

Partial Mole in Ectopic Pregnancy

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Abstract

Background:

Gestational trophoblastic disease is a wide spectrum of abnormal pregnancy that includes: Complete molar pregnancy (CMP), partial molar pregnancies (PMP), invasive mole (IM), chorioncarcinoma (CHC), and placental site trophoblastic tumors (PSTT). Hydatidiform mole is an abnormal gestation characterized by the presence of hydropic changes affecting some or all of the placental villi. Hydatidiform mole arises as a result of the abnormal fertilization of an ovum. Tubal ectopic hydatidiform mole is a rare lesion and few cases have been reported.

Key words: Partial Mole , Ectopic Pregnancy

Introduction:

Partial or complete hydatidiform mole affects approximately 1 in 500 to 1000 pregnancies⁽¹⁾. The median maternal age is 31 (range, 15-54) years and median gestational age 10 (range 5-27) weeks⁽²⁾. Tubal ectopic hydatidiform mole is a rare lesion and only 40 cases have been reported on web search⁽³⁾. A 21 year old, nulliparous woman married for 6 months, presented with severe abdominal pain and irregular vaginal bleeding. She had no pregnancy test, and no pelvic ultrasound. She was admitted under observation and sent for a pregnancy test. Her past medical and surgical history was unremarkable. She was non smoker and had no allergies. pregnancy test was positive in the hospital. Her physical examination was normal; blood pressure was 90/60, pulse 110 and the temperature 37°C. Chest x-ray was clear and the electrocardiography (ECG) was normal. The patient had left lower abdominal tenderness by abdominal palpation the blood pressure gradually was declining. There was brown blood in the vagina. Pelvic examination revealed anteverted uterus with a left adnexal mass and positive cervical excitation. Sonography showed there was no gestational sac in the uterus; the endometrial thickness was 8 mm, a left adnexal mass consisting of a suspicious echo free area of a gestational sac 20x26 mm and free fluid in the cul-de-sac was noted. The patient underwent emergency

laparotomy. The left fallopian tube had ruptured ectopic pregnancy . Salpingectomy was performed. (See tissue section-Figure 1).

