



EP.0345 : Diagnostic delay of an invasive mole consequent to unusual β -hCG values: A case report



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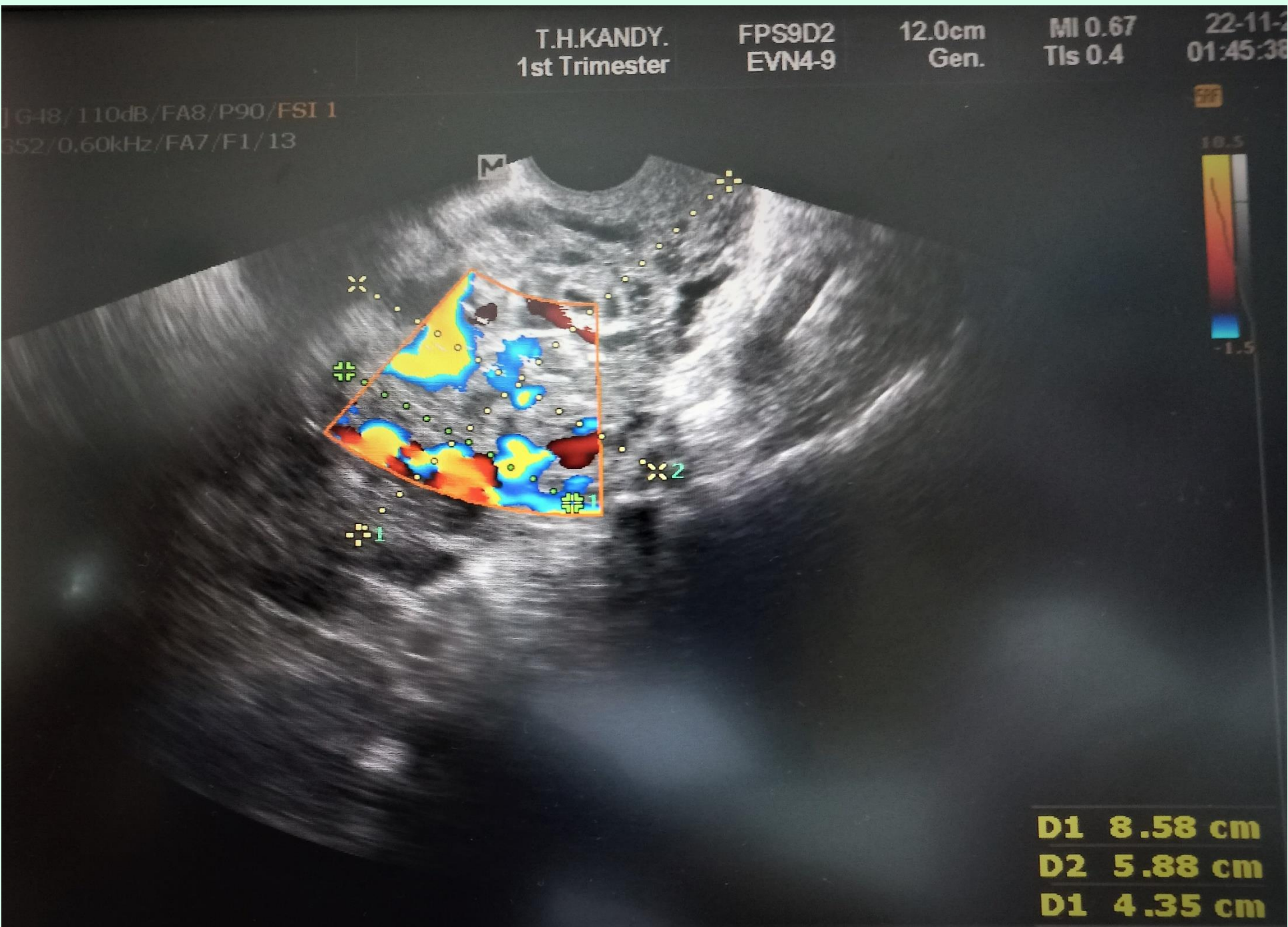
Objectives

Invasive hydatidiform mole (IHM) is an entity of post-molar Gestational trophoblastic neoplasms (GTN) which occur following complete (CHM) or partial hydatidiform mole (PHM) (1). Approximately 15% of CHM & 5% of PHM end up with myometrial invasion, causing IHMs. Characteristically, post molar GTNs give excessive pre-evacuation Beta-human chorionic gonadotrophin (β hCG) values surpassing 100,000mIU/mL. Here we present a case with diagnostic delay since initial β hCG levels were persistently low.

