

A Rare Case of Invasion of LSCS Scar by Partial Mole

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ABSTRACT

Invasive mole can mimic in presentation to inevitable, incomplete and missed abortion, and sometimes obstetric emergencies like intraperitoneal hemorrhage with heavy vaginal bleeding. Although rare, but with increasing incidence of LSCS, isolated invasion at LSCS (lower segment cesarian section) scar by partial mole may be seen, as in this case.

To exclude pregnancy before Copper-T (Cu-T) insertion is important, even in a lady with irregular period presenting at 5th day of menses because bleeding may be related to pregnancy.

Keywords: Invasive mole, LSCS scar, Copper-T.

INTRODUCTION

Gestational trophoblastic disease encompasses several entities like complete mole, partial mole, invasive mole, gestational trophoblastic carcinoma and trophoblastic carcinoma from implantation site. These entities are different from each other by their origins, morphology, evolution and treatment. Among all components, partial mole is very common (90%) and triploid genetically. This is one of the important causative factor of miscarriages. Very rarely (2-4%) partial mole can develop into invasive one presenting with features of incomplete abortion, missed abortion, and sometimes as obstetric emergencies like intraperitoneal hemorrhage and torrential vaginal bleeding.¹ This term is applied to molar pregnancy in which molar villi grow into the myometrium or its blood vessels, may extend into the broad ligament and metastasize to the lungs, the vagina or the vulva. All cases of invasive mole are sequelae of hydatidiform moles. Approximately, 15% of complete moles are associated with or precede invasive moles. The pathologic diagnosis of invasive mole is rarely made because most cases are treated medically, without hysterectomy very rarely myometrial invasion is seen at the scar site in the lower segment² and there is dilemma in diagnosing as well as managing such cases. Hence, any woman with abnormal bleeding after dilatation and evacuation should be investigated thoroughly with a possibility of invasive mole, so that timely intervention can be taken to prevent mortality and reduce morbidity because of it. With rising rate of LSCS, there is increased probability of invasion of scar site too.^{2,3}

CASE REPORT

A 28-year-old woman presented with history of bleeding PV for 15 days. Patient had one live male baby of 1 year, born by

LSCS. After LSCS, she was having irregular periods at 45 to 60 days interval, and not practicing any contraception. This time she underwent for copper T insertion on fifth day of her menstruation by some private practitioner. Though it was after 40 days of her last menstrual period (LMP), it was assumed as a normal menstrual period. After 2 days, removal of Cu-T was done in view of continuous heavy bleeding, during examination, passage of clots were seen and uterus was bulky. On ultrasonography, some retained products were suspected, and dilation and evacuation were done. During procedure, patient went into hypovolemic shock due to severe hemorrhage, received blood transfusion and vasopressor agents. Histopathology of products was sent, which afterwards showed partial molar changes, hence she was referred to our hospital. Patient was admitted in our hospital with extreme pallor. Respiratory and cardiac examination were normal. On per abdomen examination, uterus was just palpable and scar of previous LSCS was present. On per speculum examination, bleeding through os was present, bimanual vaginal examination revealed uterus to be 10 weeks' size, ballooning of cervix was present and left-sided adenexal enlargement of 4 × 5 cm was present, cervical os was closed.

Her routine investigations were normal except Hb was 7 gm%, ECG was normal, X-ray of chest had normal findings and USG showed bulky uterus, increased myometrial vascularity suggestive of endometrial collection with foci of air, hypochoic rounded 3.8 cm cervical mass/fibroid identified over endometrial canal, left-sided ovarian cyst of 3 × 4 cm was present. Her serum beta-hCG level was 12,844 IU. Patient was taken for examination under anesthesia, dilation and evacuation. On EUA no cervical fibroid was found and large amount of products of conception were removed. Grossly, no vesicles were

