



A Case of Ectopic Complete Molar Pregnancy with Ovarian Endometriosis

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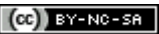
ABSTRACT

Introduction: Ectopic complete molar pregnancy in the ovary is an exceptionally rare event. We report a case of ovarian hydatidiform mole occurring in a 30 years old female with ovarian endometriosis. **Case history-** A 30 years female presented with complaints of 4 weeks amenorrhea along with nausea, vomiting, lower abdominal pain, lower backache, irregular vaginal bleeding. Per vaginal examination revealed a tender right adnexal mass. On ultrasonography, thin walled anechoic cyst was seen in right adnexa measuring 9.2×9 cms. Patient underwent myomectomy with right sided cystectomy. On gross examination, a large cyst measuring 13×8×5cms with cut surface showing thick brownish material was seen attached to right ovary along with cluster of grape like cystic structures. H & E stained sections showed endometrial glands with endometrial stroma dispersed among the ovarian stroma consistent with endometriosis. Section from the cystic structures showed hydropic degeneration of the villi and trophoblastic proliferation showing features of hydatidiform mole. **Conclusion:** While ultrasonography might not be able to fully diagnose ectopic molar pregnancies, histopathological examination of the conception products is the current gold standard for the diagnosis. However, strict criteria must be applied to prevent over diagnosis of molar pregnancies in cases of ectopic gestation.

Keywords: hydatidiform mole, ovarian, endometriosis

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INTRODUCTION

Ectopic complete molar pregnancy in the ovary is an exceptionally rare event. Molar changes may also be found in ectopic pregnancies. Molar changes could be either partial or complete. The incidence of molar ectopic pregnancy is estimated to be 1.5 per 1,000,000 births. It forms a heterogeneous group of disorders, with an incidence in Asia reaching 1 in 80 pregnancies¹. Although ultrasonography is useful in the diagnosis of uterine molar pregnancies, there is a chance of missing this diagnosis in cases of an ectopic molar pregnancy.

Endometriosis, defined as the presence of endometrium-like tissue outside the uterus, affects approximately 10% of women of reproductive age. Endometriosis affects many organs and structures, including the ovary, fallopian tube, pelvic serosa, rectum, retroperitoneal structures (e.g., the ureter), and more remote organs, including the lungs. Ovarian endometriosis typically presents as an ovarian cyst containing old blood; usually called a chocolate cyst or an endometriotic cyst, these are diagnosed in about 17% to 44% of women with endometriosis^{2,3}.

We report a case of ovarian hydatidiform mole occurring in a 30 years old female with ovarian endometriosis.

CASE HISTORY

A 30 years female presented in the obstetrics & gynecology department with complaints of 4 weeks amenorrhea along with nausea, vomiting, lower abdominal pain, lower backache, irregular vaginal bleeding. The pain was insidious in onset and gradually progressive. No significant past history was present. Per abdominal examination was unremarkable. Per vaginal examination revealed a tender right adnexal mass. Hb was 10g/dl .USG showed anteverted and bulky uterus of Size 10×5 cms with a large intramural fibroid of size 4×3.6 cms & another small subserous fibroid was seen measuring 3×2 cms. Thin walled anechoic cyst seen in right adnexa measuring 9.2×9 cms. Right ovary obscured by the cyst. Patient underwent myomectomy with right sided cystectomy and the specimen of right sided cyst was sent for histopathological examination. On gross examination, a large cyst measuring 13×8×5cms with cut surface showing thick brownish material was seen attached to right ovary measuring 3×2×1.5cms. Cut surface of the ovary also revealed multiple small cysts filled with thick brownish material. A cluster of grape like cystic structures average measuring 2-3mm was seen attached to the

ovary. H & E stained sections showed straight tubular structure lined by columnar cells representing endometrial glands with endometrial stroma composed of spindle cells dispersed among the ovarian stroma consistent with endometriosis. Some areas also show lining of hemosiderin laden macrophages. Another section from the cystic structures showed hydropic degeneration of the villi and trophoblastic proliferation showing features of hydatidiform mole.