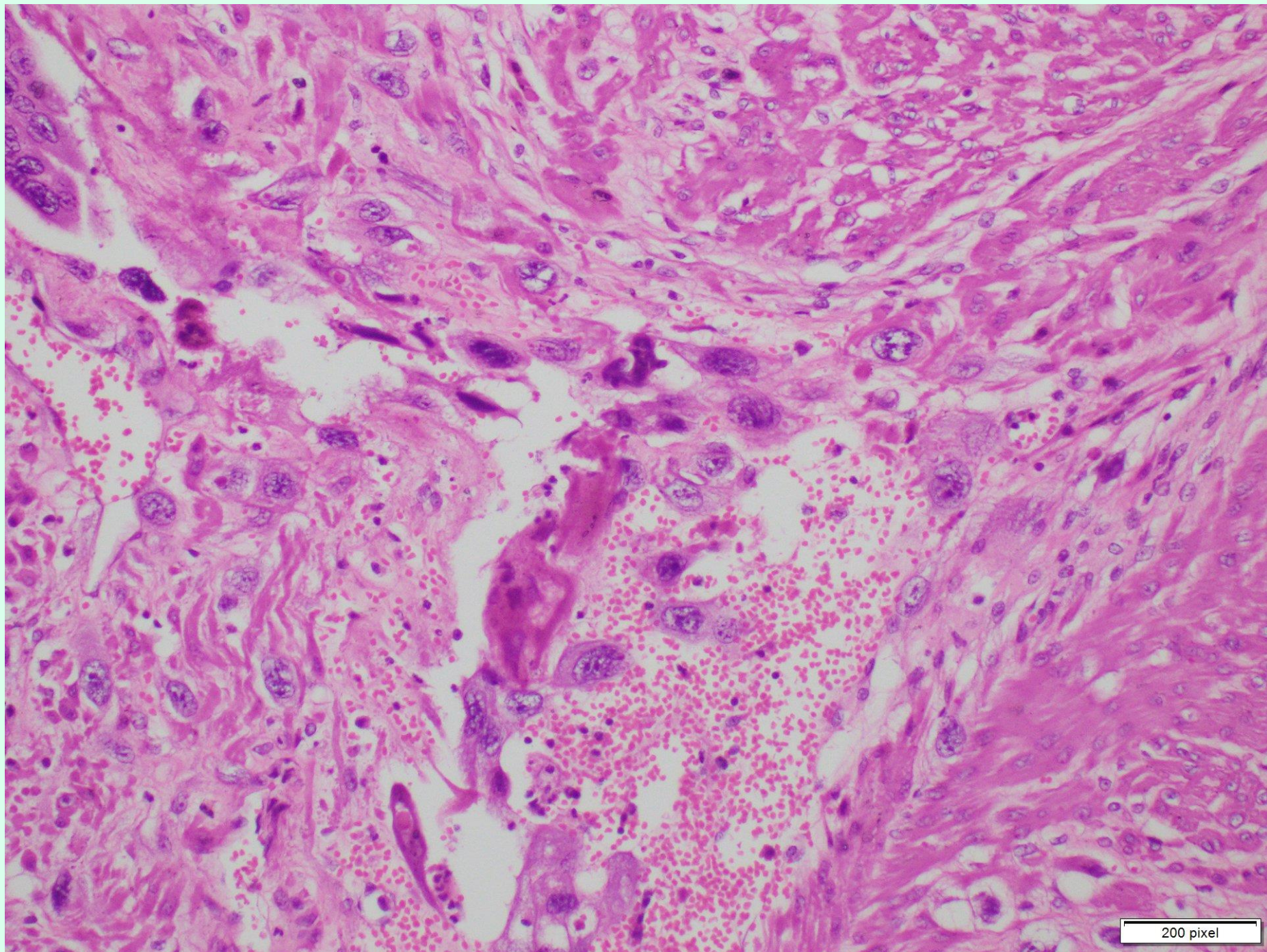
Case Report

A 37-year-old mother of two, was booked for her 4th pregnancy at period of gestation of 9 weeks. Her serum β hCG levels were assessed, since an intrauterine pregnancy was indiscernible by ultrasonography. Initial value was 3039mIU/ml and the value repeated in 48 hours was 4039 mIU/ml, and when repeated in one week indicated 4818mIU/ml. Consequent diagnostic laparoscopy was negative for extrauterine pregnancy. As she was asymptomatic, and differed Methotrexate, she was managed conservatively. She defaulted follow-up and presented few weeks later with vaginal bleeding. Ultrasound appearance suggested molar pregnancy with heterogeneous, hypervascular interior and thinned-out myometrium. She underwent suction evacuation after consenting for possible emergency hysterectomy. She had to undergo a hysterectomy, since bleeding was uncontrollable. Subsequent laparotomy revealed left parametrial spread of mole. Histology revealed an invasive hydatiform mole with myometrial full thickness involvement. A contrast enhanced computerized tomography staged it, FIGO stage II. Currently she's on single agent adjuvant chemotherapy.

