

Complete molar pregnancy in postmenopausal women

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ABSTRACT

Gestational trophoblastic disease (GTD) is an abnormal proliferation of trophoblastic tissue during pregnancy. It is a disease of reproductive age, and a few cases have also been seen in women with advanced age, although it is extremely rare in postmenopausal women. Here, we describe an uncommon case of complete hydatidiform mole (CHM) in a postmenopausal woman, who has presented to us with complaints of bleeding per vagina, vomiting with 22 weeks size gravid uterus. Ultrasound finding along with raised serum beta-human chorionic gonadotropin (β -HCG) 400,000 mIU/ml suggested the diagnosis of CHM. In view of postmenopausal status and future risk of postmolar gestational trophoblastic neoplasia, we performed a total abdominal hysterectomy. Uterus was 20 cm \times 15 cm \times 15 cm filled with cystic, grapes such as vesicles. Microscopic examination demonstrated generalized trophoblastic proliferation with hydropic degenerated villi suggested of benign CHM. Follow-up showed steady fall in serum β -HCG level and no evidence of any residual disease. A suspicion of GTD should be kept in mind while evaluating a patient with peri- or post-menopausal bleeding so that it will prevent a delay in diagnosis and treatment.

Key Words: Beta-human chorionic gonadotropin, complete hydatidiform mole, gestational trophoblastic disease, hydatidiform mole, postmenopause

INTRODUCTION

Gestational trophoblastic disease (GTD) is an abnormal proliferation of trophoblastic tissue during pregnancy. It includes a spectrum of conditions such as complete or partial hydatidiform mole (CHM and PHM), invasive mole, choriocarcinoma, and placental site trophoblastic tumor. It usually occurs in women of reproductive age, and few cases are seen in perimenopausal women. It is extremely rare to have postmenopausal GTD. Here, we report an uncommon case of benign CHM in a postmenopausal woman.

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CASE REPORT

A 52-year-old, postmenopause for 5 years, presented with complains of bleeding per vagina and loss of appetite for 15 days. She is nulligravida, having the past history of irregular menstrual cycles. Ovulation induction and family history of GTD were negative. On abdominal examination, a mass of 22 weeks size was felt, and on per speculum examination, bleeding was present. On per vaginal examination, the uterus was soft and enlarged up to 22 weeks size. With an initial suspicion of endometrial malignancy and leiomyosarcoma, we did pelvic sonography. Ultrasound of her pelvis revealed a snowstorm pattern suggestive of CHM. We proceeded for urine pregnancy test which was positive, and serum beta-human chorionic gonadotropin (β -HCG)

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How to cite this article: Begum J, Palai P, Ghose S. Complete molar pregnancy in postmenopausal women. *J Mid-life Health* 2016;7:91-3.

Access this article online

Quick Response Code:



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www.jmidlifehealth.org

DOI:

10.4103/0976-7800.185328

level was 400,000 mIU/ml. A diagnosis of complete molar pregnancy was made. We decided to evacuate the molar pregnancy by hysterectomy in view of her postmenopausal status. Intraoperatively, a soft, enlarged uterus was the only positive finding so; we did total abdominal hysterectomy. On gross examination, the uterus was 20 cm × 15 cm × 15 cm, and the entire uterine cavity was completely replaced by grapes such as vesicles and blood clots [Figure 1].

Microscopic examination of endometrial tissue revealed generalized trophoblastic proliferation involving the entire circumference of villi with central cavitations. The histopathology findings were suggestive of benign noninvasive complete mole [Figure 2]. A steady fall in the levels of serum β-HCG and no evidence of recurrent disease was seen on subsequent follow-up.

DISCUSSION

The incidence of hydatidiform mole shows wide regional variations and has been up to 2 in 1000 pregnancies in Southeast Asia.^[1] Age of the patient and previous history of hydatidiform mole is the two most established risk factors. At the age of <21 years and >35 years, the risk of having CHM is 1.9 times higher and at age >40 years the risk increases by 7.5 times.^[2,3] The risk of having repeat molar pregnancy after single molar is about 1% which is about 10–20 times the risk for the general population.^[2,3] Pelvic sonography is the most sensitive method for diagnosis, which shows a characteristic vesicular pattern due to complete or partial hydropic degeneration in chorionic villi known as “snow storm” appearance.^[4,5] Depending on the age, desire for fertility, and willingness for postmolar evacuation follow-up, treatment can be suction curettage, chemotherapy, or hysterectomy.^[3] Till date isolated cases of benign hydatidiform pregnancy in postmenopausal women have been reported in literature with patients more than 50 years of age, whereas our patient was 52 years with 5 years of postmenopausal status.^[6] The

mean age of menopause in India is 48.4 ± 4.5 years.^[7,8] Tsukamoto *et al.* reported twenty cases of trophoblastic disease in women aged 50 or older. The lesions were seven hydatidiform mole (35%), eight invasive mole (40%), and five choriocarcinoma (25%); however, none was postmenopausal.^[9]

Clinically, our patient had irregular probably anovulatory menstrual cycles since menarche which could have been the cause for her infertility. Sometimes anovulatory cycles may be interspersed with ovulatory cycles. A period of 1-year amenorrhea with elevated follicle stimulated hormone and luteinizing hormone may mimic menopause, but this can be followed by an ovulatory cycle. Pregnancy in older age is fairly uncommon and may end up in spontaneous abortion or molar pregnancy which could have possibly happened in our patient. The risk of postmolar malignant sequelae after suction curettage is reported to be 56.3% in women >50 years of age. Hysterectomy has an advantage of simultaneous treatment, sterilization, and decreases further risk of postmolar gestational trophoblastic tumor (GTT).^[10] However, there remains an 8–20% risk of postmolar GTT in the elder patients after hysterectomy; therefore, regular follow-up with serum β-HCG is indicated.^[10,11] Our patient, being postmenopausal, had no scope for future fertility so, we proceeded with hysterectomy.

Although GTD is rare, it can still occur in postmenopausal women. Therefore, a high index of suspicion for GTD should be kept in mind when evaluating postmenopausal women with bleeding which can prevent delay in diagnosis and treatment.

Acknowledgments

I would like to sincerely thank the Departments of Pathology, Mahatma Gandhi Medical College and Research Institute, and Puducherry for their support in interpreting and providing the histology slides and images.



Figure 1: Gross picture of uterus showing uterine cavity completely replaced by grape-like vesicles

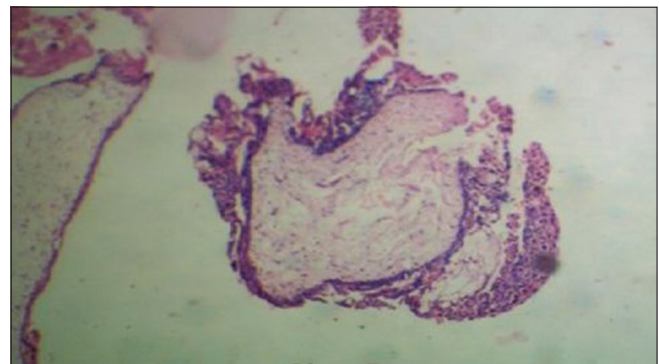


Figure 2: Microscopy picture, H and E, ×400, complete mole showing trophoblastic proliferation involving entire circumference of villi, with enlarged chorionic villi with central capitation

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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