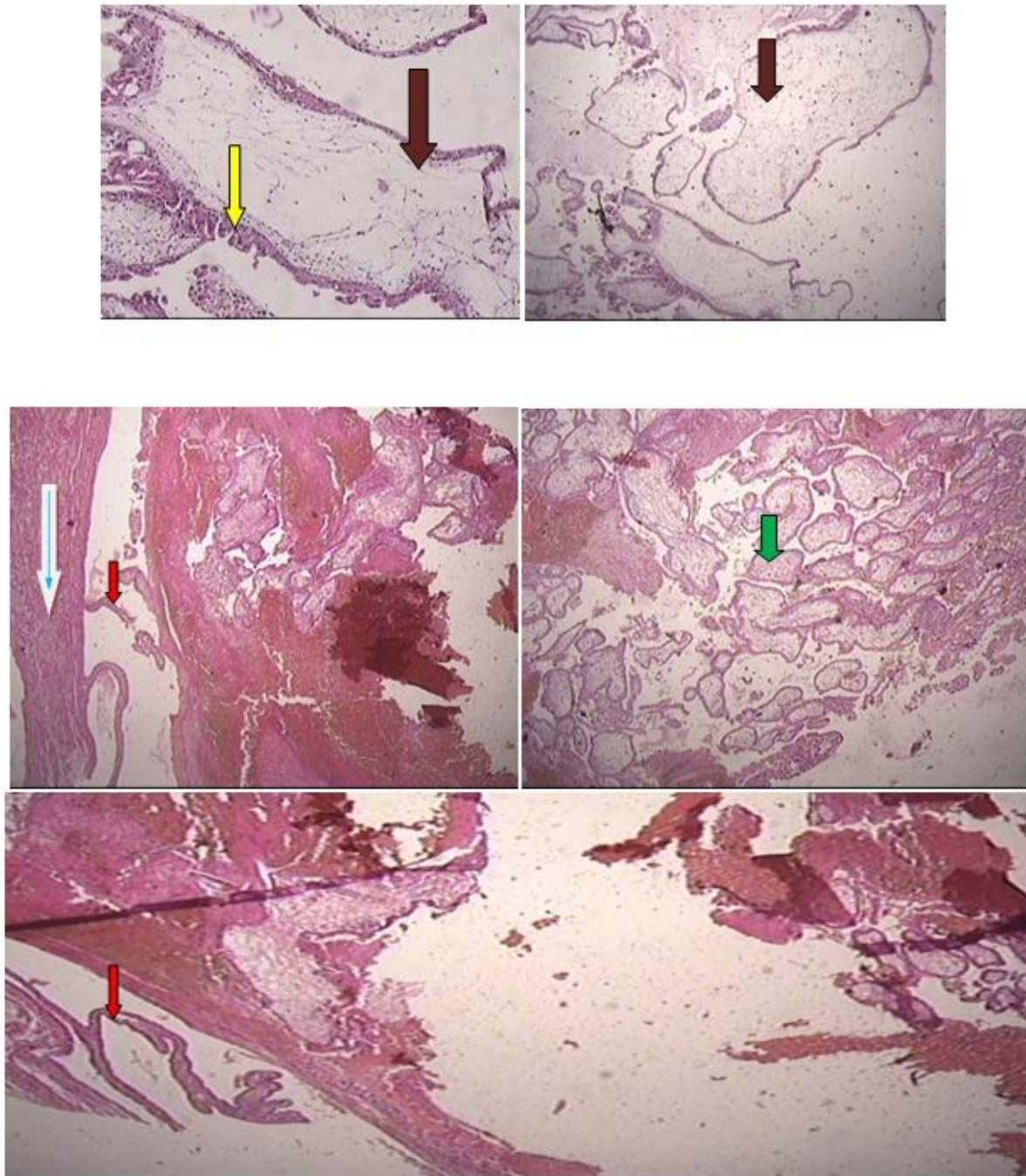


Figure (1): Tissue section showed fallopian tube with ectopic hydatidiform mole ; the hydropic villi(brown arrow), trophoblastic proliferation(yellow arrow).

Review of articles:

Partial or complete hydatidiform mole affects approximately 1 in 500 to 1000 pregnancies⁽¹⁾. Tubal ectopic hydatidiform mole is rare and only 40 cases reported in the web literature⁽³⁾. By Sonagrah , a hydatidiform mole, placental site trophoblast tumor, and choriocarcinoma typically exhibit a heterogenous, hypo-echoic, solid mass with cystic vascular spaces. Fowler *et al* (2006)⁽²⁾ concluded after an extensive study that routine pre –evacuation ultrasound examination identifies less than 50% of hydatidiform moles .More over detection rate is higher for complete compared to partial moles ,and improves after 14 week 's gestation. Hence histopathological examination of products of conception remains for correct diagnosis .There is also the possibility of over diagnosis by histological examination ,because early ectopic tubal pregnancy with a more florid extra-villous trophoblastic proliferation may mimic a molar pregnancy!. Transvaginal sonography has enabled early diagnosis of interstitial (cornual) pregnancy to be identified in which an ectopic gestation is located within the uterine myometrium, occasionally miss diagnosed for molar pregnancy.

Burton *et al*⁽³⁾ investigated the incidence of tubal ectopic molar pregnancy in women for a period of ten years and concluded that tubal ectopic mole is a rare entity and it is often over diagnosed because of its confusing appearances. Molar trophoblastic proliferation and hydropic villi are features of early placentation of hydropic abortion⁽³⁾. Sheets of extra villous trophoblast may be particularly prominent in tubal ectopic gestation confusing the histological picture.

Sebire *et al* ⁽¹⁾ stated that the pathologist should be aware that the degree of extravillous trophoblastic proliferation may appear more florid in ectopic gestation as compared to evacuated uterine products of conception⁽¹⁾.

Cortes-Charry *et al* ⁽⁴⁾ in their study concluded that the prevalence of gestational trophoblastic disease (GTD) in ectopic pregnancy was 0.16:1000 deliveries implying strict morphological criteria for GTD when a sample of ectopic pregnancy is analyzed to monitor those patients with careful beta –hCG follow up⁽⁴⁾.

Galvez *et al* ⁽⁵⁾ stated that choriocarcinoma in ectopic pregnancy ,is extremely rare and generally are very aggressive .Therefore a careful histological

examination of the tubes is mandatory in all ectopic pregnancies

Although Laparoscopy will remain the main method of diagnosis and treatment for women with ectopic pregnancy ,because it provides obvious advantages over open surgery .Most cases have been treated with salpingectomy without complications i.e. persistence or recurrences but in this case with the evidence of ruptured ectopic and critical phase of haemodynamics , laparotomy was performed , and ruptured left fallopian tube was found salpingectomy with an intact pregnancy was removed .

The final diagnosis of gestational trophoblastic neoplasia in ectopic pregnancy is made by histopathological examination, but in cases of medical treatment ,appropriate monitoring of beta – hCG titers is mandatory ,not only to diagnose persistent ectopic gestation ,but also to exclude the presence of malignant trophoblastic disease ⁽⁶⁾ .

Conclusion:

Ectopic molar pregnancy is a rare condition,which can occur at any part of genital tract .Invasive mole and choriocarcinoma might even

follow such a pregnancy .However,ultrasonography might not be cap able to diagnose ectopic molar pregnancies, but histopathological examination of the conception products is important to exclude molar pregnancy specially partial mole.

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