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CASE REPORT

Heterogenous Presentation of Chorioadenoma Destruens

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Introduction

Invasive mole also known as chorioadenoma destruens comprises about 15 % of all gestational trophoblastic neoplasia [1]. It is a trophoblastic tumor characterized by myometrial invasion by direct extension or through venous channels. The most common presenting symptom is vaginal bleeding (97 %) [2]. The diagnosis is usually suggested after a hydatidiform mole is removed and βhCG remains elevated and there is no evidence of metastasis. We had an opportunity to see four women with unusual presentations.

Presenting as Ruptured Ectopic Pregnancy

A 32-year-old female presented in a state of shock with a history of amenorrhea for 2 months, bleeding per vaginum and pain in the abdomen for the past 6–8 h. She was third gravida with LCB 12 years ago and H/O spontaneous first trimester abortion 2 months ago. Her general condition was very poor with marked pallor, tachycardia, and hypotension. There was generalized rigidity and tenderness all over the abdomen. On per vaginal examination, cervical movements were tender and the exact size of the uterus could not be assessed. The patient was immediately resuscitated and taken for exploratory laparotomy with a provisional diagnosis of ruptured ectopic pregnancy.

On opening the abdomen, 1.5–2 l of blood was removed from the peritoneal cavity. The uterus was enlarged, soft, and about 12–14 weeks in size. There was a rupture at the right cornu with multiple vesicles seen protruding from the site, suggestive of a perforating hydatidiform mole involving a large area (as shown in Fig. 1). Both the tubes and ovaries were found to be normal. The decision for total abdominal hysterectomy was taken. Her baseline βhCG titer was 20,372 miu/ml and her liver function tests, renal function tests, thyroid function tests, and X-ray chest were within normal limits. The uterine specimen was sent for histopathologic examination and it was reported as an invasive mole. Her βhCG came to normal after two courses of methotrexate given at an interval of 14 days. She is under follow-up.

Presenting as Incomplete Abortion

A 26-year-old woman, gravida three, para two, with the last childbirth 9 months ago, was referred with a history of 1st trimester MTP 2 months ago with complaints of continuous bleeding per vaginum since then. On examination, the uterus was soft and about 12 weeks in size. She came with two different USG reports, suggestive of bicornuate uterus with incomplete abortion or degenerated fibroid. Her previous βhCG level (15 days back) was 335.94 miu/ml. We sent her samples for βhCG, which was now reported as 90.50 miu/ml. Her other investigations including X-ray

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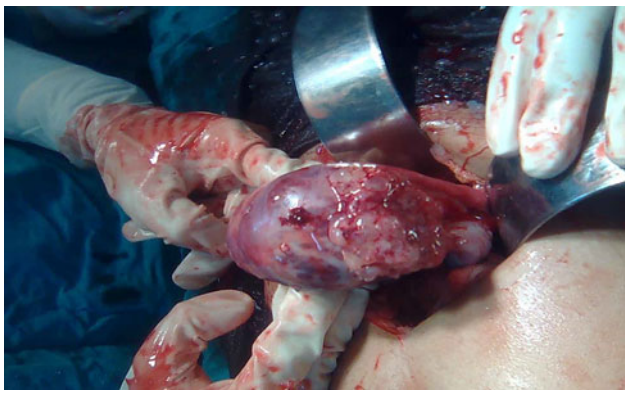

Fig. 1 Showing rupture at the right cornu with multiple vesicles seen protruding out

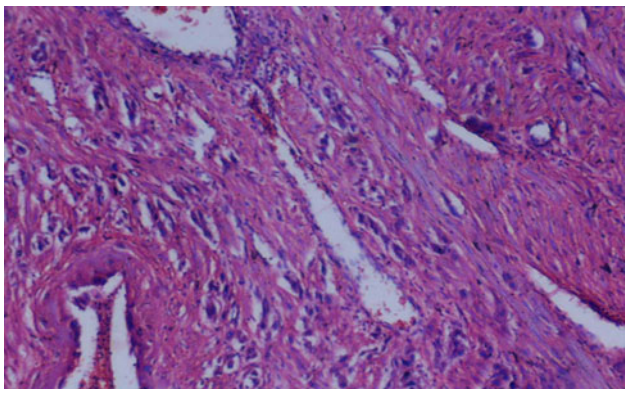

Fig. 3 Sheets of syncitiocytotrophoblast seen in the myometrium

chest were absolutely normal. She was suspected to be having an incomplete abortion and was taken for evacuation. During the procedure, she started torrential bleeding for which laparotomy was done immediately followed by subtotal hysterectomy. There were dense adhesions of the bladder due to the previous caesarean sections. The uterus was soft, enlarged, about 14 weeks in size, and showed a soft bluish bulge of about 7–8 cm toward the left cornu of the uterus (as shown in Fig. 2). On cut section, it appeared like a degenerated fibroid. Histopathologically, it was reported as an invasive mole with invasion up to the myometrium (as in Fig. 3).

