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CASE REPORT

Diagnose and Management of Ectopic Complete Molar Pregnancy

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We present a rare case of ectopic molar gestation presenting excessive vomiting, lower abdominal pain, and 15 weeks amenorrhea corresponding to her last menstrual period. The ultrasonography showed a right tubo-ovarian mass containing a sac with vesicules, cyst in the left ovary and an empty uterus. The quantitative β-human chorionic gonadotrophin (β–hCGà) was 93,854 UI/L. The management was surgical. Right salpingectomy was done, and the specimen was sent for histopathological examination which later confirmed on the microscopy the presence of chorionic villi of variable sizes, some cystically dilated and focal trophoblastic proliferation. She was followed up with weekly then a monthly serum β-hCG measurements (1 year after negativation).

Key words: Ectopic complete molar pregnancy, management, N'djamena chad

INTRODUCTION

The incidence of partial or complete hydatidiform mole is approximately 1 in 500 to 1 in 1000 pregnancies.[1] Molar changes may also be found in ectopic pregnancies. Ectopic pregnancy occurs in 20/1000 pregnancies.[2] Thus, the ectopic molar gestation is very rare. Its malignant potential is similar to that of an intrauterine molar pregnancy.[3] Although ultrasonography is useful in the diagnosis of uterine molar pregnancies, there is a chance of missing this diagnosis in cases of an ectopic molar pregnancy.[4,5] We report a case of ectopic molar gestation diagnosed by ultrasonography.

CASE REPORT

Female MD, 35 years old, Chadian women, married, multiparous (5 alive children, 2 miscarriages), without notable medical history, presented to the gynecological emergency unit of N'Djamena Mother and Child hospital, for excessive vomiting, lower abdominal pain, and 15 weeks amenorrhea. No vagal symptoms were reported. On the clinical examination, the arterial pressure was 120/60 mmHg; her vital signs were stable with no pallor or edema. Per abdominal examination revealed tenderness over the left iliac fossa, without any guarding or rigidity. Per vaginal examination showed a normal-sized uterus and a tender right adnexal mass measuring 5 cm × 4 cm.

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The urine pregnancy test was positive. The ultrasonography showed a right tubo-ovarian mass containing a sac with vesicles [Figure 1], cyst in the left ovary and an empty uterus [Figure 2]. The quantitative β-human chorionic gonadotrophin (β-hCG) was 93,854 UI/L. Chest X-ray and computed tomography scanning, of the brain, chest, abdomen, and pelvis were normal.

The management was surgical. A laparotomy was performed under general anesthesia. There was a complex mass in the right fallopian tube. Ampullary segment of the right tube was dilated and congested. The left ovary and tube were normal. The uterus was bulky. Right salpingectomy was done, and the specimen was sent for histopathological examination which later confirmed on the microscopy the presence of chorionic villi of variable sizes, some cystically dilated and focal trophoblastic proliferation. She was followed up with weekly serum β-hCG measurements. The tests showed a decreasing trend and turned negative at the end of the 6th week. The monitoring of serum β-hC was kept monthly during 1 year after negativation. Barrier contraception was advised, and she was discharged in a stable condition on the 5th postoperative day.

DISCUSSION

The implantation and development of fertilized ovum outside the uterine cavity are observed in approximately

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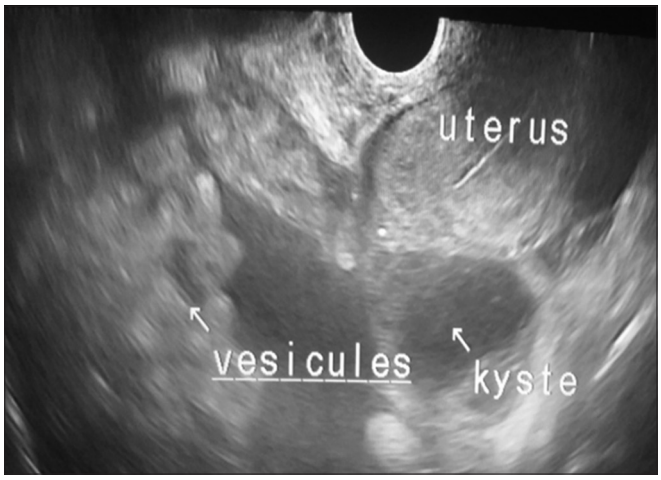