She was followed up by weekly serum β -hCG measurements. The tests showed a decreasing trend and turned negative at the end of the 6th week.

DISCUSSION

Gestational trophoblastic disease (GTD) comprises a range of tumours of placental origin, including hydatidiform moles (partial and complete), invasive moles, choriocarcinoma and placental site trophoblastic tumours. Risk factors include extremes of reproductive age (<15 years or >40 years), Asian ethnicity and previous molar pregnancy. Ovarian site ectopics form <1% of all ectopic gestations. Ectopic molar gestation is very rare. The incidence is estimated to be only 1.5 per million births.⁴ Our case was a 30 year old female with no previous history of molar or normal pregnancy.

In previous reports of ovarian molar pregnancy, the patient presented with symptoms of ectopic gestation like abdominal pain, nausea and vomiting, rather than typical features of a molar pregnancy (large for gestational age, vaginal bleeding, hyperemesis gravidarum etc).^{5,6,7} Our case had similar presentation. Interestingly most of the previous cases^{5, 6, 7} presented in the right ovary. Similar was the presentation in our case.

Histopathologically, complete moles show features like universal oedema of chorionic villi (hydrops), with cistern formation, circumferential proliferation of trophoblast with absence of nucleated fetal red blood cell.⁸ Histopathological examination of the grape like structures in our patient revealed all of the above features were present in our case.

Microscopically, early ectopic gestations, as compared with early intrauterine gestations, characteristically show exaggerated extravillous trophoblastic proliferation and patchy villous edema and so can often be misdiagnosed as molar pregnancies. The presence of circumferential proliferation of definitively atypical trophoblast surrounding diffusely edematous villi differentiates a molar pregnancy from an early ectopic gestation⁹. In addition, the presence of villi excludes a

diagnosis of gestational choriocarcinoma. So our case was confirmed to be a case of ectopic molar pregnancy in ovary. However what needs to be emphasised here is that strict criteria for diagnosis must be followed to avoid the problem of over-diagnosis of hydatidiform mole in ectopic pregnancies, as non-molar tubal ectopics can also exhibit hydropic villi.

In our case, ovarian molar pregnancy was found to be associated with endometriosis in the same sided ovary which is a rare occurrence and has not been reported in previous studies.

The most common symptom in younger patients is endometriosis-associated pain including dysmenorrhea, which, if mistreated, may lead to endometriosis-associated infertility.² Because the symptoms and problems in patients with endometriosis vary according to the woman's age & the severity of the disease, appropriate treatment should be applied. Complete molar pregnancy has an excellent prognosis with surgical and/or medical intervention and close clinical follow-up of the serum hCG. In most cases patients have found to

be disease free. However, appropriate clinical management and counselling regarding future pregnancies are necessary upon arriving at the correct pathologic diagnosis. Whenever a histopathologic examination of products of conception is performed, it is important that a hydatidiform mole can be ruled out, and that may sometimes require additional analysis such as immunohistochemistry and DNA ploidy. In cases in which a gestational trophoblastic disease is suspected, it is necessary to monitor serum hCG until values are negative.

CONCLUSION

Ectopic molar pregnancy is a rare condition, which can occur at any place in the pelvic cavity. However, ultrasonography might not be able to fully diagnose ectopic molar pregnancies, leaving histopathological examination of the conception products the current gold standard for the diagnosis. In this, however, strict criteria must be applied to prevent overdiagnosis of molar pregnancies in cases of ectopic gestation.

