

Complete Hydatidiform Mole in a Perimenopausal Woman: Clinical Case

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ABSTRACT

Background: Hydatidiform moles are divided into a complete mole and partial mole, the former originates from the fertilization of an enucleated ovum by two spermatozoa with independent genetic load and the predominant clinical manifestation is hemorrhage. The uterine size is usually larger than normal with subjective symptoms of pregnancy. The importance of this type of tumor is that it is a pre-malignant tumor that can develop into a trophoblastic neoplasm in such a way that in the complete mole it will transform into a neoplasm. **Clinical case:** A 43-year-old female attends for evaluation after suffering a fall from her support plane for 3 days with pelvic and hypogastric pain, colic type without transvaginal bleeding, reports pregnancy, unaware of her date of the last period, without prenatal control or previous USG. On physical examination: globular abdomen at the expense of a hypertrophic uterus of 16x12x10 cm, beta chorionic gonadotrophic hormone (HCG- β) > 150,000.00 mIU/ml. Endovaginal and pelvic USG: uterus in anteversoflexion, central, enlarged due to the presence of a snowflakes ultrasound image. Diagnosis: data suggestive of hydatidiform mole. She has been admitted for an abdominal hysterectomy. Findings: enlarged uterus at the expense of a complete mole, adnexa without alterations. **Discussion:** Hydatidiform mole can occur in both reproductive and peri or postmenopausal. **Conclusion:** Our case was presented in an elderly patient with an incidental diagnosis by ultrasound and with the management established for this type of case in elderly people who have resolved their parity, which evolved satisfactorily under surveillance by the service.

Keywords: Molar pregnancy; Gestational trophoblastic disease; Hydatidiform moles.

INTRODUCTION

The hydatidiform mole is divided into complete and partial moles; the first originates from the fertilization of an anucleated ovum by two spermatozoa with an independent genetic load. It can also occur due to fertilization with a sperm, which undergoes a division after penetration. The chromosome pattern can be 46XX or 46XY.

Partial hydatidiform mole is hydropic degeneration that is limited to a certain area of the placenta. In this clinical form, there may be a fetus, which may be viable, but usually presents chromosomal abnormalities. The predominant clinical manifestation is bleeding, hence its resemblance to spontaneous abortion.

The symptoms can be irregular bleeding and of variable intensity. The uterine size is usually larger than normal and subjective symptoms of pregnancy. Toxemia may appear in the first trimester, with symptoms of pre-eclampsia in the early phase [1].

The importance of this type of tumor is that is a premalignant tumor that can develop into a trophoblastic neoplasm in such a way that in the complete mole it will transform into neoplasm in 15 to 20%, while the incomplete mole only reaches less, only 5% of the cases. Both types of mole are monitored by measuring serum hCG levels and the clinical picture such as bleeding and persistent pregnancy symptoms [2].

CLINICAL CASE

43-years-old female, 13-year-old menarche, regular 30x8-eumenorrhea rhythm, unknown LMP. Beginning of active sexual life: 18 years-old, family planning method: none, pregnancies 6, deliveries 5, cervical cytology: 1 year ago with no results. She went for evaluation after suffering a fall from her plane of support for 3 days, pelvic and hypogastric pain, and moderate-intensity colic without transvaginal bleeding, she reported pregnancy, and she did not know her last period date, without prenatal control or previous USG. On physical examination: soft, globose depressible abdomen at the expense of a 16x12x10 cm hypertrophic uterus, with no signs of peritoneal irritation, vaginal examination, thick posterior long cervix without transvaginal bleeding. Laboratories: blood count normal; normal liver function test; normal blood chemistry; VDRL negative; beta fraction chorionic gonadotropin hormone (β -HCG) > 150,000.00 mIU/ml. negative general urine test; normal thyroid profile. US of the liver and bile ducts without alterations, endovaginal and pelvic USG: uterus in anteversoflexion, central, increased in size due to the presence of the ultrasound image in snowflakes (Fig. 1). Both ovaries normal. **Conclusion:** data suggestive of hydatidiform mole. She is admitted for a total abdominal hysterectomy. Findings: enlarged uterus at the expense of a complete mole, adnexa without alterations (Figs. 2, 3).

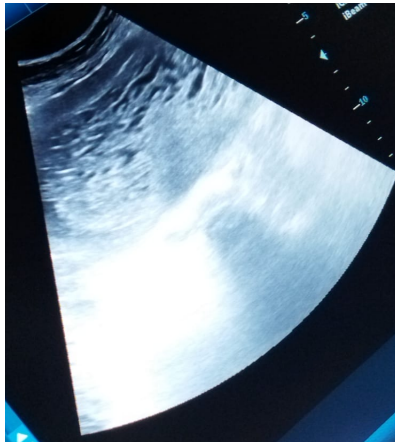


Figure 1. Image by endovaginal ultrasonographic tracking in snowflake.

