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Acute Surgical Abdomen Due to an Invasion Mole: A Description of One Case and Review of Literature

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Abstract | **Case Report**

The invasive mole is a gestational trophoblastic tumor complicating an hydatiform mole. We report a case diagnosed as invasive mole at the stage of uterine rupture following an unrecognized hydatiform mole. The aim of this work, through this case and a review of the literature, is to show that the delay in diagnosis and treatment could affect the prognosis and lead to the death of the patient.

Keywords: Uterine rupture, invasive mole, gestational trophoblastic tumor, molar pregnancy, hemoperitoneum.

INTRODUCTION

Gestational trophoblastic tumors (GTTs) are the malignant entity of gestational trophoblastic disease. There are four histologic types: invasive mole, choriocarcinoma, placental site trophoblastic tumor and epitheloid trophoblastic tumor.

The invasive mole has a strong metastatic profile and can have a serious and a fatal complication like uterine rupture if it's not early recognized and threated.

CASE REPORT

48-years-old patient without medical or surgical antecedents. G4P4 4 vaginal deliveries. Admitted in the emergency room with an hypovolemic shock: the patient was conscious, her vital signs were: blood pressure= 09/05cmhg, pulses of 110 beats / min ,respiratory rates of 25 breaths per minute. A supportive care were provided.

In her medical history the patient report a vaginal bleeding since 2 months. The clinical examination shows an abdominal guarding and an abdominal tenderness to palpation. The gynecological exam find a vaginal bleeding with a significant uterine and annexial tenderness and pain to mobilization

The pelvic ultrasound demonstrated an important peritoneal effusion with a normal uterus, endometrium measuring 7mm, and a latero-uterine mass measuring 74mm/40mm hypervasularized with multiples cystic images (Figure-1).

Laboratory testing demonstrated a quantitive serum level HCG of 74000 ui /l, hemoglobin=7 g/d.

The diagnostic of an extra uterin molar pregnancy was strongly suggested .the patient was taken directly to the operating room. She benefited the laparatomy, required the aspiration of hémopéritoneum (1.5L) (Figure-2); we found posterior uterine rupture (Figure-3). An interannexiel hysterectomy was done .patient required 2 units of packed red blood cells. Its histopathological examination demonstrated a uterine rupture with an invasive hydatiform mole with foci of trophoblastic proliferation within the myometrium and myométrial vessels.

The diagnosis of uterine rupture due to an invasive hydatiform mole was confirmed. The abdominal and pelvic ct scan didn't show any metastatic sites. Our patient was classified as a low risk patient and didn't required a chemotherapy.

The level of a plasmatic B-hcg become low 2 days after the surgery (B-HCG= 250mui/ml) and it was negative after 01 months. Its monitoring has been ensured during 12 months without increasing in its levels.

DISCUSSION

Gestational trophoblastic disease has 2 entities:

- The benign entity: the hydatidiform mole (HD), complete or partial
- The tumor entity: invasive mole (IM), choriocarcinoma, the placental site trophoblastic tumor and the epitheloid trophoblastic tumor.

The invasive mole (IM) is a complication of a molar pregnancy. It is an infiltrating hydatidiform mole characterized by the presence of edematous chorionic villi with trophoblastic proliferation that invades into the myometrium and / or myometrial vessels [1].

The diagnosis of the invasive mole is by the pelvic ultrasound that shows the myometrial infiltration and / or the abnormality of monitoring of the B-hcg levels after an hydatiform mole treatment. In our case the diagnosis of invasive mole was suspected during the surgery and confirmed by the histological examination [2].

The abdominal CT scan is recommended to evaluate for the extent of the disease. Imaging of symptomatic systems is appropriate (CT chest, cerebral MRI).

The FIGO developed a staging prognostic score that helps the particien to build an effective therapeutic plan treatment and to predict patient's prognosis we have 2 groups:

- A low risk group with a score of 6 or less with or without metastatic sites: it has a good prognosis and require a mono-chemotherapy.
- A high risk group with a score of 7 and more, with or without metastatic sites: requires intense treatment with a poly chemotherapy.

