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CASE STUDY

An unusual lower segment deeply invading partial 'Mole Previa Percreta' necessitating hysterectomy

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1. INTRODUCTION

The incidence of vesicular mole in Asia is 1:80 and in India is 1:400[1].Approximately 3.5% of these cases are partial molar pregnancies. Partial moles are usually (90%) triploid in origin, remaining are tetraploid or mosaic conceptions. The classic features of molar pregnancy are irregular vaginal bleeding, hyperemesis, excessive uterine enlargement and early failed pregnancy. According to RCOG guidelines, suction curettage is the method of choice of evacuation for partial molar pregnancies except when the size of the fetal parts deters the use of suction curettage and then medical evacuation can be used. (Tidy J and Hancock BW, 2010; Tidy J, 2003) The need for chemotherapy following a complete mole is 15% and 0.5 % after a partial mole. (Tidy J and Hancock BW, 2010)

2. CASE REPORT

Our patient, Mrs.XYZ, 24 years old female $G_4P_1L_1A_2$ with previous one LSCS and two surgical termination of pregnancies in first trimester. Unaware of her pregnancy she was referred from medical OPD with complaints of irregular bleeding per vaginum. On probing she gave history of intermittent, dull aching pain localized to lower abdomen since two months. Last menstrual period was two months back was followed by 3-4 episodes of spotting / light bleeding per vaginum with no period of amenorrhea.

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UPT done in the hospital was positive.

General condition was fair, vitals stable and no pallor. Abdomen was soft with no guarding, rigidity or tenderness. On speculum examination there was minimal dark red bleeding. On PV examination uterus was enlarged to 10 weeks size, soft, retroverted and bilateral fornices clear.

Ultrasonography showed single live intra-uterine gestation of 10 weeks with coexisting focal cystic spaces in placental tissue suggestive of partial mole. No mention of location in upper segment or otherwise was made.

On admission, Hb was 10gm% and rest investigations were within normal range.

Subsequently, she started having bleeding per vaginum and she was posted for emergency suction curettage. During the procedure torrential bleeding ensued with difficulty in evacuation and a sense of incomplete curettage. All measures of controlling homeostasis including bimanual uterine massage and utero-tonics were tried but to no avail. We were faced with an incompletely evacuated mole, possibly densely adherent to lower uterine segment and hemorrhaging profusely. It gave an impression of mole densely adherent to lower uterine segment. Patient's vitals were now falling. Immediate Exploratory laparotomy had to be performed as a life-saving procedure.

In situ, a mole in the lower segment attached to previous scar and deeply invading the myometrium breaching the lateral myometrium, so as to be visible on the lateral serosal surface amounting to mole previa percreta, a term not described in literature. Further, separation was not possible and as the patient was exsanguinating rapidly the difficult decision to perform obstetric hysterectomy was taken. The procedure was uneventful except from careful dissection along the lateral aspect. Ureter was kept in view throughout the surgery and hence left untouched.

Figure 1
Mole seen invading the lower uterine segment

Figure 2
Histopathological report was s/o deeply invasive lower segment molar pregnancy. Periodic serum HCG levels showed a falling trend.

3. CONCLUSION

In literature, very few case reports are published where unplanned hysterectomy had to be done in the course of management of molar pregnancy (Singh S et al, 2014; Sánchez-Ferrer ML et al, 2104; Aguilera M et al, 2012; Suri S et al, 2009).

In a case of vesicular mole, unusually difficult and bloody evacuation should be viewed with concern. There are very few indications for laparotomy like sepsis, uterine rupture;"mole previa percreta" is one of them. There is a report of a normal fetus with a twin presenting as a complete hydatidiform mole (CMCF) and placenta previa, wherein intra-arterial balloon catheters were considered before caesarian delivery (Klatt TE, 2006).

Typically moles occur in the upper segment. In cases with previous scar, lower segment mole if present could be deeply invading and as such should be treated as a high-risk condition. We suggest that if molar pregnancy follows a previous LSCS, a USG may be useful tool to detect invasion. An MRI, pre-evacuation is a good guide to locate the EXACT SITE of the mole and rule out invasion. Any suggestion of invasion warrants discussion of the possibility of difficulty in evacuation, hemorrhage and requirement of emergency hysterectomy. Even small moles that are less than 12 weeks are potentially invasive and at no time should caution be abandoned. Intra operative, torrential hemorrhage warrants aggressive treatment and early laparotomy. Moles are not protected by normal fetal membranes and as such are prone to get infected easily. Being in the previa position would clearly increase the risk and early institution of higher antibiotics is advisable. Cases of

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abscess formation and septicemia have been reported. Molar pregnancies should be managed by a senior obstetrician with adequate availability of blood. Awareness of this rare entity, namely mole previa percreta may save lives.

REFERENCES

1. Tidy John, Hancock BW. *Management of Gestational Trophoblastic Disease*. Royal College of Obstetricians and Gynaecologists. Green Top Guideline no. 38. 1st edition. London: RCOG; 2010
2. Tidy John. *The role of surgery in the management of gestational trophoblastic disease*. In: Hancock BW, Newlands ES, Berkowitz RS,Cole LA, editors. Gestational Trophoblastic Disease. 3rd ed.London: International Society for the Study of Trophoblastic Disease; 2003 [www.isstd.org/isstd/book.html]. P. 430-446.
3. Singh S, Angra K, Davis B, Shokrani B. *Complication of Invasive Molar Pregnancy with Clostridium perfringens Sepsis.* Case Rep Obstet Gynecol. 2014; 2014:282141.
4. Sánchez-Ferrer ML, Hernández-Martínez F, Machado-Linde F, Ferri B, Carbonel P, Nieto-Diaz A. *Uterine rupture in twin pregnancy with normal fetus and complete hydatidiform mole.* Gynecol Obstet Invest. 2014;77(2):127-33.
5. Aguilera M[1], Rauk P, Ghebre R, Ramin K *Complete hydatidiform mole presenting as a placenta accreta in a twin pregnancy with a coexisting normal fetus: case report*. Case Rep Obstet Gynecol. 2012;2012:405085.
6. Suri S, Davies M, Jauniaux E. *Twin pregnancy presenting as a praevia complete hydatidiform mole and coexisting fetus complicated by a placental abscess.* Fetal Diagn Ther. 2009;26(4):181-4.
7. Klatt TE, Franciosi RA, Cruikshank DP. *Normal fetus with a twin presenting as both a complete hydatidiform mole and placenta previa.* Obstet Gynecol. 2006 Feb;107(2 Pt 2):527-30.

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