

DOI: 10.5455/2320-1770.ijrcog20130953

Case Report

## Invasive mole presenting as pain abdomen

Swati Singh\*, Navdeep Kaur, Swapan Joshi

Department of Obstetrics and Gynecology, MMIMSR, Mullana, Ambala, India

**Received:** 13 July 2013

**Accepted:** 4 August 2013

**\*Correspondence:**

Dr. Swati Singh,

E-mail: swatisingh0011@gmail.com

© 2013 Singh S et al. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

### ABSTRACT

Gestational trophoblastic neoplasms (GTN) are proliferative as well as degenerative disorders of placental elements and include complete or partial mole (90%), invasive mole (5.8%), choriocarcinoma (1-2%) and placental site tumor (1-2%). 15% of complete mole can develop into invasive mole. Very rarely (2-4%) partial mole can develop into invasive one presenting with features of incomplete abortion, mixed abortion and sometimes as obstetric emergencies like intraperitoneal hemorrhage. So, proper diagnosis and timely intervention can prevent mortality and reduce the morbidity of the patients.

**Keywords:** Invasive mole, Gestational trophoblastic neoplasm, Ultrasound

### INTRODUCTION

Gestational trophoblastic disease (GTD) varies widely among various populations with figures as high as 1 in 20 pregnancies in some areas of Asia and South America compared with 0.6-1.1 per 1000 in the United States.<sup>1</sup> It comprises of partial mole, complete mole, invasive and metastatic mole, choriocarcinoma, placental site trophoblastic tumor and epitheloid trophoblastic tumor. About 92% of hydatiform mole resolve spontaneously after evacuation.<sup>2</sup> However, rest of them may develop gestational trophoblastic neoplasia. Low risk disease is treated by single agent chemotherapy while high risk is treated by multi-agent chemotherapy. The overall cure rate is more than 90% and most of the patients can preserve fertility and anticipate normal pregnancy outcomes.

### CASE REPORT

A 21 year old women, P0L0 presented to our hospital with complaints of pain in abdomen on and off since 6 months. She was diagnosed as having a partial mole and underwent dilatation and curettage on 5<sup>th</sup> Sept., 2011. After this, patient had amenorrhoea and about 3 months after curettage beta-HCG based was 2926.45mIU/ml.

On admission, her vitals were stable and respiratory and cardiovascular examination revealed no abnormality. Bimanual examination revealed a bulky uterus with tenderness in left fornix. UPT was positive. Her baseline investigations were within normal limits except a raised serum  $\beta$ -hCG (774.65mIU/mL). The patient was diagnosed left adnexal cyst of size 5.cm on USG. On TVS, no e/o intrauterine/extruterine gestational sac was seen. Chest X-ray was normal. She was treated with single agent chemotherapy i.e. methotrexate (1mg/kg body weight) and folinic acid for 7 days. Patient showed improvement by reduction in serum  $\beta$ -hCG values (66.14miu/mL) and slight reduction of size of altered area in myometrium on USG. After two weeks of chemotherapy, there is more reduction in  $\beta$ -hCG value i.e. 8.56miu/mL. About 1 month later patient came for follow up and then  $\beta$ -hCG value was <2mIU/mL and on USG there was reduction in vascularity and hypoechoic area in uterus, when compared with previous USG.

### DISCUSSION

Gestational trophoblastic disease (GTD) are a group of disorders that arise from fertilization of an empty egg by two spasm or normal ovum with two sperms leading to

formation of either complete or partial mole, invasive mole or choriocarcinoma. There is increased risk in teenager and women over 35 years and rate increase 10 fold after the age of forty.<sup>3</sup>

An invasive mole results from myometrial invasion of a complete or partial mole, which without exhibiting the histological features of malignancy can even metastasize to other organs like vagina and lungs.<sup>4</sup> Typically, patient presents with persistent vaginal bleeding following a molar pregnancy or abortion. The demonstration of the complete hydatiform mole invading the myometrium or the presence of villi in the metastatic lesion. Myometrial invasion is difficult to document on pelvic USG and also or uterine curetting unless there is sufficient myometrium to demonstrate invasion. So, correlation of clinical findings, quantitative  $\beta$ -hCG and ultrasound is necessary for diagnosis.<sup>5</sup> Other diagnostic modalities include CT scan of chest, brain, liver and MRI.<sup>2</sup>

Clinical staging of GTD has been evolved for selection of treatment. Homonds system is the most commonly used.<sup>6</sup> Women with low risk GTD com usually be cured with single agent chemotherapy,<sup>7,8</sup> while those with high risk can be managed with multi-aged chemotherapy. Serial close monitoring of serum  $\beta$ -hCG is mandatory because gestational trophoblastic disease persists and progress even in women at low risk. Therefore, a protocol consists of a monitoring serum  $\beta$ -hCG weekly until normal for 3 consecutive weeks, followed by monthly serum  $\beta$ -hCG until normal for 6 consecutive months and yearly for one to three years.<sup>9</sup>

*Funding: None*

*Conflict of interest: None declared*

*Ethical approval: Not required*

## REFERENCES

1. World Health Organization. Classification of Tumors International Agency for Research on Cancer (IARC). Pathology and genetics tumors of the breast and female genital organs. Fattanch A, Devillee TP, Eds. IARC Press, Lyon, 2003;250-254.
2. Smith DB, O'Rcilly SM, Newlands ES. Current approaches to diagnosis and treatment of gestational trophoblastic disease J. Ultrasound Med 1993;12:59-62.
3. Grudzinakas JG, Stabile. Ectopic pregnancy: are biochemical test are all useful? Br J Obstet Gynaecol 1993;100:S10-11.
4. Palmer JR. Advances in the epidemiology of gestational trophoblastic disease. J Reprod Med 1994; 39:1555-62.
5. Society of gynecologic oncologist clinical practice guideline. Gestational trophoblastic disease oncology. Huntington. 1998;12:455.
6. Goldstein DP, Zanten-Przybysz IV, Bernstein MR, Berkowitz Rs. Revised FIGO staging system for gestational trophoblastic tumor. Recommendations regarding therapy. J Reprod Med 1998;43:37.
7. Roberts JP, Lurian JR. Treatment of low risk metastatic gestational trophoblastic tumos with single agent chemotherapy. Am J Obstet Gynecol 1996;174:1917.
8. Wong LC, Wgan HY, Chong DK, Wg TY. Methotrexate infusion in low risk gestational trophoblastic disease. Am J Obstet Gynecol 2000;183:1579.
9. Masad LS, Abu-Rustum NR, Lee SS, Renta V. Poor compliance with past molar surveillance and treatment protocols by indigent work. Obstet Gynecol 2000;96:94.

DOI: 10.5455/2320-1770.ijrcog20130953

**Cite this article as:** Singh S, Kaur N, Joshi S. Invasive mole presenting as pain abdomen. *Int J Reprod Contracept Obstet Gynecol* 2013;2:480-1.