

Molar Ectopic Pregnancy after Tubectomy

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Abstract- Tubal ectopic hydatidiform mole is an uncommon but very important complication of pregnancy. The clinical manifestation is the same as ectopic pregnancy and in all of the cases management was the same as tubal ectopic pregnancy. We present a case of tubal ectopic pregnancy that after laparotomy and salpingectomy, pathologic examination reported hydatidiform mole within ectopic gestational tissue. So, a high index of suspicious is necessary for prompt diagnosis and correct follow up of the patient.

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Introduction

Incidence of ectopic gestation is almost 2% of all pregnancy and highest rate occurred in women aged 35-44 years (CDC report) (1).

Molar pregnancy arises from abnormal fertilization of ova and the incidence of complete and partial hydatidiform mole has been reported 1:1945 and 1:695 respectively. Women older than 40 years have a 5 to 10 fold greater risk of having a complete mole. Molar ectopic pregnancy is very uncommon and only 132 cases have been reported in the literature up to 2005 (2,3).

Case Report

The patient was a 34-years-old multiparous woman (G4P3) with history of tubal ligation. She presented with abdominal pain, missed period (based on last menstrual period was 7wk + 4d) and vaginal bleeding. On physical examination, her vital signs were stable. In bimanual exam, cervical motion was painful with a normal uterine size and a tender 20 x 30 mm mass was palpated in left adnexa.

Laboratory findings were hemoglobin: 11.1 g/dl, β hCG: 31907 u/ml and blood group: O positive Rh.

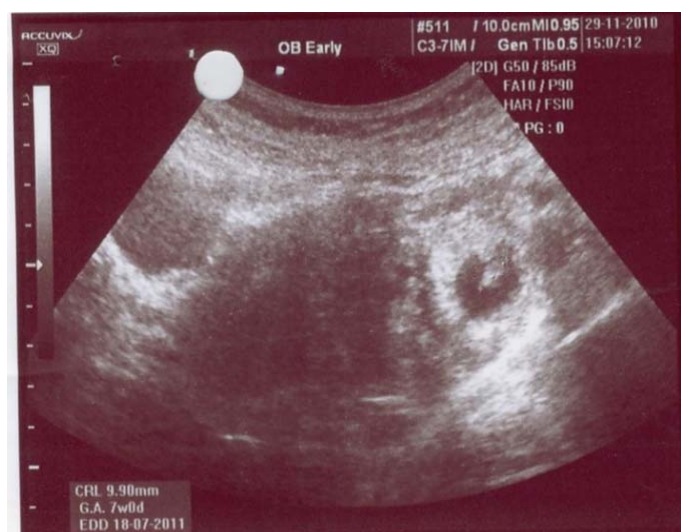


Figure 1. Gestational sac with fetus in left adnexa.

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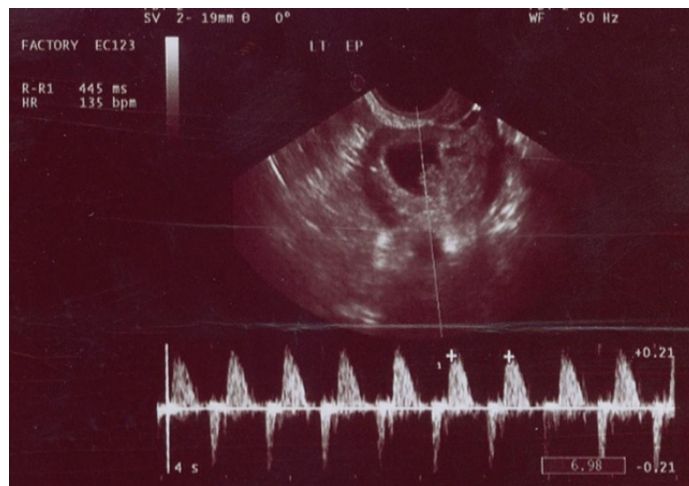


Figure 2. Fetus with FHR.

Ultrasonographic scan revealed an alive fetus (CRL 10 mm) with positive fetal heart rate between left ovary and uterus, and a free fluid in posterior *cul-de-sac*. The endometrial thickness was 11 mm.

The patient underwent laparotomy which revealed one liter free blood in abdominal cavity and a ruptured ectopic pregnancy (30 x 40 mm) in left tube.

Left salpingectomy was done. Her postoperative period was uneventful and she was discharged within 48 hours after surgery.

Histologic section showed ectopic partial molar pregnancy so it was decided to be followed by weekly β hCG measurement which was negative four week after surgery.

Discussion

The incidence of hydatidiform molar pregnancy is 1 in 1000 to 2000 pregnancies (1). Tubal ectopic hydatidiform moles are rare occurrences and only 132 cases have been reported in the literature up to 2005 (2). All patients who present with a hydatidiform mole complain of abdominal pain; some also have vaginal bleeding. The condition can mimic the usual symptoms of ectopic pregnancy particularly when a hemoperitoneum is present however it is actually an ectopic molar pregnancy (3). Ectopic pregnancies, where managed surgically, should be submitted for histopathologic examination; however, the pathologist should be aware that the degree of extra villous trophoblast proliferation may appear more florid compared with evacuated uterine products of conception (4). Flow cytometry and immunostaining for maternally-expressed genes are helpful in distinguishing early

complete hydatidiform mole from partial hydatidiform mole or hydropic abortion (6). Immunohistochemical markers such as P57KIP2, which has been recently described, can also be useful for diagnosing early moles even on the basis of minimal tissue since this protein is not expressed in the villous trophoblast or the stroma of complete hydatidiform moles (7). In our case pathologic sections were double checked with two expert pathologists. Systemic methotrexate therapy can be administered to treat the possible remnants of the molar pregnancy.

Molar ectopic pregnancy can be successfully treated with laparoscopic and systemic methotrexate therapy (1). β hCG monitoring to ensure return to normal levels is suggested (2). After achieving even one non-detectable hCG level ($\text{hCG} < 5 \text{ mIU/ml}$). Patients with persistent low levels of hCG should undergo tests to determine if the hCG is real or phantom. If the hCG is real, then further tests should determine what percentage of the total hCG is hyperglycosylated hCG and free beta subunit to establish a proper diagnosis and management. After achieving remission, patients can generally expect normal reproduction in the future (6). In conclusion, in every ectopic pregnancy, molar pregnancy may be happen, so measurement of β HCG before introduction is useful. It seems, we should confirm our diagnosis with flow cytometry in addition to histopathology to provide excess management and follow up.

Acknowledgment

The authors declare that they have no competing interests.

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