



CASE REPORT

Uterine intramural persistent mole: A case report following molar pregnancy evacuation with arteriovenous malformation



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Abstract The differential diagnosis of intramural vascular lesions of the myometrium includes arteriovenous malformation, gestational trophoblastic neoplasia, hemangiomas, sarcoma, and interstitial pregnancy. We present a case of irregular uterine bleeding after evacuation of vesicular mole. The laboratory investigation showed rising serum beta human chorionic gonadotropin levels (beta HCG). Transvaginal ultrasound and Color Doppler images showed arteriovenous malformation. These data were consistent with persistent mole.

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1. Introduction

Gestational trophoblastic diseases (GTD) present most commonly as molar pregnancy in the form of fluid filled vesicles, with snow storm appearance on ultrasound. The commonest symptom being irregular vaginal bleeding preceded by amenorrhea. Uterine arteriovenous malformation with GTD is a very uncommon disorder and can be diagnosed by arteriography or color Doppler. Twenty percent of complete moles can go for invasion. Invasive moles (chorioadenoma destruens) are locally invasive, rarely metastatic lesions characterized microscopically by trophoblastic invasion of the myometrium with identifiable villous structures. Patients have persistent

vaginal bleeding with elevated beta HCG titers post evacuation. Histopathology is the only confirmatory evidence of invasion. The first line of therapy for invasive and persistent moles is chemotherapy. Invasive moles also have shown to have spontaneous regression (1,2). Risk factors for developing GTN after the evacuation of GTD are large theca-lutein cysts (ovaries > 5 cm), extremely enlarged uterus, women above 40 years, previous GTD, and very high HCG levels (3,4). We present a case of GTD which was diagnosed post evacuation of vesicular mole as an invasive mole with a unique and unusual morphologic feature of arteriovenous malformation.

2. Case report

A 28 year old female, gravida 1 was admitted to our hospital with recurrent episodes of bleeding per vagina. She had vesicular mole two months before being treated by suction evacuation outside our hospital. Post evacuation ultrasonography

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findings were negative for remnants of conception. Beta HCG level prior to evacuation was 80,000 miu/ml. Tissues were sent for histopathological examination after dilatation and curettage (D&C) revealing complete mole. Follow up with beta HCG revealed post evacuation level of 20,000 miu/ml with plateau levels around this level through weekly beta HCG measurements. A private clinic doctor assured her recommending follow up with alleged ultrasound to be free. At the time of admission vitals were stable; she was showing no vaginal bleeding. On per vaginal examination external os was closed. Uterus was 8 weeks gestational age size. Her hemoglobin was 10 gm%, bleeding and clotting time were normal. Transvaginal ultrasonography (USG) with Color Doppler imaging showed a highly vascular heterogeneous hyper echoic intramural mass measuring 3.5 cm × 3 cm size with prominent vessels in the posterior myometrium separable of the endometrium that was free. Colour Doppler showed prominent blood flow signals within and around the lesion suggestive of neovascularization. Pulsed Doppler showed low vascular impedance arterial blood flow. These findings were suggestive of AV malformations which raised the suspicion of persistent mole. Also, left complicated ovarian cyst was evident on ultrasound, there is intracystic septation and turbid content, it was more likely a hemorrhagic cyst .i.e. Persistent corpus luteal cyst. The cyst was 6 × 6 cm (Figs. 1–3). The clinical suspicion of invasive mole was raised by the myometrial mass with positive beta HCG after molar evacuation. Also the suspicion was enforced by the presence of left ovarian theca lutein cyst. Cranial, thoracic, and abdominal computed tomography did not reveal any evidence of metastatic disease. Oncologist's opinion was taken and she was given chemotherapy. She was treated with a single agent chemotherapy i.e. methotrexate (1 mg/kg

body weight) and folic acid for 7 days. Thereafter the USG reports showed a decreasing size of mass and vascularity. She was followed up weekly till her beta HCG values were undetectable, thereafter monthly for 6 months, following which a repeat USG was done, that revealed a normal scan with no evidence of the mass.

3. Discussion

Invasive mole results from the myometrial invasion of a complete or partial mole, which does not show malignancy features but can metastasize especially to the vagina and lungs (5). Patients usually present with continuous vaginal bleeding since prior molar pregnancy or abortion. Myometrial invasion is difficult to detect on ultrasound as uterine curettage unless there is a significant myometrium invasion. Clinical findings, beta HCG and ultrasound all together are necessary for the diagnosis (6). Other diagnostic methods are CT scan of chest, brain, liver and MRI (7).

Acquired uterine arterio-venous malformation is a rare life threatening condition that must be considered in the differential diagnosis of sudden, severe vaginal bleeding following uterine curettage (8). They may occur as a late postpartum or post abortion hemorrhage, due to spontaneous vessel rupture or triggered by D&C or GTD. Dilatation and curettage is contraindicated in emergency as it worsens the condition. This is if a vascular mass with low resistance flow is seen (8). Transvaginal Color Doppler ultrasonography has replaced angiography in the diagnosis, with the latter reserved for cases where intervention is required (9). Ultrasound findings are nonspecific including hypoechoic tubular structures within the myometrium

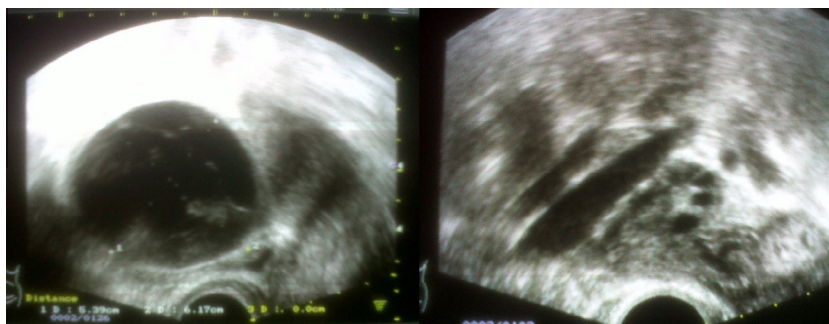


Fig. 1 Ultrasound showing left ovarian cyst (left) and normal right ovary (right).

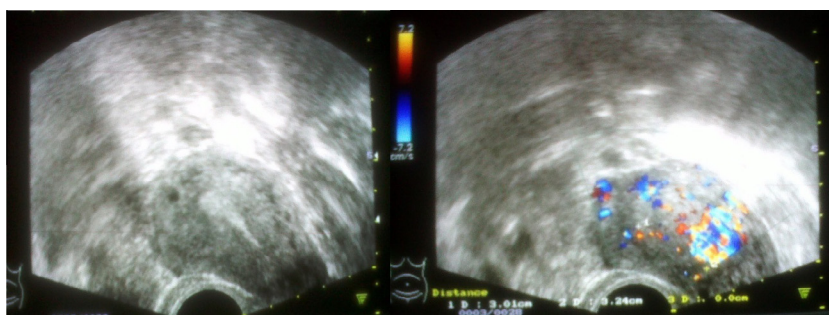


Fig. 2 Transvaginal ultrasound showed an ill defined heterogeneous hyper echoic solid lesion with cystic areas seen in the myometrium away from the endometrium. Ultrasound also showed uterus with empty cavity (left) and vascular intramural mass with AVM (right).

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