Case Report

Management approach of a postmenopausal woman with a completely massive molar pregnancy: A case report

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ARTICLE INFO

Keywords:
Vaginal bleeding
Molar pregnancy
Amenorrhea
Symptoms
Patient

ABSTRACT

Introduction and importance: Molar pregnancy typically manifests in the first trimester and is associated with several symptoms, including vaginal bleeding and larger than expected uterine size. The hallmark symptoms of this disorder are rapid uterine growth, nausea and vomiting, and an unusually high quantitative bHCG level. Ultrasonography is a reliable and sensitive technique for the diagnosis of complete molar pregnancy, which showed a “snow storm” pattern as a result of hydropic degeneration in chorionic villi.

Total hysterectomy is the best treatment option for older-age women who do not desire to have children. It appears to greatly minimize the risk of later GTN.

Case presentation: In this case study, we present a 46-year-old female patient who presented with vaginal bleeding and weakness. A transvaginal Ultrasound revealed a mixed solid and cystic mass-like structure in her pelvis. A total abdominal hysterectomy was performed on the patient due to severe vaginal bleeding. After three months, the beta-HCG level had entirely stabilized. During the follow-up, no symptoms of gestational trophoblastic neoplasia were found.

Clinical discussion: A case report of postmenopausal women with a completely massive molar pregnancy with significant grape-like bleeding is a rare case of life-threatening conditions that may be discovered as a result of persistent significant vaginal bleeding.

Conclusions: complete hysterectomy should be performed to avoid significant complications such as bleeding, hypovolemic shock, and risk of GTN.

1. Background

Molar pregnancy typically manifests in the first trimester and is several symptoms, including vaginal bleeding (the most common), the fetus and mole develop from double sperm fertilization, and cytogenetically, the fetus and mole are often triploid and share the same alleles [1].

Oral contraceptive usage, maternal type A or AB blood types, maternal smoking, and maternal alcohol misuse are all possible risk factors [2].

The first of these, a partial hydatid form compose is of chorionic and embryonic tissue. It occurs due to the fertilization of an oocyte by two sperm resulting in a triploid karyotype (69 chromosomes). The second, complete hydatid form mole (CHM), occurs when the empty oocyte is fertilized by one or general. In general, CHM has a diploid karyotype (46 chromosomes; 46, XY or 46, XX), but a 23, X karyotype Molar [3].

Molar pregnancy appears in two types: partial, which is less common, and complete molar pregnancy. The tissue is hemorrhagic and necrotic, leading to vaginal bleeding. Furthermore, because of the rapid growth of the tissue, the uterus enlarges at an accelerated rate, which might impact pregnancy timing [4].

The incidence of complete hydatidiform mole CHM and PHM is one and three per thousand pregnancies, respectively. A complete hydatidiform mole is highly rare in postmenopausal women, with just about 14 instances published in the international literature since its original description in 1973 [5].

The purpose of this case report is to highlight a very unusual case of molar pregnancy in a postmenopausal woman. Because of its late presenting symptoms and characteristic traits, this case is of considerable interest. Such is huge vaginal bleeding it is rare for this sort of patient to evacuate diagnostic tissue in the ED at this stage of the patient’s condition leading to an emergency operation.

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https://doi.org/10.1016/j.amsu.2022.104099
Received 20 May 2022; Received in revised form 24 June 2022; Accepted 24 June 2022
Available online 30 June 2022
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2. Case presentation

A 46-year-old female patient with complaints of vaginal bleeding and weakness presented to the emergency department.

The patient had reported a history of vaginal bleeding and mild cramping abdominal pain for the past seven days. Gravida 8, para 8, multiparous woman, two years after her last menstrual period.

The examination patient was semiconscious and not oriented and she was in obvious distress. She appeared pale, nervous, and sickly. Her temperature was 98.2° Fahrenheit. She was tachycardia with thread peripheral pulses. A large amount of champagne-colored grapelike spongy material was seen during a vaginal examination. No fatal parts were identifiable.

Transvaginal Ultrasound was performed reportedly and revealed a mixed solid and cystic mass-like structure in the uterine cavity and no adnexal pathology (Fig. 2).

Laboratory results were BHCG 1500.0 hemoglobin of 3.7 g/dl., hematocrit of 11.6%, white blood count at 2.55 × 1000/mm3, platelets 150 × 1000/mm3.

The patient was bleeding profusely. We gave oxytocin and Methergine but there was no response, and heavy bleeding continued also the patient was shocked. The patient decided to operate, six-unit erythrocytes, three units of thrombocyte, and four units of plasma were ready.

