

A RARE CASE OF COMPLETE MOLE IN A POSTMENOPAUSAL WOMAN

Asha Gopi Nath¹, Subitha Kandamuthar², Beenakumari Raghavan³, Fiji Raj⁴

¹Associate Professor, Department of Obstetrics and Gynaecology, Government Medical College, Kottayam.

²Associate Professor, Department of Pathology, Government Medical College, Kottayam.

³Additional Professor, Department of Obstetrics and Gynaecology, Government Medical College, Kottayam.

⁴Junior Resident, Department of Obstetrics and Gynaecology, Government Medical College, Kottayam.

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PRESENTATION OF CASE

A 52-year-old postmenopausal lady was referred to our hospital as a case of postmenopausal bleeding with increased serum bHCG. She was a P3 L2 A1. First one was a spontaneous abortion, then two full-term normal deliveries and one neonatal death due to congenital heart disease. She had attained menopause one and a half years back. She developed acute onset of breathlessness three weeks back for which she consulted a local hospital and it subsided with symptomatic treatment. Next day, she had postmenopausal bleeding, one episode with history of passing clots followed by spotting per vaginum, which was persisting. There was no history of any hormonal intake or trauma or any history of passing vesicles or nausea or vomiting.

She attained menarche at 14 years of age. She had regular cycles and attained menopause 1½ years back. She had underwent a cholecystectomy 10 years back.

General condition stable. Pulse rate 74 per minute. BP 130/80. Respiratory rate 14 per minute. Afebrile. Breast and thyroid normal. Gynaecological examination, vulva and vagina appeared normal. Cervix was healthy. OS closed. Blood-stained discharge was present. Uterus was enlarged to 18 weeks size, soft and nontender and fornices were free.

DIFFERENTIAL DIAGNOSES

Since, she was a postmenopausal lady presenting with bleeding, the following diagnosis were considered-

1. Carcinoma endometrium.
2. Functioning ovarian tumour.
3. Vesicular mole.
4. Choriocarcinoma.

CLINICAL DIAGNOSIS

Since, bHCG was elevated, a diagnosis of gestational trophoblastic disease was considered.

DISCUSSION OF MANAGEMENT

Haematological and lab investigators revealed Hb 11 g/dL, PCV 33, TC 7, 100, PLC 2.19, TSH 0.01, FT₃ 808 pg/dL, 7T₄

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Corresponding Author:

Dr. Asha Gopi Nath,

Neelambari, Udayanapuram,

P.O. Vaikom, Kottayam-686143.

E-mail: drgnathasha@gmail.com

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1.17 mg/dL and INR 1.54. USG showed multiple cysts of varying sizes and a hypoechoic area 19.2 × 11.7 mm in the posterior myometrium with a suspicion of vesicular mole. BHCG was done to confirm the sonological suspicion of vesicular mole and it was 14,69,799. CXR revealed no lung metastases/any cause of breathlessness. Considering her age and the future risk of development of gestational trophoblastic disease, she was taken up for surgery after starting beta blockers to prevent thyroid storm.

