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Complete Hydatidiform Mole at Menopause: A Case Report from Panzi Hospital, Bukavu, Democratic Republic of Congo

Julien Bwama[1,2,3*], De-Joseph Kakisingi Mibi[1,3], Nsenga Bin Musa[1,2], Jeff Andrea Mbozi[1,2], Déborah Kambonesa Salire[1,2], Dieudonné Kakusu[1,2], Christine Amisi Tina[2], Aroni Toto[4], Tchass Chasinga Baharanyi[5], Denis Mukwege Mukengere[1,2,6], Olivier Nyakio Ngeleza[1,2,7,8]

[1]Department of Gynaecology-Obstetrics, Faculty of Medicine and Community Health, Evangelical University in Africa, Bukavu, Democratic Republic of Congo
[2]Gynaecology-Obstetrics Department, Panzi General Referral Hospital, Bukavu, Democratic Republic of Congo
[3]Saint Vincent Hospital, Bukavu, Democratic Republic of Congo
[4]Medical Imaging Department, Panzi General Referral Hospital, Bukavu, Democratic Republic of Congo
[5]Anatomopathology Department, Panzi General Referral Hospital, Bukavu, Democratic Republic of Congo
[6]Panzi Foundation, Bukavu, Democratic Republic of Congo
[7]Department of Gynaecology-Obstetrics, Faculty of Medicine, Official University of Bukavu, Bukavu, Democratic Republic of Congo
[8]Department of Gynaecology-Obstetrics, Faculty of Medicine, University of Kindu, Kindu, Democratic Republic of Congo
Email: *jbwama@gmail.com

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Abstract

Gestational trophoblastic disease is an abnormal proliferation of trophoblastic tissue during pregnancy. It occurs in women of childbearing age, although a few cases have also been observed in post-menopausal women, although it is extremely rare in the latter. Here we describe a rare case of complete hydatidiform mole in a 56-year-old female patient who presented with genital bleeding combined with nausea and vomiting and a gravid uterus 16 cm in height. The ultrasound findings and the increase in serum β-HCG to 182566.00 mIU/ml suggested a diagnosis of complete hydatidiform mole. Given the post-menopausal state and the future risk of post-molar gestational trophoblastic neoplasia, we opted for total hysterectomy without preservation of the adnexa via a transabdominal approach, followed by antimitotic treatment with methotrexate. The uterus measured 18.45 cm × 11.18 cm with intra cavitary vesicles. Microscopic examination showed chorionic villi of variable size and shape, most of which were dilated and oedematous, associated with trophoblastic cell proliferation and haemorrhage suggestive of complete benign hydatidiform mole. Follow-up showed a consistent decrease in serum

β-HCG levels and no evidence of residual disease. A suspicion of gestational trophoblastic disease should be borne in mind when evaluating a patient with peri- or post-menopausal bleeding to avoid delay in diagnosis and treatment.

Keywords

Complete Hydatidiform Mole, Menopause, *β*-HCG, Panzi, Bukavu, DRC

1. Introduction

Hydatidiform mole is a gestational disorder in which a trophoblast proliferates uncontrollably, forming hydropic vesicles [1]. A complete hydatidiform mole is diploid and the result of an anucleated egg comprising only paternal DNA due to the duplication of one spermatozoon or, more rarely, the presence of 2 spermatozoa [2]. The frequency of molar pregnancies varies from less than 1/1000 in high-income countries to more than 1/400 in lower-income countries [2] [3]. We report a case of complete hydatidiform mole discovered by chance in a patient aged 56.

2. Observation

Mrs BN, aged 56, married, consulted her doctor for intermittent genital bleeding of moderate severity, dating back one year, with no aggravating factors. The most recent episode was about 5 months ago, with moderate bleeding accompanied by nausea and vomiting. Given the exacerbation of the symptoms, the patient decided to seek treatment.

Further history revealed dizziness and palpitations. No fevers or recent trauma were reported. In her history, she is gesture 10, parity 9, living children 8 with one death. Her last menstrual period was around 5 years ago, she had her menarche at 13 and her last child was 17.

On physical examination, the patient was lucid, coherent and oriented in time and space. Her general condition was unchanged, her body mass index was 33.74 kg/m^2, her haemodynamic state was unstable, with a blood pressure of 155/95mmHg, a heart rate of 100 beats per minute with a radial pulse synchronous with the heartbeat, polypnoea at 25 respiratory cycles per minute, no mucocutaneous pallor and slight chills in the extremities.

