J Obstet Gynecol India Vol. 57, No. 2 : March/April 2007 Pg 171-172

CASE REPORT

The Journal of Obstetrics and Gynecology of India

An unusual case of complete hydatidiform mole with postoperative eclampsia

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Keywords : complete hydatidiform mole, postoperative eclampsia

Introduction

Eclampsia in a case of hydatidiform mole is very rare. Eclampsia complicating a molar pregnancy is generally preceded by typical preeclamptic symptomatology and always by severely elevated blood pressure [1]. We report one such case of complete hydatidiform mole who developed eclampsia postoperatively.

Case report

A 42 year old para 5 was admitted on 19th April, 2004 for excessive vaginal bleeding for 5 days. She had similar episode of bleeding 20 days back which lasted for 10 days. She gave history of irregular bleeding for last 3 months. Prior to 3 months her periods were normal. At the time of admission she was severely anemic. Respiratory and nervous systems were normal. Blood pressure was 140/90 mmHg and pulse rate 120 /minute.

On abdominal examination a firm mass, elastic in consistency, reaching about 5 cm above the umblicus and corresponding to 32 weeks pregnancy was felt arising from the pelvis. It was mobile from side to side. No fetal parts were palpable. There was tenderness on deep palpation in right iliac region. On pelvic examination the mass was felt through all the fornices of the vagina. Uterus could not be felt separate from the mass. Bleeding was present. Her hemoglobin was 4g dL. Urine was negative for albumin and sugar. Renal and liver function tests were normal. Serum uric acid was 6.4 mg/dL. Platelet count was 1.6 lakh /m^3. Thyroid profile showed early thyrotoxicosis with TSH 0.685 ?IU/mL. Echocardiography showed mild mitral regurgitation with all the chambers slighly dilated. Total serum proteins were 5 g/dL. Urine pregnancy test was positive upto 1:500 dilution. Chest x-ray was normal. Serum ?hCG was 1,230,675 mIU/mL. Ultrasonography showed grossly enlarged uterus with typical snow storm appearance of complete hydatiform mole. No gestational sac was seen. Both ovaries were enlarged and lying in right and left hypochondrium. They showed multiple thecalutein cysts of 2-3 cm size. No fluid was seen in the culdesac. There was hepatomegaly with normal echopattern. She was given nine units of blood transfusion. Considering various risk factors like high serum ?hCG levels, bilateral multiple thecalutein cysts, age>40 years, large size of mole, and completed family, she was taken up for total abdominal hysterectomy with bilateral salpingo-oophrectomy on 26th April, 2004. During operation the uterus was found markedly enlarged upto 22-24 cm. It had smooth surface with engorgement of overlying vessels. Bilateral multiple ovarian cysts measuring 3-5 cm in size were present. On right side there was torsion of and hemorrhage in the ovary with bluish black discoloration. Both ovaries were enlarged upto 15 cm. On opening the uterine cavity it was seen filled with a mass consisting of grape like vesicles. No obvious infiltration of the mass into myometrium could be seen (Figure 1). Postoperatively she was shifted to ICU. She had a sudden rise in blood pressure to 210/110 mm Hg on 3rd postoperative day. Investigations showed blood urea 80 mg/dL, serum creatinine 1.6 mg/dL, platelet count 88,000/m^3 and urine positive for albumin. She developed pedal edema. On the next day she had generalised tonic clonic convulsions but there was no focal deficit. She had no past history of epilepsy. Nitroglycerine drip was given. Dilantin and antihypertesive drugs were started. She recovered well and was shifted to

Paper received on 15/10/2004 ; accepted on 29/10/200x

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the ward on 9th postoperative day. Urine pregnancy test was repeated on 10th postoperative day and was positive in 1:100 dilution and after one week, it was negative in 1:10 dilution.

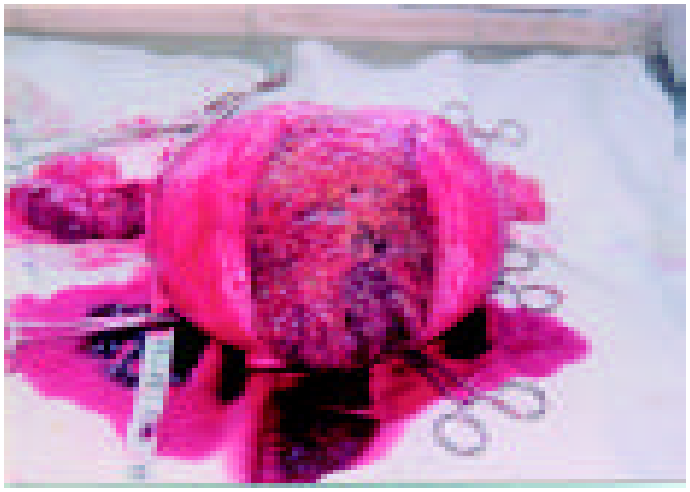

Figure 1. Uterus with complete mole and theca lutein cysts of right ovary with torsion and hemorrhage.

Histopathology report showed that the basal layer of endometrium was well preserved showing endometrial glands in the secretory phase and the stroma showing sheets of decidual tissue. No invasion of trophoblastic tissue was seen in the myometrium. Sections from the mole showed presence of villi. Right ovary showed areas of hemorrhage, necrosis and infilteration by acute and chronic inflammatory cells. Left ovary showed multiple follicles with corpus luteum. Repeat chest x-ray was normal. Repeat serum ?hCG level on 35th postoperative day was 1130 mIU/mL. She was discharged in a satisfactory condition on 7th June, 2004 with an advice to come for regular follow up. There was no sign of persistence of disease or metastasis anywhere at the last follow up examination on 22nd January, 2005.

Discussion

Molar pregnancy can be partial and complete. The most common presenting symptom in patients with complete mole is vaginal bleeding. About half of the patients with complete mole show signs of exuberant trophoblastic growth, uterine enlargement, and high levels of ?hCG. The diagnosis of complete mole is usually confirmed sonographically when a vesicular pattern is noted [2]. Toxemia of some degree is very frequent in molar pregnancy. Albuminuria is commonly present. Occasionally cases of associated eclampsia are reported in the literature. Thyrotoxicosis may exceptionally be a feature [3]. Suction evacuation is a treatment of choice for molar pregnancy. Abdominal hysterectomy is the most radical treatment selected for females above 40 years of age because their chances of developing chorionepithelioma are relatively high [3]. Nearly 20% of complete moles progress to gestational trophoblastic tumor which may be an invasive mole or choriocarcinoma [4]. Occurence of eclampsia in molar pregnancy may be an independent risk factor for persistent trophoblastic disease [5]. Hence it is necessary to closely observe all cases of hydatidiform mole, even after evacuation of the mole, for early warning signs of inpending eclampsia.

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