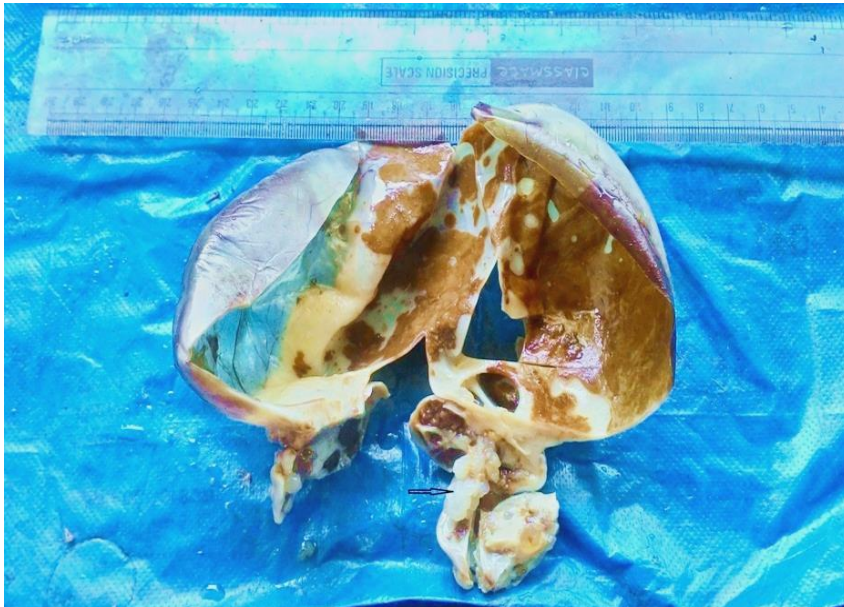


Fig 1 showing gross picture of ovary with hydatidiform mole (see arrow).

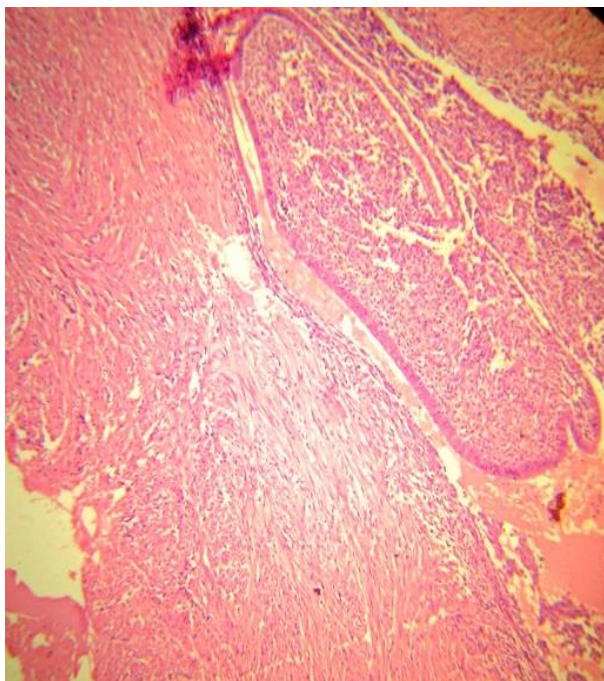


Fig2 showing ovarian endometriosis (H & E, 40X)

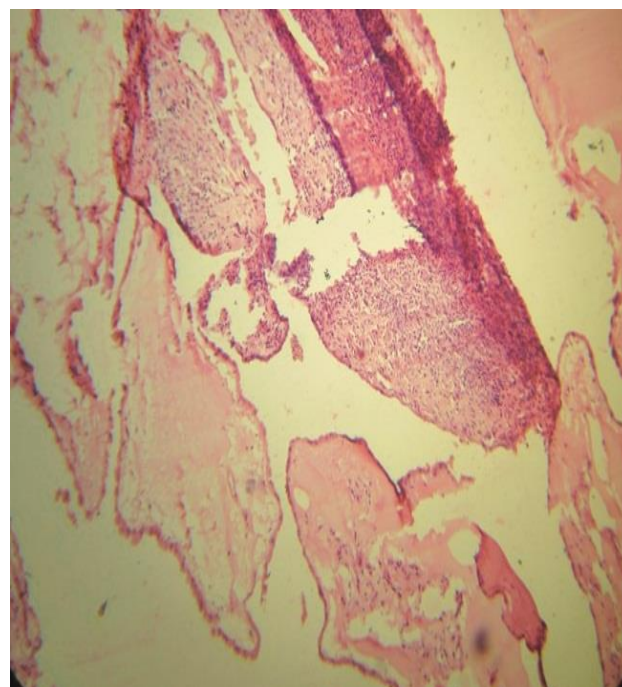


Fig3 showing histopathological picture of complete mole(H&E,40X)

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