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ECTOPIC (TUBAL) MOLAR GESTATION: REPORT OF TWO CASES

* MA Abdul, * AJ Randawa, **SM Shehu

*Departments of *Obstetrics & Gynaecology, and **Histopathology, Ahmadu Bello University Teaching Hospital Zaria, Nigeria.*

ABSTRACT

Background: Ectopic molar gestation is a rare event. Its malignant potential is similar to that of an intrauterine molar pregnancy.

Objective: To document two cases of tubal molar gestations seen over a 10-year period.

Study Design: Case series.

Results: Two young Nigerian undergraduates presented with features of ruptured tubal pregnancy. They had total salpingectomy and histopathological analysis of the tubal specimens revealed complete hydatidiform mole. HCG level normalized in both cases within three weeks of treatment.

Conclusion: Ectopic molar gestation does occur occasional in our setting. It is pertinent that clinicians in this part of the world be aware of this and to take routine histological examination of tubal specimens in ectopic pregnancy very seriously in order to diagnosed cases of ectopic molar gestations early and mount appropriate post treatment surveillance.

Key Words: Ectopic, Tubal, Molar Gestation.

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INTRODUCTION

Molar gestation is a benign form of gestational trophoblastic disease (GTD) a spectrum of diseases characterized by an abnormal proliferation of trophoblasts.¹ The incidence of molar gestation showed regional variation particularly from hospital based data.¹ It ranges from 1.1 to 10.0 per 1,000 pregnancies in South Asia¹ 0.7 to 0.8 per 1,000 in North America¹ and 1-2 per 1000 deliveries in Sub-Saharan Africa.^{1,2}

Ectopic molar pregnancies are rare with an estimated 1.5 per 1,000,000 births in the U.K.³ Most cases of ectopic gestational trophoblastic disease including molar gestation occur in the fallopian tube and ovary³⁻⁹ and occasionally in the cervix.¹⁰ Recently Chen and colleagues reported a case of primary choriocarcinoma occurring on the surface of a subserous leiomyoma,¹¹ and Wu et al reported a molar pregnancy that occurred in a cesarean scar.¹²

Tubal molar gestation clinically mimics normal tubal ectopic⁵ pregnancy and the post treatment surveillance is like that of intrauterine molar gestation. We report two cases of tubal molar gestation seen over a 10 year period (January 1997 December 2006), in Ahmadu Bello University Teaching Hospital Zaria, Nigeria.

Case I

Miss M.V was a 25-year old undergraduate Para⁰⁺¹ admitted into the gynaecologic ward of Ahmadu Bello University Teaching Hospital Zaria on the 2nd April 1998 with 10 hours history of sudden onset lower abdominal pains and seven weeks amenorrhoea. There was no history of vaginal bleeding or syncopal attacks. She had termination of a first trimester pregnancy in 1997 and appendectomy in 1994. Physical examination revealed moderate pallor, blood pressure of 100/70mmHg, moderate tenderness over the lower abdomen and positive shifting dullness. Vaginal examination showed marked cervical motion tenderness, with closed cervical os and slightly bulky uterus.

An impression of Ruptured tubal pregnancy was made. She was resuscitated and had laparotomy. At laparotomy, a right-sided ruptured tubal pregnancy at the isthmic portion of the fallopian tube was evident with about 2 litres of haemoperitoneum. There was no evidence of pelvic inflammatory disease. Right-sided total salpingectomy was performed and her postoperative course was uneventful. She was discharged on the seventh postoperative day. Histopathological analysis of specimen revealed partial hydatidiform mole. submit of HCG two weeks after salpingectomy was 160 I.U/L but returned to normal level at the third week. She was followed up for two years and there was no evidence of malignant transformation.

Correspondence: Dr MA Abdul
E mail: maabdul90@yahoo.com

Case II

Miss L.M was a 25-year old undergraduate Para⁰⁺² who presented at the Gynaecologic ward of Ahmadu Bello University Teaching Hospital Zaria on the 14th June 2002 with acute onset lower abdominal pains, vaginal bleeding for one day and six weeks amenorrhoea. There was no history of collapse or shoulder tip pain. Examination revealed mild pallor, stable cardio-pulmonary system and lower abdominal tenderness. The cervix as anteriorly placed, soft, long, closed external cervical os and moderate motion tenderness. The uterus was difficult to delineate due to tenderness and the right adnexae was full and tender. The POD was however free. An impression of subacute tubal pregnancy was made. Pelvic ultrasonography revealed an enlarged but empty uterus and a right complex adnexal mass with fluid in the pouch of Douglas. She was admitted, resuscitated and had laparotomy. Laparotomy findings include a right ruptured tubal (ampullary) pregnancy and blood collection in the pouch of Douglas of about 700mls. There was no evidence of pelvic Inflammatory Disease. She had a right sided total salpingectomy and smooth postoperative course. Histopathological analysis of the specimen revealed hydatidiform mole. HCG level had normalised by the second week postoperative. She was lost to follow-up after six months of surveillance.

DISCUSSION

The two cases seen over a ten year conforms with the observation of Chauhan⁵ and colleagues and Diouf et al⁸, that tubal molar gestation are rare and clinically mimics normal tubal pregnancy. It also underscores the importance of histological analysis of all tubal pregnancy specimen- an important or critical observation in sub-Saharan Africa where availability of histopathological services is largely a luxury.

Although tubal ectopic moles are rare lesion, Burton and colleagues⁹ observed an over diagnosis of ectopic moles in their regional referral center and recommend two criteria for diagnosis viz- the presence of circumferential trophoblastic proliferation combined with hydropic change. The two cases presented fulfilled these criteria.

The poor follow-up culture for post treatment surveillance for gestational trophoblastic disease among patients in our setting has been well established^{2,13}. This is basically due to combination of ignorance, poverty and poor communication. Case II was lost to follow-up six months after laparotomy. The need for intensive counseling on the importance of follow-up cannot be overemphasized. The employment of the services of medical social workers may also improve the follow-up rate of our patients with gestational trophoblastic disease.

The establishment of Regional Centers for the management of Gestational Trophoblastic Disease in Nigeria (as obtainable in developed world) is advocated. This will improve the quality of care and

research in this area of gynecologic oncology in Nigeria.

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