

CASE REPORT

Mole in the Hole: A Rare Case of Recurrent Invasive Vesicular Mole in an Ectopic Pregnancy at Scar Site with Bladder Invasion

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ABSTRACT

Background: Cesarean scar pregnancy is a rare form of ectopic pregnancy with an incidence of 1:1800 to 1:2200 pregnancies. There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of subsequent pregnancies.

Case report: We report here a very rare case of recurrent vesicular mole in an ectopic pregnancy at scar site with bladder invasion and its management.

Conclusion: There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of subsequent pregnancies. We show that medical management was effective in this patient but further studies are needed to decide ideal management in such cases.

Keywords: Vesicular mole, Ectopic scar site pregnancy, Bladder invasion, Methotrexate therapy.

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INTRODUCTION

Population studies presently available suggest a worldwide range of hydatidiform moles somewhere between 0.5 and 2.5/1000 pregnancies.¹ In 10 to 15% of cases, hydatidiform moles may develop into invasive moles. Cesarean scar pregnancy is a rare form of ectopic pregnancy with an incidence of 1:1800 to 1:2200 pregnancies. There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of

subsequent pregnancies.² We report here a very rare case of recurrent vesicular mole in an ectopic pregnancy at scar site with bladder invasion and its management.

CASE REPORT

A 30-year-old female married since 5 years, gravida 3 parity 1 living 1 molar pregnancy 1 with 8 weeks of gestation had, come with a regular antenatal scan suggestive of intramural ectopic pregnancy of 7 weeks 5 days at previous cesarean scar site. She also had complains of vomiting since 1 month, 2 to 3 episodes daily, more in morning. Vomit was nonprojectile, nonbilious and contained only food materials. She had no complaints of bleeding or passing any mass per vaginam. She had no other complaints. As per her LMP, she was at 8 weeks of gestation and her ultrasonography (USG) showed the ectopic pregnancy of 7 weeks 5 days. Her past menstrual cycles were regular and painless. As per her obstetric history in her first pregnancy, she had one male child of 4 years via emergency cesarean operation for breech presentation, who was alive and well. Her second pregnancy was a molar pregnancy. She was diagnosed to have an invasive mole, 5 months ago for which she was admitted and 2 cycles of injection. Methotrexate were given. Postmethotrexate her beta-hCG dropped 14 to 2.27 IU (negative) and she was discharged. She also had history of appendectomy 4 years ago. On examination, general condition was fair and her vitals were stable. No pallor or signs of dehydration were present. Per abdomen was soft with no guarding, tenderness or rigidity. Scar of appendectomy and lower segment cesarian section (LSCS) was present. Per speculum cervix and vagina were healthy. On per speculum examination, uterus was 8 weeks, anteverted with bilateral fornices free and nontender. All her routine investigations were normal. Beta-hCG was 1,58,612 IU corresponding to 8 to 9 weeks of gestation before initiating treatment which gradually declined to 1 IU (negative) over 20 days. Her USG pelvis (Figs 1 and 2) showed multiple small, 1 to 2 mm, cystic areas in the endometrium and part of myometrium in the region of fundus upper part of body, anteriorly. Single g. sac was noted just next to above areas. Fetal poles were visualized. Fetal cardiac activity was not visualized. CRL was 8 mm corresponding to 6 weeks 5 days.

