

## Mortality in hydatidiform mole: Should we blame thyroid?

Sir,

We read with interest the case report “Hydatidiform mole: A sour encounter with a grapy case” by Madhuri S Kurdi.<sup>[1]</sup> It is laudable that Dr. Madhuri and her team tried their best to save the life of a patient with the available resources. We have a slightly different perspective on the probable diagnosis of the case report, although that would not have altered the management and the outcome of the patient.

“Pulmonary artery hypertension with inadequately controlled hyperthyroidism resulting in cardiac failure and pulmonary oedema” is cited as the possible cause of death of this patient by the author, but no investigation was done to confirm the same. The preoperative pulse rate of the patient was 100/min after injecting Metoprolol and, in fact, there was an improvement in the thyroid functions postoperatively. The patient was restless and tachypnoeic after extubation, developed crepitations in the lungs and became hypoxic, requiring high positive end expiratory pressure (PEEP) and high fraction of inspired oxygen (FiO<sub>2</sub>). All these signs

suggest the possibility of trophoblastic embolisation during the intraoperative period leading to pulmonary artery hypertension (PAH) and pulmonary oedema rather than uncontrolled hyperthyroidism, as suggested by the author. The incidence of embolisation as reported in the literature is more than 50%.<sup>[2]</sup> A bedside echocardiography could have been useful in this case. It could also have helped in knowing the functional status of the right ventricle. Bossone *et al.* have recommended the use of echocardiography as an essential component of the diagnostic algorithm of PAH and to differentiate PAH related to congenital shunts or secondary to thromboembolic phenomenon and pulmonary venous hypertension. It also helps in predicting the prognosis, monitor the efficacy of specific therapeutic interventions and detect the preclinical stage of the disease.<sup>[3]</sup> Computerised tomography of the chest should have been performed to confirm the diagnosis of pulmonary embolisation by trophoblastic tissue.

Regarding the management, general anaesthesia (GA) was preferred by the author over regional anaesthesia (RA) with the aim of providing haemodynamic stability, although in her article she has listed the advantages of RA. Considering the fact that the patient became haemodynamically stable even in the preoperative period after injection Metoprolol, we feel that RA could have been a better choice in this patient. A conscious patient under the RA may help in the early diagnosis of embolisation by complaining respiratory distress. RA would have decreased the cardiac preload as well. Safe use of spinal anaesthesia in patients with hydatidiform mole and hyperthyroidism has been reported in the literature.<sup>[4,5]</sup>

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