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PERSISTENT TROPHOBLASTIC DISEASE WITH INVASIVE MOLE- A CASE REPORT

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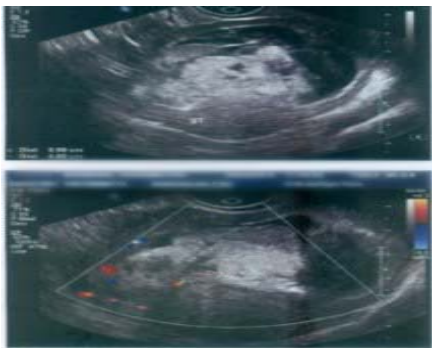
Abstract :
Persistent trophoblastic disease also known as a Non- metastatic locally malignant gestational trophoblastic disease (5-10 percent) are invasive. Persistent moles erode the wall of the uterus, burrow into myometrium and may even perforate through the uterus into either the peritoneal cavity or the broad ligament ensuing dangerous internal hemorrhage. Up to 15 percent (1) of women with hydatiform mole show persistence of the tumor in the uterus following surgical evacuation of the products of conception as in the present case. Here we report a case of Persistent Trophoblastic Disease - Invasive mole that presented with irregular vaginal bleeding and persistently raised serum B-hcG levels following evacuation of a molar pregnancy.

Keyword :
Persistent Trophoblastic Disease, Invasive mole, serially raised B-hcG levels, methotrexate- weekly single dose regimen.

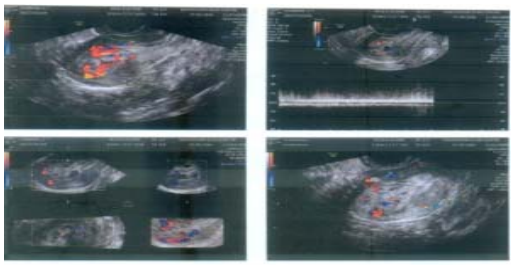
A 23 year old woman presented with bleeding per vaginum for 3 days following 36 days of amenorrhoea associated with mild lower abdominal pain,with a urine pregnancy test report which was weekly positive. Early scan done at 5 weeks, showed no signs of pregnancy. Ectopic pregnancy/early miscarriage was suspected and the patient was adviced serum BhcG immediately. However the patient came only after two and a half weeks for review with a history of spotting per vaginum intermitently. Her general condition was stable. The obstetrics examination findings showed an anteverted bulky uterus, with no adnexal mass or tenderness.Cervical os was closed with brownish discharge per vaginum. We did a repeat scan along with a serum BhcG. USG showed a well defined hyperechoeic contents with small cystic spaces seen within the intrauterine cavity suggesting a possibility of molar pregnancy.



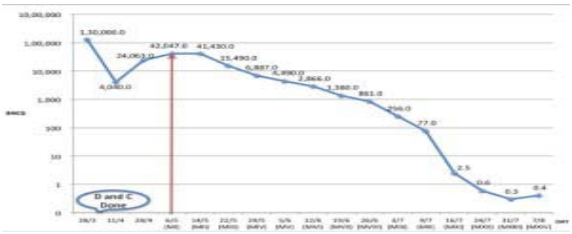
Well defined hyperechoeic content with small cystic areas seen within the intrauterine cavity The serum BhcG report was 1,30,000 showing a high value. Our differential diagnosis was molar pregnancy. Ectopic pregnancy was ruled out as the scan done did not show any extrauterine adnexal mass. Missed abortion with hydrophic degeneration of placenta was also ruled out in view of high BhcG**.** Suction evacuation was done and abundant products which appeared like multiple grape like vesicles were sent for histopathological examination. **Histopathological examination confirmed it as VESICULAR MOLE. No evidence of invasive mole or choriocarcinoma was noted.** Following evacuation, serial Beta-hCG monitoring was done.There was a significant fall in ß-Hcg levels initially post evacuation for 2 weeks, but surprisingly it started to rise again thereafter.

Follow up USG :

Heterogenous hyperechogenic lesion(3.1 x 2.7 cm) with small cystic areas in it seen in the endometrium of fundus of the uterus invading the myometrium. Color Doppler showed increased flow. Findings were suggestive of Invasive mole.