Presenting as Carcinoma Endometrium

A 42-year-old woman, seventh para, was admitted with H/O continuous bleeding P/V for 1 month. She was cachexic and pale (Hb 6.6 gm%) with the last childbirth 3 years ago and an enlarged uterus about 10–12 weeks in size. The sonography showed an inhomogeneous mass in the enlarged uterus (410 cc). The endometrial thickness was 44 mm. Her βhCG titer was 139.50 miu/ml. After improving her general condition, she was taken for surgery with a provisional diagnosis of endometrial carcinoma or choriocarcinoma. The only intraoperative finding was an enlarged soft uterus. The adnexa were normal. The liver was found to be normal. There were no palpable para aortic and parametrial lymph nodes. A cut section of the uterus showed an irregular and fragile mass occupying almost half of the uterus (as shown in Fig. 4). Histologically, it was diagnosed as an invasive mole (Fig. 5).

Presenting as Menorrhagia Sec. to AV Malformation

A 33-year-old multiparous woman came to the OPD with irregular, heavy menses and H/O MTP 2 months ago. Her uterus was normal sized with βhCG level 19 miu/ml and sonography showed a thickened endometrium (12 mm) with increased vascularity and turbulent flow on Doppler examination, suggestive of AV malformation (as shown in Fig. 6). She was taken for hysterectomy. Intraoperatively, the uterus looked absolutely normal from the outside, but the cut section showed a small degenerated mass at the fundus. Histopathologically, it was reported as a mole with myometrial invasion.

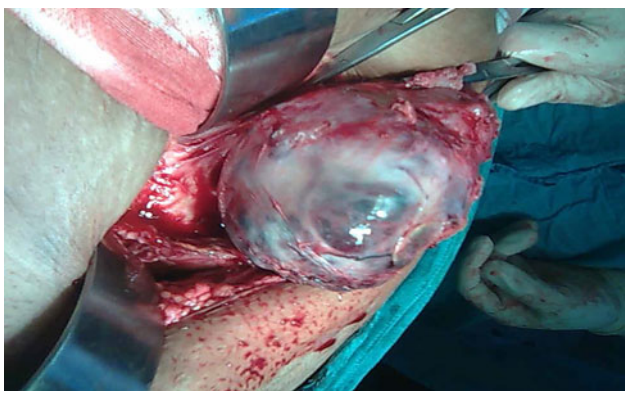

Fig. 2 Showing a soft bluish bulge toward the left cornu of uterus

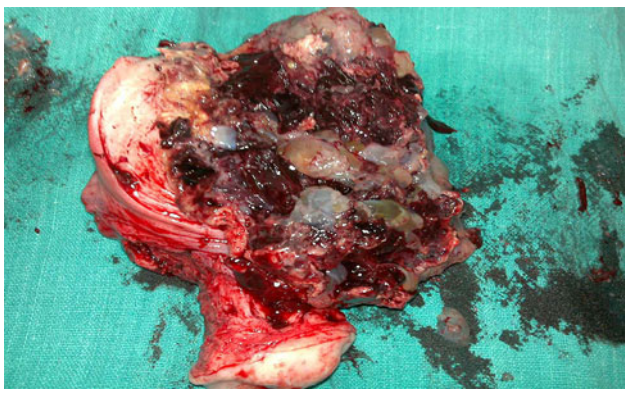

Fig. 4 Cut section of the uterus showing irregular and fragile mass occupying almost half of the uterus