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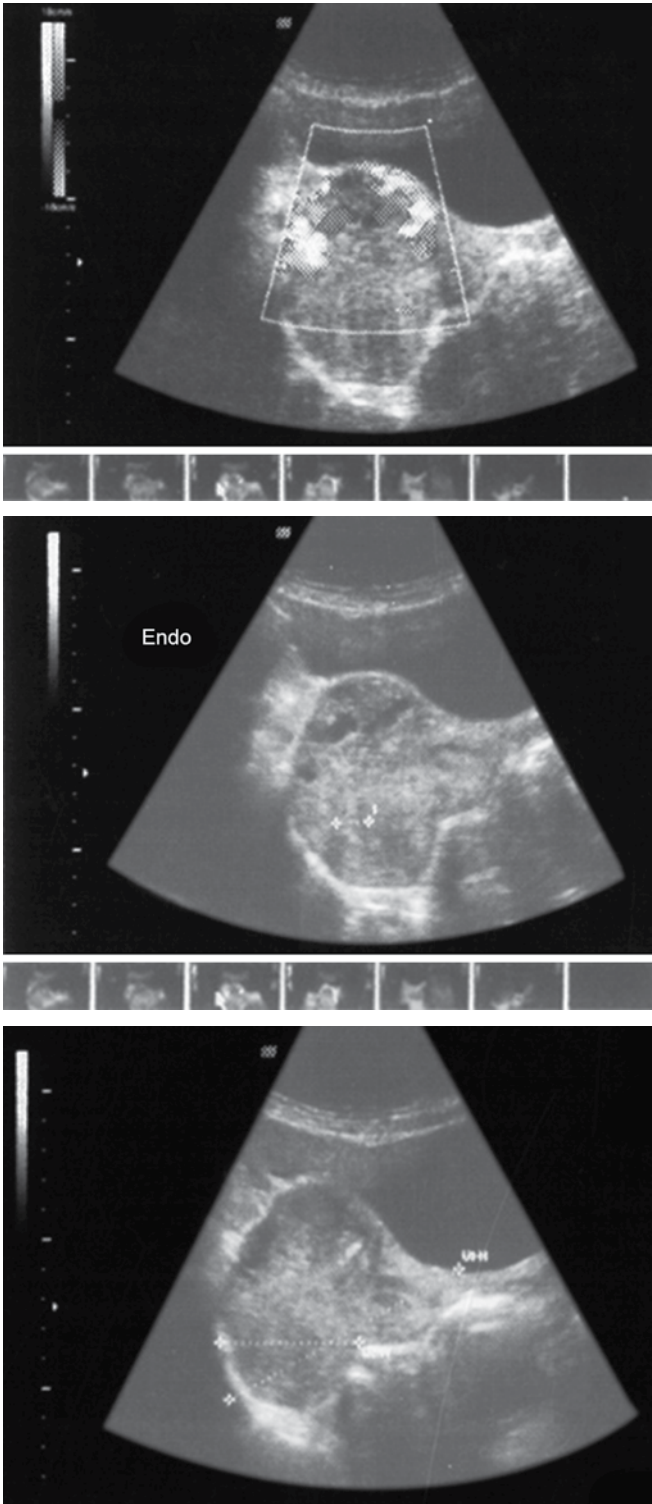