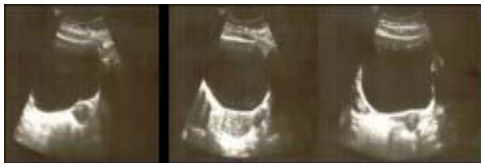


Chest X-ray , CT Brain, USG abdomen was done which showed no metastasis.As the risk score was 4(WHO) (low risk),Oncologist opinion was sought and the patient was planned for SINGLE DOSE WEEKLY METHOTREXATE REGIMEN(50 mg/m2) along with allopurinol. Allopurinol was added to counteract the effect of MTX, as MTX increases the levels of uric acid due to tumour necrosis leading to kidney damage. CBC,UREA,CREATININE,LFT, were also checked before each methotrexate dose was given. As per the regimen, the patient was given weekly MTX injections(90 mg im) with weekly monitoring of BhcG levels, till the levels were undetectable.**(3)** In this patient, after each dose of MTX, there was a significant fall in BhcG levels which reached undetectable levels (2.5 mIU/ml) ,only after 11 doses of weekly injections. Oncologist review was sought,and three more doses of methotrexate injection were given as maintainance therapy**(3),(5)** after the normalisation of BhcG levels**.** The final BhcG level was 0.4 mIU/ml after the 14th dose. No side effects were noted throughout the entire treatment.



		BhcG
28/3	Initial BhcG	1,30,000
31/3	Suction Evacuation Done	
11/4	Post Suction Evacuation	4,040
28/4		24,063
6/5	(MTX I Dose)	42,047
14/5	(II Dose)	41,430
22/5	(III Dose)	15,490
29/5	(IV Dose)	6,887
5/6	(V Dose)	4,490
12/6	(VI Dose)	2,866
19/6	(VII Dose)	1,380
26/6	(VIII Dose)	861
3/7	(IX Dose)	256
9/7	(X Dose)	77
16/7	(XI Dose)	2.5
24/7	(XII Dose)	0.6
31/7	(XIII Dose)	0.3
7/8	(XIV Dose)	0.4

Thereafter the patient was asked to come for monthly follow up with ß-hcG level. Post chemotherapy scan was also found to be normal. Patient was asked to use contraception for 1 year and to do serial monitoring of ß-hcG monthly along with scan. But unfortunately the patient had lost follow up one month post normalisation of BhcG levels(one month post chemotherapy).



Post chemo scan showing empty uterine cavity and normal ovaries.

DISCUSSION:

Persistent Trophoblastic Disease belongs to the group Non-metastatic malignant Gestational Trophoblastic Disease. Invasive moles locally invade the myometrium erode the wall of the uterus, and may even perforate through the uterus into either the peritoneal cavity or the broad ligament ensuing dangerous internal hemorrhage. Overall cure rate—nearly 100% though locally invasive. In the vast majority of patients, treatment of PTD is with chemotherapy. Only about 10% of patients with PTD can be treated successfully with a second curettage.

CRITERIA FOR DIAGNOSIS (1)

1. Histological diagnosis
2. when plateau of hCG lasts for 4 measurements
3. When there is a rise of hCG on three consecutive weekly measurements.
4. PTD is diagnosed when the hCG level remains elevated for 6 months or more.

Commonly used regimens: (WHO)

1 . T h e 8 - d a y C h a r i n g C r o s s r e g i m e n . (c o m m o n l y u s e d)

2 . Biweekly pulsed dactinomycin regimen.

3. Weekly methotrexate regimen (proposed to have better outcome with less side effects)**(3) (Used in our patient)**

During treatment, the serum hCG levels are monitored every week. Two additional courses of chemotherapy is administered after a normal serum hCG level. After 3-4 normal serum hCG levels, the levels are observed once per month for 1 year. A switch from methotrexate to actinomycin D is made if the serum hCG levels rise or plateau. **Is there a place for Hysterectomy?** Hysterectomy for treatment of molar pregnancy is not recommended as routine practice . Patients who have completed their families may be offered hysterectomy to avoid the need of chemotherapy and its complications / surveillance.

CONCLUSION:

This report emphasizes the importance of strict follow up of all patients with molar pregnancy, as the disease is associated with high chances of recurrence. The advantage of the single weekly regimen used here is no leucovorin rescue, only weekly visit, daycare therapy, no major side effects even with a high dose of methotrexate injection.**(4)**

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