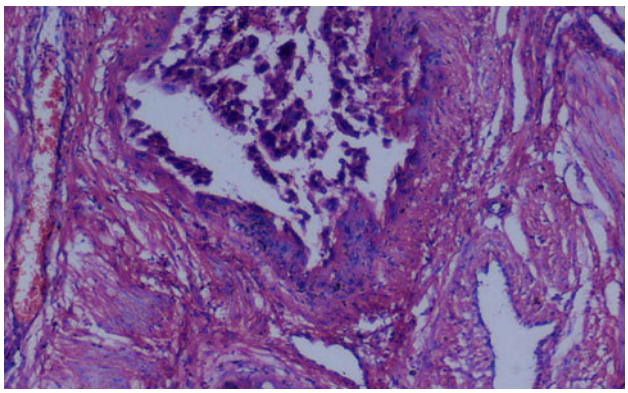

Fig. 5 Molar tissue seen along with the sheets of myometrium

Discussion

Invasive moles are histologically identical to complete moles; but, with invasion into the myometrium without intervening endometrial stroma, it is seldom diagnosed definitely without a hysterectomy. The diagnosis is usually suggested after a molar pregnancy is terminated and βhCG titers remain elevated with no evidence of distant metastasis. Untreated invasive moles tend to invade the uterine wall locally, which can result in uterine perforation and hemorrhage. Cases of gestational trophoblastic neoplasia with uterine rupture are often catastrophic owing to profuse bleeding, which could potentially be lethal. Management often entails removal of the uterus, but among patients in the reproductive age group, uterine resection of localized disease can be performed as reported by Mittal et al. We performed hysterectomy in our first case presenting as ruptured ectopic due to the large area involved at the cornual region. The delayed presentation of this case as rupture was due to the absence of sonography prior to D&C by her treating doctor and absolute denial by the patient regarding irregular bleeding. Transvaginal sonography

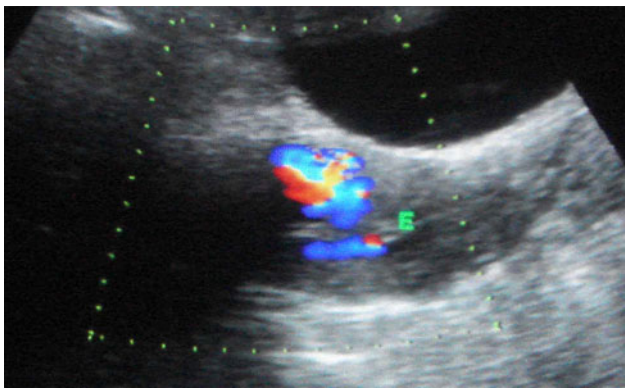

Fig. 6 Increased vascularity and turbulent flow on Doppler suggestive of AV malformation

combined with HCG titers is a useful diagnostic tool. Color flow Doppler can define lesions of increased vascularity as seen in invasive disease. Myometrial invasion is difficult to diagnose on pelvic ultrasound unless there is sufficient myometrium to demonstrate the invasion. In a study conducted by [3], sonography failed to show any specific changes in the uterus even one month after the development of GTN, and he concluded that USG is of limited value in detection of partial moles and malignant GTNs. However, massive tissue destruction, hot spots (hypervascularization), and low resistance index are characteristic USG findings of malignant GTNs.

Accurate, dependable assays of hCG are essential for reliable diagnosis and therapeutic decisions. In the second case, an enlarged uterus (14–16 weeks) after evacuation and sonography did give a lead toward a vesicular mole, but decreasing BβhCG levels (from 335.9 to 90.50) within a span of 15 days favored incomplete abortion and not an invasive mole. Most women with molar pregnancies undergo hCG level regression after evacuation to normal limits and require no further therapy. Following the wide availability of sensitive hCG assays, histologic grading of molar tissue has assumed less importance. The recommendations for post-molar follow-up include serum βhCG levels every 1–2 weeks after evacuation until normal, hCG levels 2–4 weeks after the first normal level, and hCG surveillance every 1–2 months for 6 months after the first normal hCG level. Serial hCG monitoring of women with disease in prolonged remission (greater than 1 year) often provides early evidence of recurrence, though GTT may rarely be associated with undetectable levels of hCG.

In the third case, apart from her multiparity, the rest of the clinical signs and symptoms were in favor of endometrial carcinoma with past history not suggestive of molar pregnancy. Vassilios et al. [4] reported a case of uterine rupture secondary to choriocarcinoma with a time interval of 2 years between a live birth pregnancy and diagnosis of the disease after rupture with a urine pregnancy test negative. Parikh et al. [5] reported an unusual case of choriocarcinoma 8 years after spontaneous abortion presenting as hemoptysis. Prolonged degenerative changes in the trophoblast along with hyalinization were found to correlate with low or declining levels of BhCG. However, detection of hCG in a symptomatic older, postmenopausal woman strongly suggests the diagnosis of latent GTT. Although we had the opportunity to see four heterogeneous presentations of invasive moles, many other unusual presentations have been reported in the past [6–10]. Our experience showed that a high index of suspicion should be kept in women with H/O abortion and irregular bleeding. Chemoprophylaxis may be particularly useful in patients with a high-risk complete mole when hormonal follow-up is either unavailable or not affordable and chances of losing

the woman to follow-up are high. The role of magnetic resonance imaging studies or positron emission tomography in the evolution of women with GTN is not yet defined. Transvaginal Doppler combined with BhCG titers is non-invasive and perhaps the best way of diagnosing, treating, and performing follow-ups for women with an invasive mole at present.

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