INVASIVE MOLE- A CASE REPORT

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ABSTRACT
A patient with malignant GTN was treated by means of MTX-FA. Changes in serum β-HCG levels and changes in USG findings were checked after regular intervals. Finally patient responded after 12 cycles of chemotherapy with 3 consecutive negative values of serum β-HCG. This is a case report of invasive mole in a 19 year old female with possibility to preserve reproductive health. GTN developed 3 months after spontaneous abortion in 8th week gestation. 3 months after abortion and 1 month after GTN confirmed she started on her chemotherapy cycles with MTX-FA.

Keywords: GTN, HCG, MTX-FA

INTRODUCTION
Malignant GTN can develop as invasive mole, choriocarcinoma, PSTT. Ovarian theca lutein cysts usually follow malignant GTN. Reproductive organs can be severely damaged in malignant GTN. Early diagnosis and treatment according to accepted protocols could preserve reproductive health in malignant GTN. Serum β-HCG is of great value for early diagnosis and checking the effects of treatment.

CASES
A 19 year old female presented to a GP in the periphery around Jan’14 with history of amenorrhoea for 2 months with complaints of expulsion of products and pain abdomen. Her UPT was positive and USG reports showed incomplete abortion. She underwent D & E. During that time her Hb was 9.2 and blood group B+ve with TC, DC-WNL. Around end of Feb’14 she again presented with complaints of vomiting and no periods following D & E, her UPT was positive. USG (5/3/14) showed early intrauterine pregnancy of 5 weeks gestation with no cardiac activity. She was admitted in the periphery from 9/3/14 to 12/3/14 with complaints of low back pain. On examination she was pale with tenderness all over her abdomen. On bimanual pelvic examination the uterus was soft and bulky with suspected pelvic mass. Her sonography on 15/3/14 showed bulky uterus with no definite G.sac with few cystic areas in myometrial and endometrial cavities with? Gestational trophoblastic disease which was confirmed with another scan few days later. Thus she was planned for D & E with endometrial biopsy in which endometrial biopsy showed only decidua like changes of the endometrium; serum β-HCG value was around 201841.65 mIU/ml. On 30/3/14 she complained of pain abdomen and on examination there was a pelvic lump. Thus she was advised for a CT scan of pelvis in which the report came out to be? intramural invasive mole. At that time her complete haemogram, liver, renal parameters, coagulation profiles all were within normal limits and serum β-HCG value (8/4/14) was 724133.17 mIU/ml.

With these reports she was admitted in our hospital and advised complete metastatic work up including serum biochemistry, chest x-ray, CT brain, which did not reveal any evidence of metastasis. Radiotherapy department was consulted and she was planned for chemotherapy with Methotrexate and Leucovorin. She received her first dose on 11/4/14 and at interval of 15 days she received total 6 cycles at our hospital. During this time her β-HCG was on 6/5/14- 5879.78, on 4/6/14- 74.67, on 5/7/14 -15.98mIU/ml. She received another 5 cycle of chemotherapy with Methotrexate and Leucovorin, the last dose of which was around
14/10/14 at Burdwan medical college. During this time all her metastatic work ups were within normal limits.
She received the 12th cycle of chemotherapy on 29/10/14 at our hospital and then finally on 28/11/14 her USG whole abdomen showed marginally bulky uterus with bilateral bulky ovaries. Serum β-HCG values in the next consecutive 3 months were within normal limits. Patient is still under follow up of radiotherapy and Gynae department in our hospital; presently on OCP having regular periods; waiting to plan her future pregnancy eagerly.

**Results**
This patient had long cycle of chemotherapy (12 cycles). USG confirmation of response to chemotherapy was of great help. In this patient the reproductive health could be preserved thankfully since she was so young. The treatment of this progressive malignant GTN was successful.
USG (28/11/14)) showing marginally bulky uterus

DISCUSSION
Serum β-HCG is the most relevant parameter in GTN detection as well as in checking the efficacy of administered therapy (Bright et al., 2000; Borchert et al., 1973). Successful treatment of malignant GTN does not mean that reproductive health can always be preserved. Chemotherapy plus hysterectomy is sometimes the method of choice in advanced malignant GTN treatment (Bright et al., 2000; Borchert et al., 1973; Goldstein et al., 2000; Newlands, 2000). Malignant GTN does not have specific sonographic pictures and it is not easy to detect specific changes in uterine structure. Massive tissue destruction, hypervascularisation, low R.I., ovarian theca luteal cysts could be characteristic USG findings for GTN. According to recommendations CRCOG (Lukić and Nikolić, 2004; Altaras et al., 1994) USG is of limited value in detection of partial mole and malignant GTN (Lukić and Nikolić, 2004; Altaras et al., 1994).

Conclusion
Progressive changes in uterine structure could be of great help in therapy decisions along with changes of serum β-HCG levels. Treatment can be longlasting with good prognosis but it needs good collaboration between gynecologist, radiologist, radiotherapist and patient including all kinds of support.

REFERENCES
Case Report