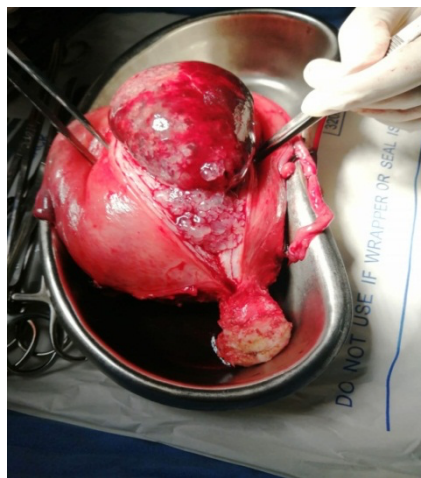


Figure 2. Post hysterectomy uterine dissection.

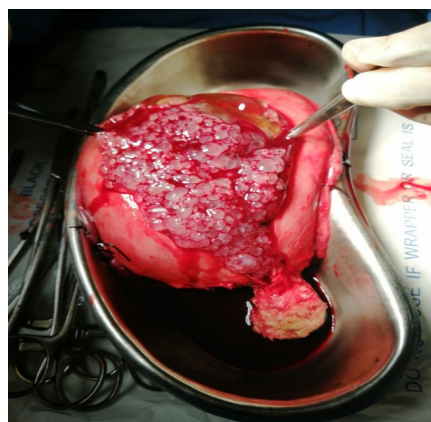


Figure 3. Exposure of molar tissue with the presence of hydropic vesicles.

DISCUSSION

Hydatidiform mole can present at any age, both reproductive and peri- or postmenopausal. Mekni K et al [3] report a case of hydatidiform mole in a 28-year-old patient who presented abdominal pain after seven weeks of amenorrhea with a normal gynecological examination but with ultrasound normal fetal heart rate was observed and several sacs were observed around the sac (*lacunae*) without fluid, which led to suspicion of the diagnosis; hCG samples were taken that were 37920 mIU/mL with a diagnosis of partial hydatidiform mole, received contraceptive treatment and hCG β monitoring until normal values were reached.

Fatusic J et al [4] report a case of hydatidiform mole in a 57-year-old multiparous woman with two years of her last menstrual period and prolonged and moderate uterine bleeding and endometrial hyperplasia who, during curettage, expelled a spontaneous molar-type tumor mass with a level of hCG β of 193.057mIU/mL, a total hysterectomy was performed with bilateral ovariectomy and she was discharged eight days after her hospital admission in good health conditions.

In the same way, Ismail et al [5] report another case of a 55-year-old woman admitted for severe vaginal bleeding of 10 days of evolution accompanied by abdominal pain, diarrhea, and vomiting, who underwent total hysterectomy with bilateral salpingo-oophorectomy with histopathological results. of invasive mole with lung metastasis detected by chest CT scan, and she received adjuvant chemotherapy but the result was not good.

Yu-Xin Dai, et al [6] also report a study in 20 patients with hydatidiform mole associated with pulmonary metastases that can present bilaterally or unilaterally and found that no surgery, apart from initial evacuation, as well as no chemotherapy treatment is recommended when the patients evolve satisfactorily, their β -hCG levels decrease satisfactorily, and the pulmonary nodes decrease in size and number or disappear. Long-term monitoring is recommended.

As it is known, the malignant potential of these tumors is high. McNally L, et al [7] reported a series of nine cases in which five of them had a complete mole associated with a fetus, two of them were born alive and hCG levels β of 200,000 IU/L in all cases and none of the patients developed gestational trophoblastic neoplasia. Maternal symptoms, fetal abnormalities, β -hCG levels, and placental growth pattern help differentiate between a complete hydatidiform mole, coexistent fetus, and placental mesenchymal dysplasia.

The association of mole and live product are frequent within the rarity of this pathology, in such a way that Chhetry M et al [8] report a case of this association in a 21-year-old pregnant woman with 39 weeks of gestation who incidentally, a diagnosis of the hydatidiform mole was made, a cesarean section was performed and a live product was obtained with its placenta and another placenta containing the mola was discharged satisfactorily with follow-up of her hCG β levels, which normalized at week 12 after her check-up.

Irani RA et al [9] in a large study found that antenatal complications occurred in all patients with complete hydatidiform mole as postpartum hemorrhage with 71%, hypertensive disorders of pregnancy with 29%, and only four patients out of 14 cases developed gestational trophoblastic neoplasia.

In a 20-year study Mangla M et al, [10] found 44 cases of molar pregnancy with a live fetus in which less than half of the patients were asymptomatic (19/44; 43.2%), the majority (56.8%) had their baby without complications and only 3/44 (6.8%) developed the gestational neoplastic disease.

