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[CLINICAL VIGNETTE]

Cervical molar pregnancy, profuse bleeding and urgent surgical treatment

Short title: **Case of cervical molar pregnancy**

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ABSTRACT

The association of cervical pregnancy and gestational trophoblastic disease is extreme rare, but it is obvious that such combination is associated with devastating effects on future fertility. We present a case of the patient with cervical molar pregnancy, who was admitted due to hemorrhagic shock caused by profuse metrorrhagia at 7th gestational week. Slightly enlarged uterine corpus, with bulky cervix and normal adnexa were found on laparotomy. Total abdominal hysterectomy with the conservation of one ovary was performed. Pathohistological examination confirmed cervical molar pregnancy. In the case of an ectopic, molar or ectopic molar pregnancy,

the early visit to gynecologist would give the opportunity to plan the treatment and to preserve the uterus for further pregnancies.

Key words: bleeding; cervical pregnancy; molar pregnancy; urgent hysterectomy

INTRODUCTION

Cervical ectopic pregnancy is the implantation of pregnancy in the endocervical canal. Cervical pregnancy is rare, but often associated with significant morbidity. Gestational trophoblastic disease (GTD) is a disorder of accelerated trophoblastic proliferation. The incidence of hydatidiform mole is one per 1.000 pregnancies [1].

The association of cervical pregnancy and GTD is extreme rare, but it is obvious that such combination is associated with devastating effects on future fertility as well as substantial challenges in the treatment.

CASE PRESENTATION

Patient, 35 years, parity 2 (caesarean deliveries), was admitted to our Clinic due to massive uterine bleeding at 7^{th} gestational week. The pregnancy was uneventful till then, except nausea. On admission, she was pale, her blood pressure was 70/30 mm Hg, pulse was 98/min, filiform. On speculum examination, cervix was enlarged, with uterine bleeding. Bimanual examination revealed bulky cervix with small and soft uterine body. Transvaginal ultrasound examination revealed uterus with empty uterine cavity and bulky cervix with complex heteroechogenic formation with prominent peripheral hypervascularity on color Doppler ultrasound examination. Both ovaries appeared with no pathological structures. Her hemoglobin was 6.4 g/dL and beta-HCG was 29655 mIU/mL.

Patient was informed and due to haemodynamic instability and vital endangerment of the patient, a decision was made to perform the surgery. Slightly enlarged uterine corpus, with bulky cervix and normal adnexa were found on laparotomy (Fig. 1A and B). Total abdominal hysterectomy with the conservation of one ovary was performed. Pathohistological examination confirmed cervical molar pregnancy (Fig. 1C).

DISCUSSION

Known risk factors for cervical pregnancy were not present in our patient. She had two caesarean deliveries in her medical history, no dilatation and curettage, no anatomic abnormalities and fibroids. We speculate that inappropriate healing of caesarean scar could change the uterine motility resulting in cervical implantation of an early embryo.

Ectopic GTD is a rare condition, with incidence of approximately 1.5 per 1.000.000 births [2, 3]. Cervical GTD is an extremely rare, but potentially fatal condition. Our own review of the literature (Medline data base, through electronic searches by keywords without language restriction) showed a total of six reported cases of cervical molar pregnancies worldwide during the last 61years [4–9]. Four of them were treated conservatively (surgery evacuation followed by arterial ligation or haemostatic sutures) [4-7] and in two cases hysterectomy was performed [8, 9].

The management of ectopic molar pregnancies consists of complete removing of the conceptus [10]. In the case of our patient with cervical molar pregnancy, the urgency of the condition didn’t allow the use of methotrexate. The decision to perform the total abdominal hysterectomy was made as a desperate measure and due to vital indications. Data from available literature, as well as previous experiences in the treatment of cervical-molar pregnancy are very scarce and do not provide a clearly defined algorithm of behavior in such extremely serious situation.

If it is about an ectopic, molar or ectopic molar pregnancy, just an early visit to gynecologist would give the opportunity to plan further treatment, especially the possibilities of conservative treatment to preserve the uterus for further pregnancies.