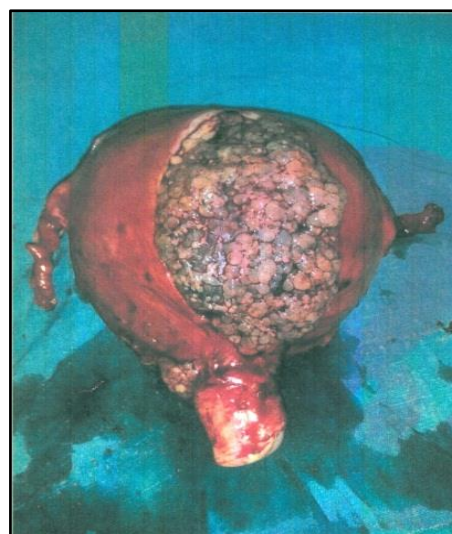


Figure 1. Hysterectomy Specimen Showing Multiple Vesicles

PATHOLOGICAL DISCUSSION

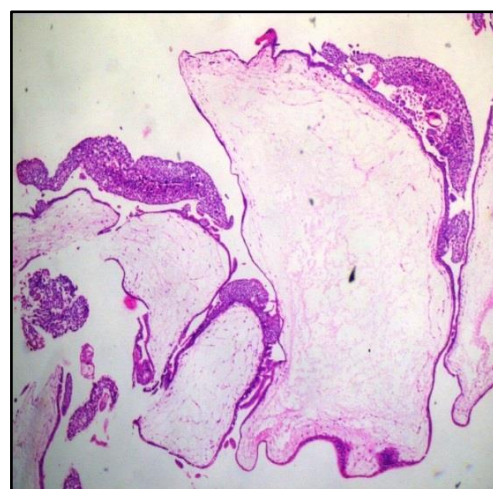
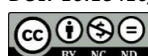


Figure 2. Showing Hydropic, Degeneration with Trophoblastic Proliferation Suggestive of Molar Change



Histopathology was consistent with complete mole. There was no evidence of gestational trophoblastic neoplasia.

FINAL DIAGNOSIS

Complete Vesicular Mole

There have been only a few reported cases of complete mole in postmenopausal ladies. In the world literature, it is well established that the occurrence of gestational trophoblastic disease in women older than 50 years is rare, but it can occur and in postmenopausal women, gestational trophoblastic disease is usually malignant.

Garcia¹ et al in 2004 presented the case report of a postmenopausal woman aged 61 years who presented with vaginal bleeding. She had one year amenorrhea, USG showed complex echoes and bHCG was more than 2 lakhs. She underwent endometrial curettage and due to profuse bleeding was taken up for emergency TAH with bilateral salpingectomy. This was the third reported case of complete mole in a postmenopausal lady. Our patient was directly taken up for hysterectomy based on high bHCG of 14 lakhs, postmenopausal status and USG finding. In postmenopausal ladies, hysterectomy offers the advantages of simultaneous treatment and appears to decrease the risk of post-molar GTN.²

Faruk Abike et al³ reported the case of a 56-year-old postmenopausal woman who came with abdominal pain and vomiting for 1 month. She didn't give a history of postmenopausal bleeding. USG showed cystic areas. BHCG was 1,88,000. Patient underwent TAH with BSO. BHCG had fallen in 4 weeks. This according to them was the 4th reported case. This signifies the treating physician to consider the probability of gestational trophoblastic disease in a postmenopausal lady presenting with abdominal pain and vomiting similarly Hirst⁴ and Ferrier found hydatidiform mole in a postmenopausal patient and did hysterectomy. Also, Rabczynski et al⁵ in 2000 reported a case of complete hydatidiform mole in a 59-year-old woman.

The differential diagnosis of gestational trophoblastic disease may be supported with the use of IHC markers. HCG is diffusely positive in the syncytiotrophoblast of complete mole and choriocarcinoma, but focally positive in PSTT. P⁵⁷

is a useful immunohistochemical marker for differentiating molar from non-molar hydropic villi. The reaction for P⁵⁷ is positive in cytotrophoblast and villi mesenchyme of hydropic non-molar abortion, but negative in hydropic moles.

However, there remain an 8-20% risk of post-molar gestational trophoblastic disease in the elderly patient after hysterectomy and close follow up with bHCG is indicated.³

CONCLUSION

This case highlights the fact that gestational trophoblastic disease can occur in older patients and should be included in the differential diagnosis of post/perimenopausal bleeding to prevent delay in diagnosis and treatment. Physicians should also consider the fact that it can present with symptoms like nausea and vomiting due to increased bHCG and in the absence of postmenopausal bleeding. Recognition of gestational trophoblastic disease becomes difficult in females more than 50 years as menopause is expected and the possibility of pregnancy is often over looked. The best option for treatment is a total abdominal hysterectomy with BSO and they should be kept under follow up with bHCG, since there is an 8-20% risk of post-molar gestational trophoblastic disease.

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