rare condition, reported, generally, in one of 1000 pregnancies worldwide.¹ Even if recent progress in imaging and laboratory diagnosis largely improved its management, the treatment of this condition includes quite different options (from conservative approach to hysterectomy) and its prognosis still remains, sometimes, unpredictable and a matter of concern.¹

We present in this paper two different cases of women with hydatidiform mole. The particularity and interest of these cases is represented by the sharp difference in the clinical situations, which imposed a quite different, “opposite”, specific approach.

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CASE REPORTS

Case 1

A 26-year old woman was admitted for secondary 12 weeks amenorrhea and for irregular vaginal bleeding during the previous week. Her medical history revealed a menarche at age of 14, regular menstrual cycles and no previous pregnancy.

The gynecological examination observed a transcervical reduced bleeding, normal cervix, enlarged uterus (10/9 cm), with smooth, regular surface, low consistency, mobile, not painful and normal adnexal zones.

Arterial pressure was normal and she had no signs of hyperemesis or clinical hyperthyroidism.

Laboratory tests performed were normal, with the exception of a high serum beta chorionic gonadotropin (β-hCG) level: 6544 mIU/ml. The chest radiograph did not show any pulmonary lesion.

The ultrasound examination revealed a uterine body of 9.3/8.6 cm in size, with heterogeneous intracavitary images - with small hypoechoic parts, a nine milimeters wide myometrium and normal ovaries. (Fig. 1)
Figure 1. Case 1. Eloquent ultrasound image of a 12 gestational weeks - pregnancy hydatidiform mole.

The next day after the admittance, the patient presented a profuse vaginal bleeding. A haemostatic and biptic uterine curettage was subsequently performed and efficient hemostasis was obtained. The tissue obtained was sent for pathological examination. The patient was discharged after two more days. The pathological diagnosis was partial hydatidiform mole.

After seven days, she was readmitted for vaginal bleeding. Another uterine curettage was performed but only blood clots were evacuated. After that, the patient evolution was favorable and the patient discharged three days later with the follow up of the decreasing $\beta$-hCG levels. (Table 1) Oral contraception was advised thereafter.

Case 2

A 46-year old woman was admitted for 17 weeks amenorrhea and for intermittent uterine bleeding during the previous month, associated with nausea and dizziness.

Her medical history revealed a menarche at the age of 13, previously regular menstrual cycles, one birth and three abortions. The gynecological examination observed a normal cervix, discrete uterine bleeding, an enlarged uterus - of 12/10 cm, with smooth, regular surface, low consistency, mobile, not painful and normal adnexal zones.

The laboratory values and the result of the pulmonary radiograph were normal and $\beta$-hCG level was 77304. The ultrasound examination revealed: a uterine body of 12/10/9 cm, with a heterogeneous intracavitary mass with small anechoic, round, disseminated zones, an eight millimeters wide myometrium and both ovaries of normal appearance.

After discussing with the patient the diagnosis of molar pregnancy and its possible evolution and taking into account her age and her declared decision of no further parenthood, surgical option was chosen. The patient asked for bilateral adnexectomy. After laparotomy, we observed an enlarged uterus - 16/12 cm, of low consistency. The surgical procedure consisted in Wiart total hysterectomy with bilateral adnexectomy. The uterus was immediately sectioned letting the team observe that the cavity was filled by a mass with placental appearance, with numerous small vesicles. (Fig. 2) The pathological diagnosis was partial hydatidiform with myometrial invasion.

Table 1. The decrease of the beta-hCG levels after the removal of the mole.

<table>
<thead>
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<th>Time (days)</th>
<th>0</th>
<th>7</th>
<th>14</th>
<th>21</th>
<th>28</th>
<th>35</th>
<th>42</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\beta$-hCG level (mUI/ml)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case 1</td>
<td>6544</td>
<td>59</td>
<td>32</td>
<td>13</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Case 2</td>
<td>77304</td>
<td>2484</td>
<td>235</td>
<td>87</td>
<td>40</td>
<td>21</td>
<td>11</td>
</tr>
</tbody>
</table>

The postoperative evolution was favorable and the patient was discharged healed in the eight day after the surgery. The follow up offered normal clinical information and $\beta$-hCG levels decreased reassuringly (Table 1).