An invasive mole that is not treated early or that is under threated can be complicated by a fatal uterine rupture [3-5]; that's what happened to our patient who was admitted with an hypovolemic shock

For the patients who are in perimenopause or are not desiring other pregnancies the management of their invasive mole includes hysterectomy with or without chemotherapy.in our case the hemostatic hysterectomy was done to an 48 years old women, and we didn't needed a chemotherapy because she was classified as a low risk tumor with no metastatic sites [6, 7].

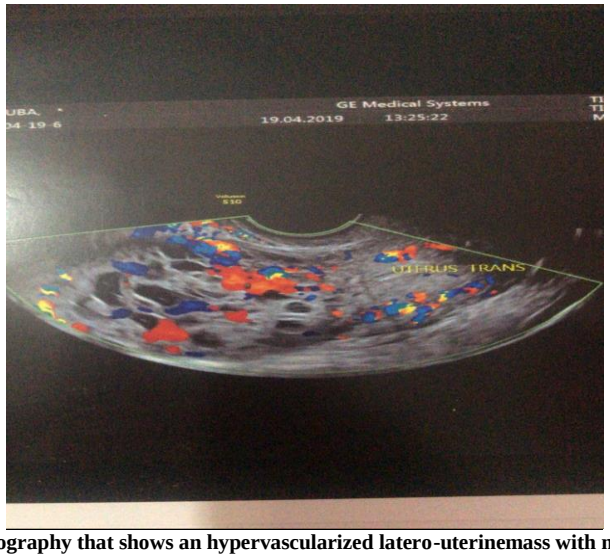

Fig-1: Pelvic ultrasonography that shows an hypervascularized latero-uterinemass with multiples cystic images

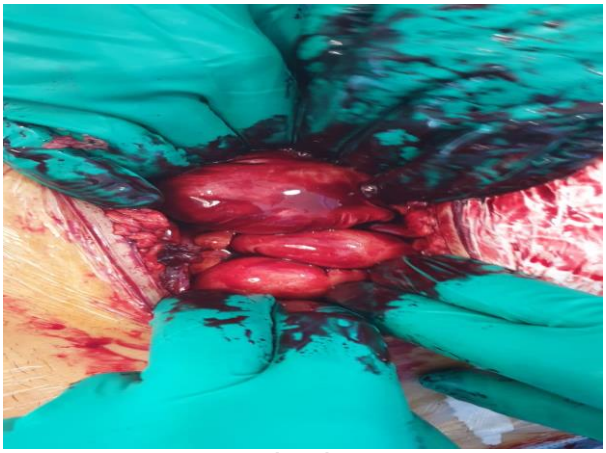

Fig-2: Hémopéritoneum

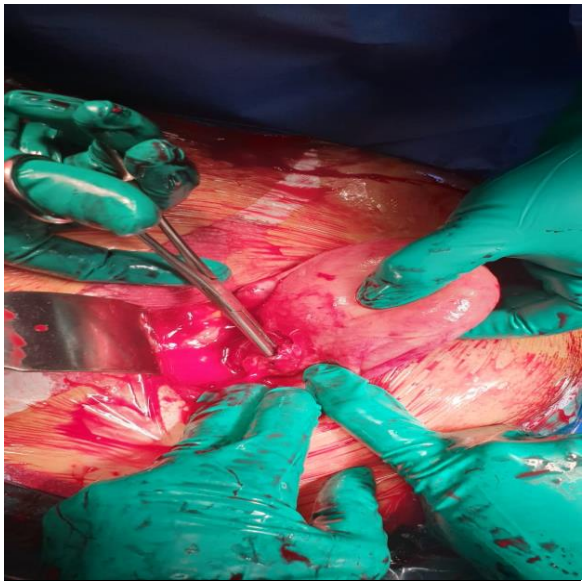

Fig-3: Posterior uterine rupture due to an inavasive mole

CONCLUSION

Early management of molar pregnancy, as well as its good post-treatment biological monitoring, allows early diagnosis and treatment of the invasive mole so we can avoid tragical complications as the uterine rupture.

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