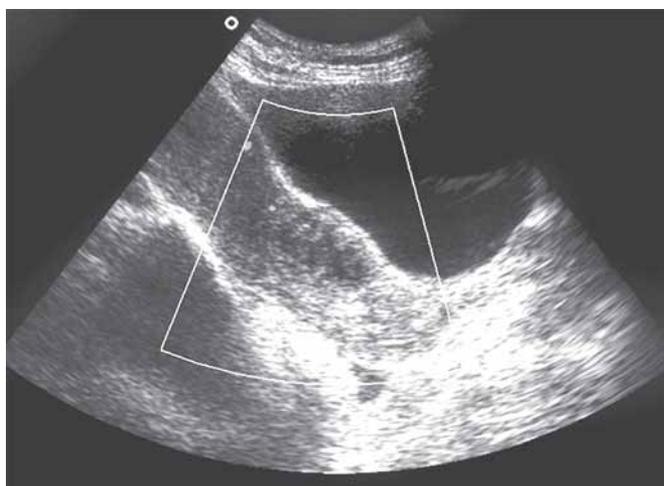


Fig. 1: Transvaginal sonography after 1 week of D&E, showing hypoechoic lesion with hydropic changes of 2.2 × 1.4 cm in the lower part of uterus invading anterior wall at the LSCS scar site

present, sample was sent for histopathology and AFB culture. AFB was negative and histopathology report showed invasive mole. Patient was put on tablet Methotrexate 5 mg tds for seven days along with hemostatics and intravenous iron sucrose. She continued to have spotting for 15 days but on USG, size of uterine and ovarian cyst were reduced. Her serum HCG after seven days was 3,284 and transvaginal ultrasound revealed well-localized lesion at the scar site of 2.2 × 1.4 cm (Fig. 1), and follow-up of the patient was kept with oral iron and second cycle of oral methotrexate 5 mg tds for 5 days was given after 15 days of first cycle. On her follow-up, weekly serum beta hCG was done, it was 1.28 IU after 35 days and she was absolutely symptom free.

DISCUSSION

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%).⁴ About 15% of complete mole can develop into invasive mole.¹ But only 2 to 4% of the partial mole transform into this variety of trophoblastic tumor. Invasive mole usually presents with symptoms of irregular vaginal bleeding, theca-lutein cysts,

uterine subinvolution or asymmetric enlargement and persistently elevated serum hCG levels.¹ It can develop both before and after treatment by D&E or S/E.¹⁻³ The trophoblastic tumor may perforate the uterine myometrium, resulting in intraperitoneal bleeding and vaginal bleeding. Treatment may include single or combined chemotherapy according to patients profile and risk status. Histopathology of invasive mole usually show sheets of anaplastic syncytiotrophoblast and cytotrophoblast without chorionic villi. Our case reported to us with complain of persistent vaginal bleeding and raised serum β-hCG even after evacuation. The histopathology report also documented the presence of invasive moles. Considering the rarity of this case and similar clinical presentations, this case report is unique.² Other emphasizing point is to have a high degree of suspicion for pregnancy at LSCS scar site in the fibrous tissue in this era of LSCS.^{2,3} The necessity of ruling out pregnancy before Copper T insertion and carrying out histopathology examination of tissue after doing dilation and evacuation are necessary. Apart from oral methotrexate, intramuscular⁴ and intramyometrial methotrexate⁵ can also be effective. Early diagnosis and prompt treatment along with proper follow-up is a key to good success rate. It is recommended to rule out pregnancy in every case of irregular menses before Cu-T insertion even if she comes as a case of 5th day of menses.

REFERENCES

1. Mandal Debasmita, Nandi Nupur, Dey Ram Prasad, Roy Biswas Ranu, Bhattacharya Amiya K, Biswas Subhash C. Partial invasive molar pregnancy: Two case reports. *Al Ameen J Med Sci* 2010;3(1):91-93.
2. Chia-Fang Wu, Chin-Yuan Hsu, Chih Ping Chen. Ectopic molar pregnancy in a cesarean scar. *Journal Taiwanese of Obstetrics and Gynecology* December 2006;45(4):343-45.
3. Tan G, Chong YS, Biswas A. Cesarean scar pregnancy: A diagnosis to consider carefully in patients with risk factors. *Ann Acad Med Singapore* 2005;34:216-19.
4. Yen-Yen Lim, Chin-Yuan Hsu, Chih-Ping Chen. Methotrexate followed by suctional curettage: A successful treatment for cesarean scar pregnancy. *Journal Taiwanese of Obstetrics and Gynecology* June 2005;44(2):168-71.
5. Su WH, Wang PH, Chang SP. Successful treatment of a persistent mole with myometrial invasion by direct injection of methotrexate. *Eur J Gynecol Oncol* 2001;22(4):283-86.