Figure 1: Uterus empty, ovary cyst, and ectopic mole pregnancy represented by vesicle in the right ovary

2% of all pregnancies. Over 95% of ectopic pregnancies develop in fallopian tubes and usually in ampullary part.[5] Due to the increase in the incidence of sexually transmitted diseases, tubal surgery and more frequent use of ovulation induction and assisted reproductive technologies, the incidence of ectopic pregnancies has grown in the past 30 years according to many reports from developed countries.[2,6]

Ultrasonic examination of the first-trimester uterus and particularly vaginal color Doppler flow ultrasound has made possible the detection of abnormalities of early pregnancy. The potential diagnosis of hydatidiform mole is often made by ultrasound, but histological examination of the evacuated material is essential to confirm the diagnosis.[7] In our case, empty uterus coexisting with high level of β-HCG suggested first an ectopic pregnancy, and gestational trophoblastic disease (GTN) was less probable. The presences of vesicules showed in the right ovary, and the cyst in the left ovary were elements in favor of gestational trophoblastic disease. One extensive study on routine preevacuation ultrasound diagnosis of hydatidiform mole suggests that ultrasonography identifies <50% of hydatidiform moles. Detection rates are, however, higher for complete compared to partial moles and improve even further after the 14th week of gestation.[8] The diagnosis of the complete mole was obvious in this case as shown in Figure 2. This was enhanced by the clinical symptom like excessive vomiting. Hextan *et al*.[7] have reported that bleeding or excessive vomiting in the first trimester requires ultrasound examination to allow a positive diagnosis of mole, multiple pregnancy, or fetal abnormality. The diagnosis of GTN is made on the basis of an elevated β-hCG.[5,9,10] For Hextan *et al*.,[7] no fetal heart or high β-hCG above 80,000 mlU/L equals mole. The level of β-HCG of 93,854 UI/L in our case confirmed these findings.

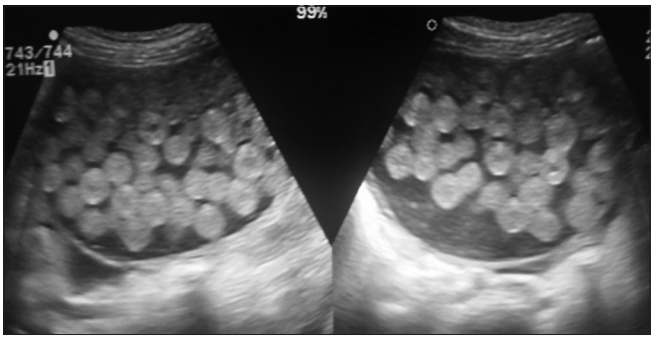

Figure 2: Complete ectopic pregnancy

Eradication of the molar tissues is the best way to reduce the risk of postmolar gestational trophoblastic diseases. In our case, the surgery remained the only possibility to remove this ectopic complete molar pregnancy. Recent studies[2,7] had reported that the current trend in the treatment of ectopic pregnancies is through conservative surgery and monitoring of β-hCG titers to avoid missing a choriocarcinoma developing in an ectopic gestation, even though this is a very rare condition. Regular monitoring of β-hCG titers was done in our which help to put our patient out of gestational trophoblastic diseases.

CONCLUSION

Ectopic molar gestation is rare. Ultrasonography is essential for the diagnosis when the mole is complete. However, clinical symptom and an elevated of β-hCG are elements making the diagnosis obvious. The management is like that of intrauterine ectopic pregnancy.

Consent

For this work, we received the patient's consent and the consent of the director of N'Djamena Mother and Child hospital (Chad). The patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that name and initial will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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