Fig. 1: USG pelvis showing invasive vesicular mole with bladder invasion

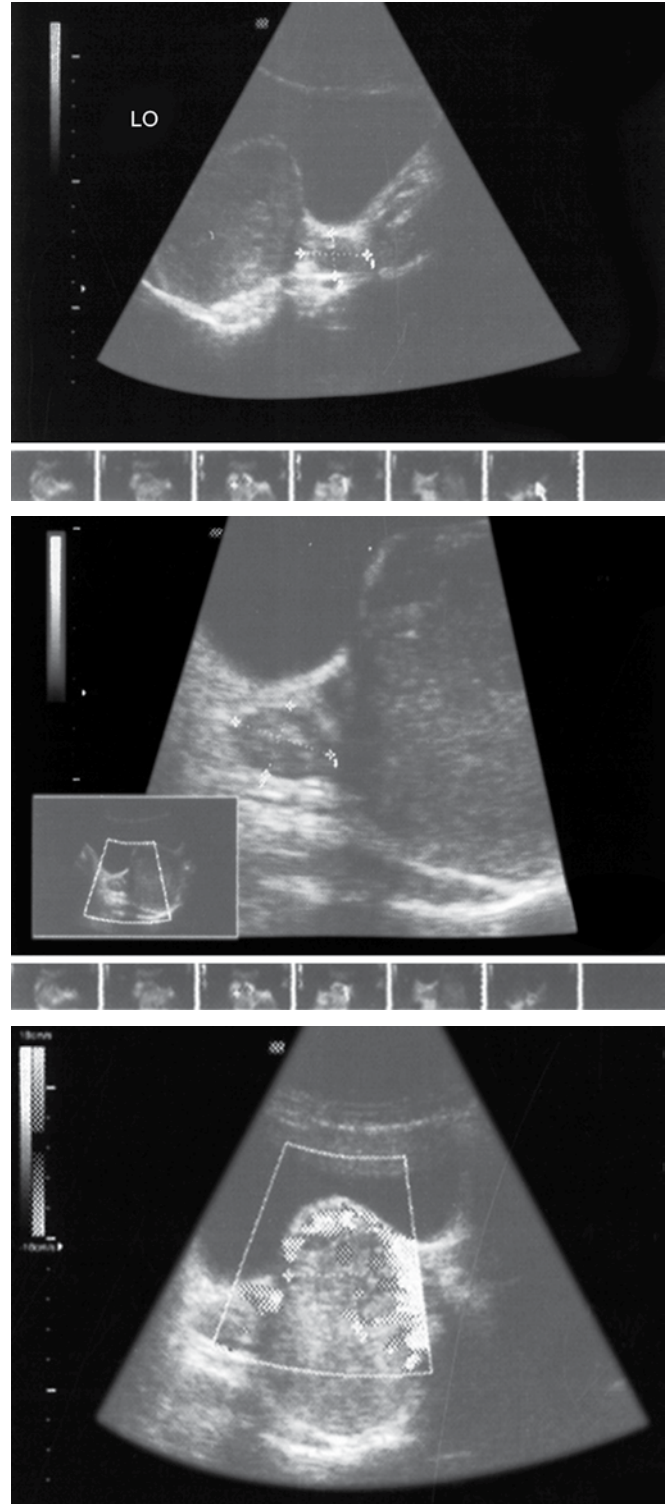


Fig. 2: USG pelvis repeat showing same findings

Chorion was regular and diffuse. Cervical length was 3.5 cm. Internal os was closed. Both ovaries were normal. No pelvic mass or collection was seen. USG abdomen was normal with no sonographically detectable metastasis. The impression was molar pregnancy/invasive vesicular mole. Her repeat USG pelvis had similar findings and decidual reaction was heterogeneous and was seen to reach the anterior subserosal region. Small suspicious area of thickening was noted in

portion of urinary bladder abutting it possibly suggestive of invasion. USG Doppler (Fig. 3) showed increased vascularity around bladder. Based on these findings, magnetic resonance imaging (MRI) abdomen and pelvis was done which showed thick walled g. sac with no obvious fetal pole in the anterior uterine myometrium of lower uterine segment at site of previous LSCS suggestive of scar implantation. The g. sac was highly vascular deriving blood supply from