The abdomen is slightly enlarged by a uterus with a long axis and a fundus palpated about 16 centimetres above the pubic symphysis.

On gynaecological examination, the vulva was eutrophic and stained with bright red blood; on speculum examination, many vesicles were found mixed with blood clots collected from a kidneyshaped pelvis after manual intravaginal extraction (**Figure 1**); a multiparous cervix was open with active bright red bleeding of uterine origin accompanied by a few vesicles. On vaginal touch combined with abdominal palpation, the uterus was slightly enlarged, the cervix softened, shortened and dilated to 2 centimetres; intracervical palpation of soft, ir-

regular and friable tissue. The fingernail came back stained with bright red blood and some debris when it was removed.

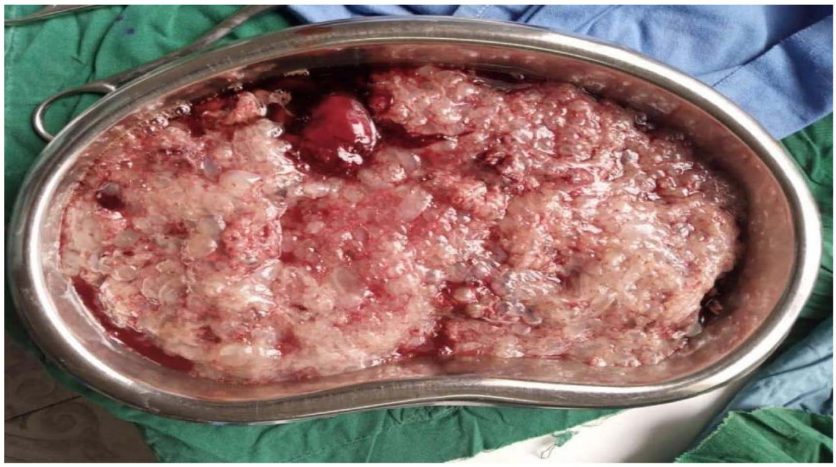
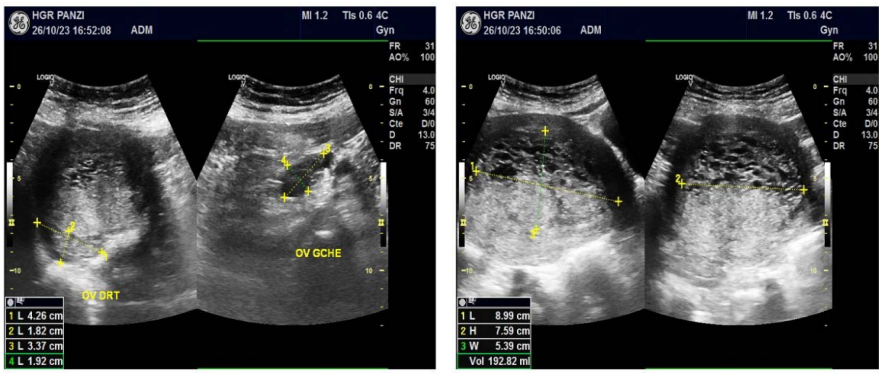


Figure 1. Macroscopic appearance of vesicles mixed with haematomas.

In view of this clinical picture, the diagnosis of molar pregnancy on a background of mild arterial hypertension was evoked: the β-HCG level returned to 182.56600 mUI/mL, haemoglobin returned to 139 g/L, and proteinuria was negative.

Ultrasound showed a large anteverted uterus containing a heterogeneous tissue formation with a liquid component of honeycomb appearance with regular contours without hypervascularisation on colour Doppler, measuring 89 × 75 × 53 mm with no abnormality of the myometrium, suggesting a complete molar pregnancy. No embryonic or foetal structures were seen. The right ovary was of normal size, measuring 42 × 18 mm, with normal echostructure. The left ovary was normal in size, measuring 33 × 19 mm, and had a normal echostructure (**Figure 2**).



(A) (B)

Figure 2. (A) Presentation of the normal appearance of the ovaries; (B) Image of a heterogeneous tissue formation with a fluid component of honeycomb appearance with regular contours, measuring 89 × 75 × 53 mm without myometrial abnormality suggestive of a complete molar pregnancy.