The patient was taken to the operating room for a laparotomy to perform a total abdominal hysterectomy. While in the operating room, the patient received four units of erythrocyte blood and two units of plasma, after the operation, the patient was admitted to the intensive care unit with intubation, and three days later, the patient was referred to the service for normal vital signs. A complete hydatidiform mole was diagnosed by surgical pathology (Fig. 3). After three months, the beta-hCG level had entirely decreased.

During the follow-up, a chest X-ray was normal. No symptoms of gestational trophoblastic neoplasia were found.

3. Discussion and conclusion

The incidence of molar pregnancy varies by region. East Asian nations have the highest incidence, with 1 in every 120 births. For women over the age of 40, the established risk factor increases by 7, 5 times. Tsukamoto et al. reported twenty cases of GTD in women above the age of 50, with 25 A hydatid form moles, 40 invasive moles, and 25 choriocarcinomas. GTD is difficult to detect in women over 50 since menopause is predicted, and the chance of pregnancy is frequently overlooked or dismissed [3].

HCG levels, a gynecologic exam, and pelvic ultrasonography are used to make a diagnosis. The most sensitive diagnostic test for molar pregnancy is ultrasonography, which shows the “snow storm” pattern caused by hydropic degeneration in the chorionic villi. However, because the potential of pregnancy is typically disregarded or dismissed in postmenopausal women with amenorrhea for more than a year, their -HCG level may not be checked. Menopause is a watershed moment in every woman’s life; it is the final episode of menstrual bleeding associated with the cessation of ovarian follicle activity, resulting in the permanent cessation of menstruation. For at least ten years after menopause begins, the aged ovaries continue to generate some estrogen and androgens [3].

During menopause, however, the number of follicles in the ovaries declines, and estrogen production continues to decline. As a result, when a level incompatible with the production of a spike in luteinizing hormone (LH) is achieved, ovulation may halt or become irregular [1].

It should be noted, that this is clinically related to irregular cycles and a shorter luteal phase, or anovulatory cycles with unopposed estrogen stimulation and endometrial hyperplasia. Anovulatory cycles may be interleaved with ovulatory cycles at times. A phase of amenorrhea with increased follicle-stimulating hormone and LH, for example, may simulate menopause but is followed by an anovulatory cycle and average gonadotropin level a few months later. This transitory stage of increasing loss of ovarian function and unpredictable ovulatory cycles describes the 46-year-old woman’s molar pregnancy [1].

A case report of a postmenopausal woman with a completely massive molar pregnancy with significant grape-like bleeding is a rare case of life-threatening conditions that may be discovered as a result of persistent significant vaginal bleeding. A complete hysterectomy should be performed to avoid significant complications such as bleeding, hypovolemic shock, and the risk of GTN.

This work has been reported in line with the SCARE 2020 criteria (6).

Conflicts of interests

This manuscript has not been submitted to, nor is it under review at, another journal or other publishing venue.

The authors have no affiliation with any organization with a direct or indirect financial interest in the subject matter discussed in the manuscript.

Sources of funding

No funding was received.
Author contribution

- Abdikarim Ali Omar: Conceptualization, Data Curation, Visualization, Investigation Writing, Original draft preparation.
- Ahmed Issak Hussein: Writing, Reviewing, and Editing.
- Khadija Yusuf Ali, Hiba Bashir Hassan: Supervision, Validation.

Registration of research studies

1. Name of the registry:
2. The unique identifying number or registration ID:
3. Hyperlink to your specific registration (must be publicly accessible and will be checked):
   *None.*

Guarantor

Abdikarim Ali Omar.

Ethics approval and consent to participate

Ethical approval was waived by the ethical committee of Mogadishu, Somalia, Turkey, Recep Tayyip Erdogan Training and Research Hospital.

Written informed consent was obtained from the patient for participation.

Consent

Written informed consent was obtained from the patient for the publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Provenance and peer review

Not commissioned, externally peer-reviewed.

Registration (for case reports detailing a new surgical technique or new equipment/technology)

N/a.

Acknowledgment

We acknowledge the education and research committees of Mogadishu, Somalia, Turkey, Recep Tayyip Erdogan Training and Research Hospital.

We acknowledge S.A, who allowed us to use her clinical information, reports, and images for this case report.

Reports, and images for this case report.

Abbreviations

LH luteinizing hormone
B HCG beta hCG
GTD gestational trophoblastic disease
(CHM) complete hydatid form mole
PHM Partial hydatid form mole
GTN Gestational trophoblastic neoplasia

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