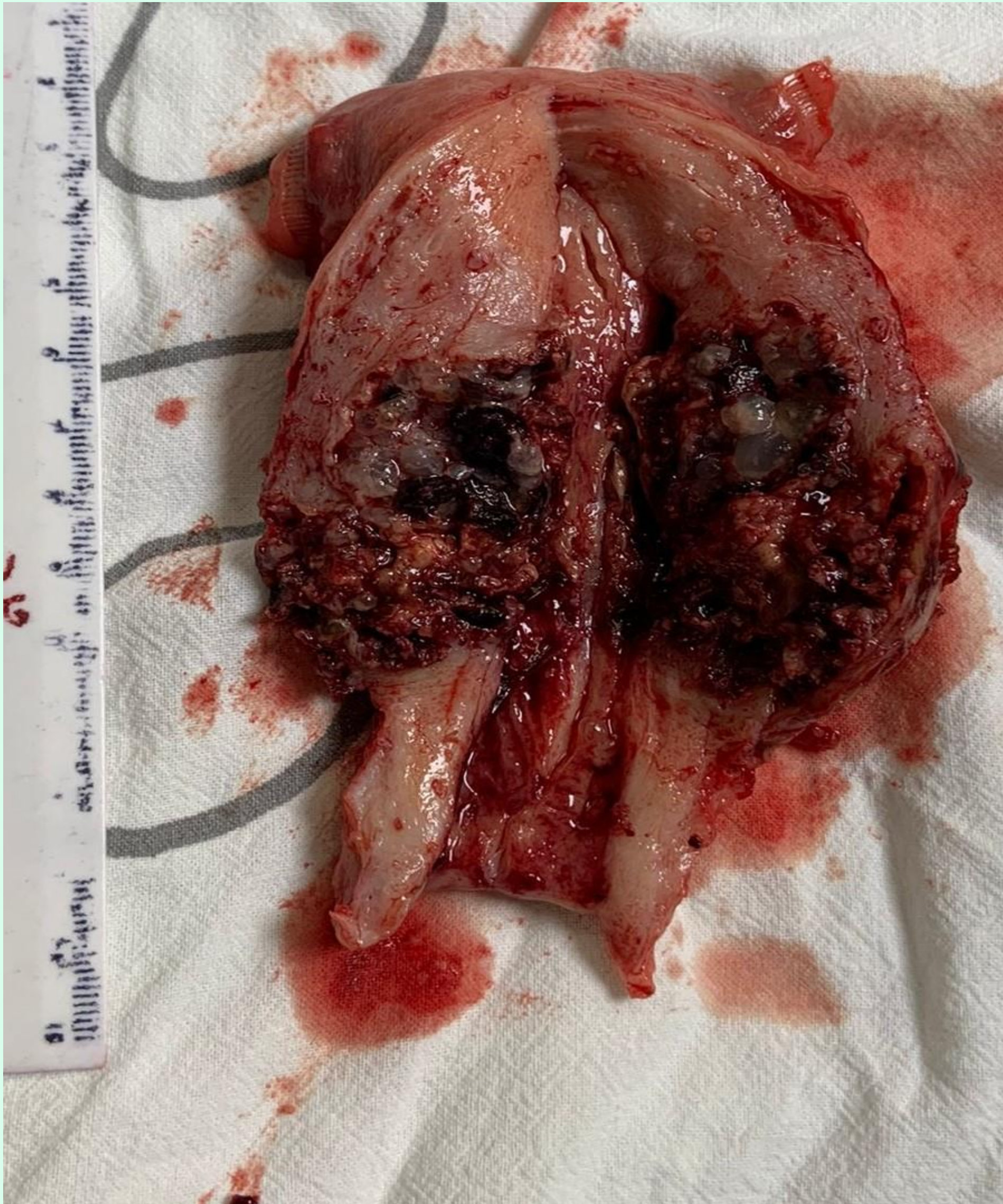
Ultrasonography – vascular assessment



Histology of myometrial invasion



Locations of parametrial invasion (intact and bisected uterus)



Discussion

Serum β hCG values over 1500mIU/ should visualize an intrauterine pregnancy by trans-vaginal sonography. When managing pregnancies of unknown location (PUL), it's recommended to assess serum β hCG levels 48 hours apart (2). If a decrease below 50%, or increase below 63% is noted, weekly β hCG levels and ultrasonography is offered to determine location & resolution, and to exclude molar pregnancy. Patient adherence for follow up is key. In the absence of fertility desire, consent for hysterectomy is crucial prior to evacuation, as about 9% had to undergo hysterectomy for profuse bleeding (1). If fertility wishes are present, uterine artery embolization is considered. Patients with non-metastatic or low risk metastatic GTN (stage II or III) with WHO risk score below 7 are offered single agent chemotherapy with Methotrexate with a cure rate of 85% & 81% respectively (1).

Conclusion

Reliability of compliance is mandatory before offering conservative care of PUL to minimize complications. Serial serum β hCG level evaluation, and frequent ultrasonic assessment of pelvis is vital to achieve a diagnosis for PUL. Informed consent is mandatory prior to evacuation.

References

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2. National Institute for Health and Care Excellence (2019) *Ectopic pregnancy and miscarriage: diagnosis and initial management* (NICE Guideline 126). Available at: <https://www.nice.org.uk/guidance/ng126> [Accessed 17 April 2019].