The incidence of twin pregnancies with hydatidiform mole is 1 case in 20,000 to 100,000 pregnancies. Santiago-Sanabria et al [11] report a case of coexisting twin pregnancy with a hydatidiform mole in a 43-year-old patient as a result of assisted fertilization where it was managed with methotrexate and uterine evacuation by aspiration with satisfactory evolution.

Raj R et al [12] report on the coexistence of hydatidiform mole with thyroid disorders since there is a molecular mimicry between HGC and thyroid-stimulating hormone (TSH) that leads to gestational trophoblastic hyperthyroidism, which increases maternal and maternal complications. of the fetus. The case was presented in a 24-year-old patient diagnosing this association where surveillance was continued and a euthyroid live product was obtained at 24 weeks of gestation with good management of the thyroid disorder, the result was satisfactory.

CONCLUSION

Our case was presented in a premenopausal patient with an incidental diagnosis by ultrasound and with the management established for this type of case in elderly people who have resolved their parity, which evolved satisfactorily and continues under surveillance by the service.

References

1. Solís-Cartas U, Calvopiña-Bejarano SJ, Martínez-Larrarte JP, Menes Camejo I, Aguirre-Saimeda GL. Mola hidatiforme como manifestación ginecobstétrica en el curso de las enfermedades reumáticas. *Rev Cub Med Milit.* 2018; 47(4):1-8. <http://scielo.sld.cu>
2. Mulisya O, Drucilla JR, Sengupta ES, Agaba E, Laffita D, Tobias T, et al. Prevalence and Factors Associated with Hydatidiform Mole among Patients Undergoing Uterine Evacuation at Mbarara Regional Referral Hospital. *Hindawi Obstet Gynecol Int.* 2018, Article ID 9561413, 7 pags. <https://doi.org/10.1155/2018/9561413>
3. Mekni K, El Fkih Ch. Aspect d'ovaire intra-utérin d'une môle partielle. *Pan Afr Med J.* 2021; 39:120. Doi:10.11604/pamj.2021.39.120.29292
4. Fatusic J, Hudic I. Complete Molar Pregnancy in Postmenopausal Woman-a Case Report. *Med Arch.* 2019 Dec; 73(6):436-7. Doi: 10.5455/medarh.2019.73.436-437
5. Ismail S, Mikhael K, Salloum N, Alshehabi Z. An invasive mole with pulmonary metastases in a 55-year-old postmenopausal Syrian woman: a case report and review of the literature. *J Med Case Rep.* 2021; 15:13 <https://doi.org/10.1186/s13256-020-02630-3>
6. Dai YX, Xiang Y, Feng FZ, Ren T, Yang JJ, Zhao J, Wan XR. Pulmonary deportation of hydatidiform mole: a 12-year, single tertiary center experience in China. *Chin Med J.* 2020; 133:1930-4. doi:10.1097/CM9.0000000000000950
7. McNally L, Rabban JT, Poder L, Chetty S, Chetty S, Ueda S, et al. Differentiating complete hydatidiform mole and coexistent fetus and placental mesenchymal dysplasia: A series of 9 cases and review of the literature. *Gynecol Oncol Rep.* 2021; 37 100811. <https://doi.org/10.1016/j.gore.2021.100811>
8. Chhetry M, Pokharel A, Chaudhary AN. Term Delivery of a Complete Molar Pregnancy with a Coexistent Normal Pregnancy Case Report. *Hindawi Case Rep Obstet Gynecol.* 2019; Article ID 5090565, 3 pages <https://doi.org/10.1155/2019/5090565>
9. Irani RA, Holliman K, Debbink M, Day L. Complete Molar Pregnancies with a Coexisting Fetus: Pregnancy Outcomes and Review of Literature. <https://doi.org/10.1055/a-1678-3563>.

10. Mangla M, Kaur H, Khoiwal K. Partial mole with coexistent live fetus: A systematic review of case reports. *J Turk Ger Gynecol Assoc.* 2022; 23:83-94.
11. Santiago-Sanabria L, Gómez-Romero A, Martínez-Villafañe E. Embarazo gemelar con mola hidatiforme completa y feto vivo coexistente. *Ginecol Obstet Mex.* 2021; 89 (9):727-34.
<https://doi.org/10.24245/gom.v89i9.5070>
12. Raj R, Uy EM, Hager M, Asadipooya K. Delivery of Euthyroid Baby following Hyperthyroidism in Twin Gestation with Coexisting Complete Hydatidiform Mole. *Clinical case. Case Rep Endocrinol.* 2019; ID 2941501.
<https://doi.org/10.1155/2019/2941501>