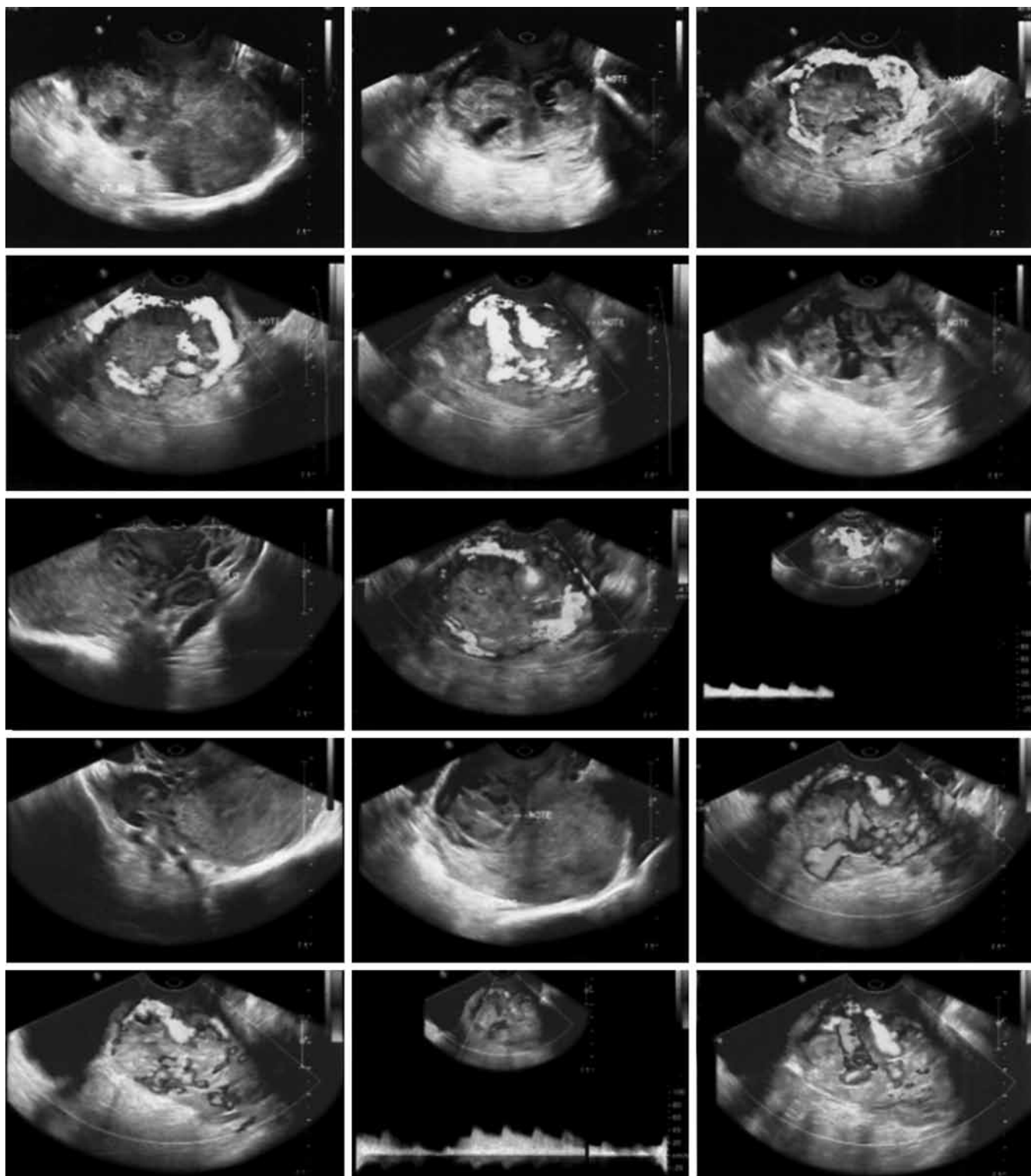


Fig. 3: Color Doppler increased vascularity around bladder

both the uterine arteries, right more than left. The lesion appeared to erode/get blood supply from dome of bladder.

Chest X-ray was normal but computer tomography (CT) scan thorax revealed few fibrocalcific foci in bilateral upper lobes with calcified pre- and paratracheal lymph nodes, sequelae to old pulmonary tuberculosis. Based on these findings and in consultation with oncosurgeons and oncologists injection, methotrexate was started. Patients vomiting

had subsided within 2 days of admission after starting IV antiemetics. Serial beta-hCG showed a gradual decline in beta-hCG till it came negative and patient was discharged.

CONCLUSION

Until this case, there have been only three previous reports of recurrent cesarean-scar pregnancies in the world literature.³⁻⁵ This low prevalence of recurrent scar pregnancies

indicates that implantation into the scar is more likely to be a chance event, rather than the result of a particular affinity of a pregnancy for implanting into the scar. There is currently no consensus as to the most effective management of cesarean-scar ectopic pregnancy, and little is known about the outcome of subsequent pregnancies.² We show that medical management was effective in this patient but further studies are needed to decide ideal management in such cases.

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