DISCUSSION

Gestational trophoblastic disease describes a spectrum of lesion which includes disorders of the
placenta characterized by abnormal proliferation and maturation of trophoblast, as well as neoplasms derived from it. The most common form of gestational trophoblastic disease is represented by the hydatidiform mole. Known from the antiquity (Hippocrates described it), mola was first used as a term by Smellie in the XVIIth century. However, real progress was made only later: pathological description (XIXth century – Velpeau and Boivin), possibility of progression to choriocarcinoma (1885 – Marchand) or presence of high level of urinary gonadotropin (Zondek).1 Hydatidiform mole, complete or partial, represents a placenta characterized by marked villous enlargement due to central edema of the stroma, variable hyperplasia of the villous trophoblast and edema. Most molar pregnancies are complete, and 25% to 43% are partial.2 The incidence of hydatidiform mole is 1:512 pregnancies (complete mole - 1:1945; partial mole - 1:695).3

The age of our cases confirm the fact that the molar pregnancy is usually a fertile women’s pathology, even there are reports of molar pregnancies developed in postmenopausal women.4,5

The age of the pregnancy reported in this paper correspond with the available data, as molar pregnancy typically presents between the 11th and 25th week of pregnancy, with an average gestational age about 16 weeks.2 The presence of abnormal vaginal bleeding was also concordant with the scientific data. Contrary to the available information, however, was the size of the uterus in both cases, which did not show excessive enlargement, as is commonly encountered. Other associated signs or pathologies were not observed in our patients. Only one patient (with a more advanced pregnancy) reported hyperemesis – and even she did not experienced severe vomiting. None of the patients developed pregnancy-induced hypertension, as it could have been possible, especially in cases of complete mole.

As expected, hCG levels were markedly elevated, more for the more advanced pregnancy; this has already described as an excellent diagnostic parameters.6 We did not consider it, however, useful to predict the subsequent development of persistent trophoblastic disease. This has also been advocated for other parameters in serum taken prior to evacuation from patients with molar pregnancies.7 The ultrasonography was very reliable and sensitive for the diagnosis of the complete mole and for eliminating the possibility of a partial mole.8 This method eliminated a frequent concomitant finding in patients with hydatidiform mole – that is the theca-lutein cysts.

We choose no prophylactic chemotherapy. The two cases eloquently illustrate the different (even opposite) treatment choices. In the first case, due to her age and her desire for fertility, evacuation was performed. In the second case there was no further pregnancy desired. Considering the age and the related higher frequency of malignant trophoblastic disease hysterectomy with mole in situ seemed a proper choice, especially as this procedure has proved to considerably reduce the probability of a recurrent disease.

As the evacuation of the molar pregnancy ensure healing only in 80% of the cases, follow-up has a huge importance.9 We used the accepted fundamental marker: the β-hCG level, which safely decreased in both cases.9

For the first patient, an important role in the follow-up was played by the contraception for one year after healing. Normal fertility is expected thereafter. Subsequent pregnancies would impose a first trimester vaginal ultrasound exam to confirm the normal evolution of the pregnancy, a pathological examination of the placenta / embryo / fetus at birth / abortion and the determination of hCG level six weeks after the birth to exclude an occult trophoblastic neoplasm.8

CONCLUSIONS

We described two cases of hydatidiform mole with somehow atypical description: no theca-lutein cysts, no serious digestive phenomena and no pregnancy-induced hypertension. Ultrasound is invaluable in diagnosis; beta-hCG levels are essential for the diagnosis and follow-up. Therapeutic strategy was quite different, adapted to the age, further desire for pregnancy and probable subsequent risks: evacuation of the uterine contents for the young patient and hysterectomy for the older one. Decrease of β-hCG levels was reassuring in both cases. Contraception completed the follow-up plan for the young, fertile patient.

REFERENCES