Conflict of interest

All authors declare no conflict of interest.

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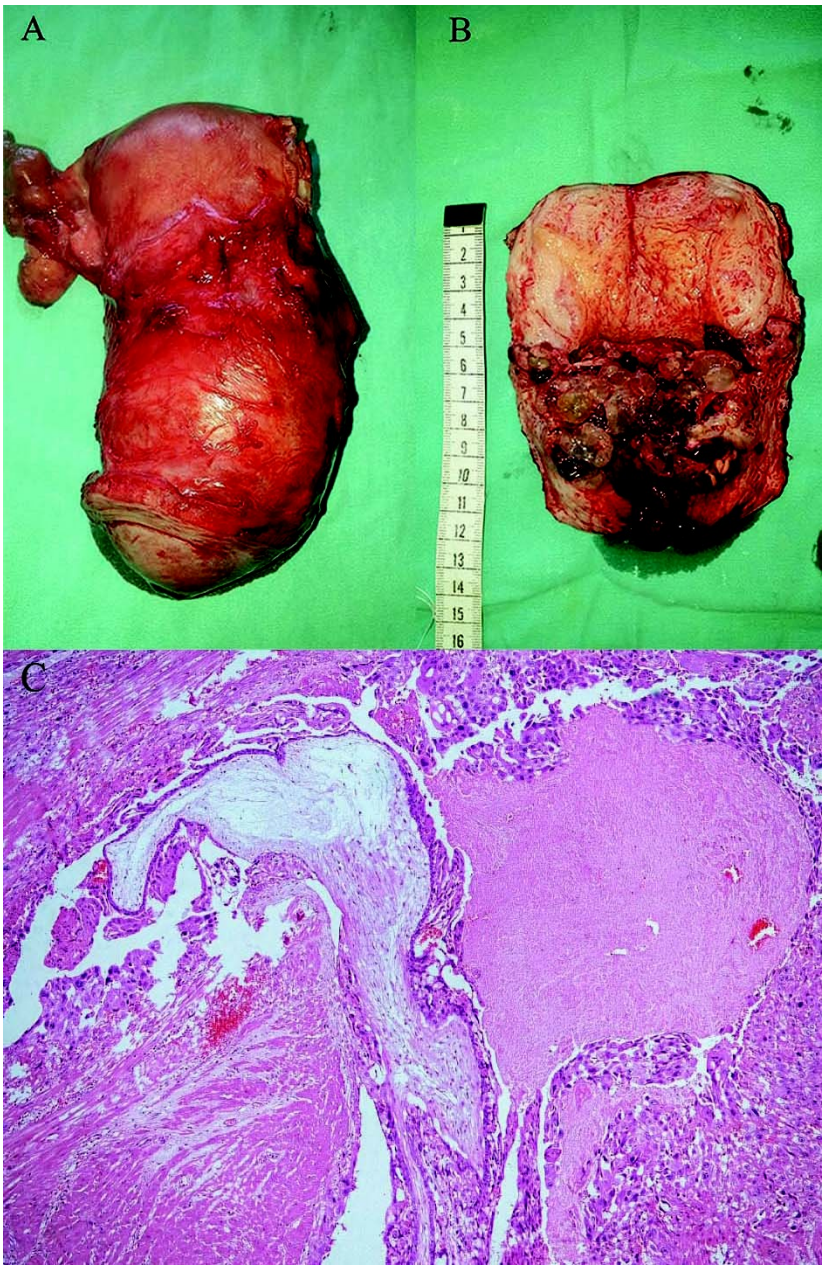

Figure 1. A. Uterus and right adnexa after hysterectomy; **B.** Uterus in cross section. Small uterine body with bulky cervix containing molar pregnancy; **C.** Histopathology: hydropically enlarged edematous placental villus with central cistern and circumferential trophoblastic hyperplasia is present within cervical stroma (HE, x 40)