The patient's metastatic assessment (chest x-ray and abdominal-pelvic ultrasound) was negative.

This allowed us to conclude that the patient had a high-risk trophoblastic tumour with a score of 9 according to the FIGO 2000 prognostic classification.

After counselling and informed consent, the patient underwent laparotomy for trans-abdominal total hysterectomy without preservation of the adnexa, given her age and parity and the future risk of high post-molar gestational trophoblastic neoplasia.

Intraoperative findings: no adhesions or infiltration of neighbouring organs; a large uterus of soft consistency measuring 18.45 cm × 11.18 cm (**Figure 3**) showing on sagittal section a cluster of well-differentiated intrauterine vesicles (**Figure 4**). The surgical specimen was sent to the pathology department for cytological analysis.

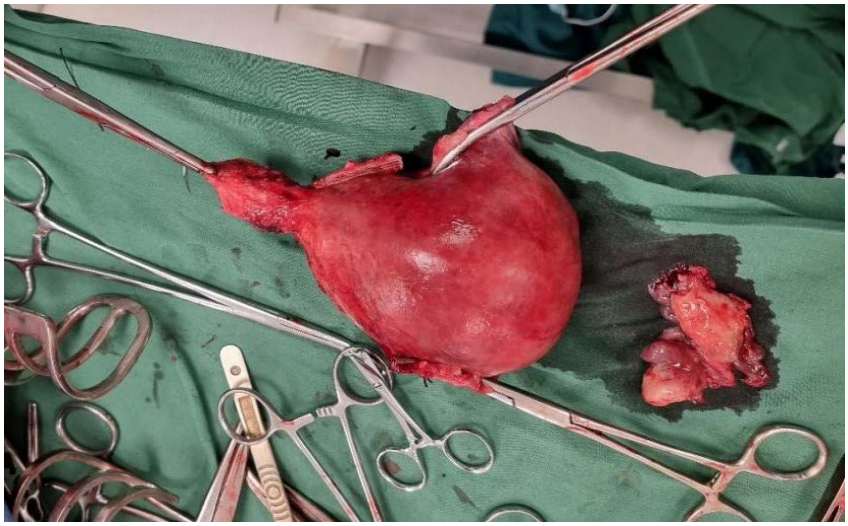


Figure 3. Macroscopic appearance of a large, soft uterus measuring 18.45 cm × 11.18 cm.

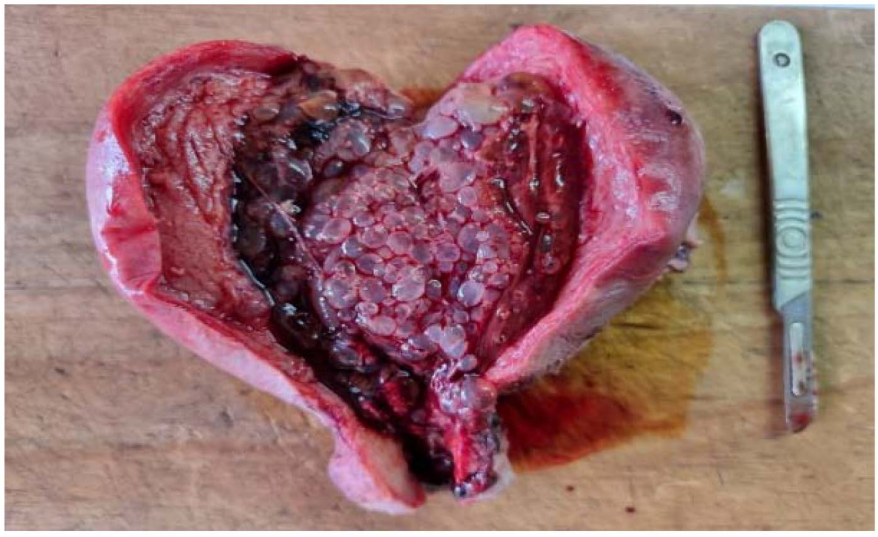


Figure 4. Sagittal section showing a cluster of well-differentiated intrauterine vesicles.

3. Result

Chorionic villus sections of variable size and shape, most of which were dilated and oedematous, associated with trophoblastic cell proliferation and haemorrhage, suggestive of complete hydatidiform mole (Figures 5-8).

Figure 5. Presentation of the different analysis slides.

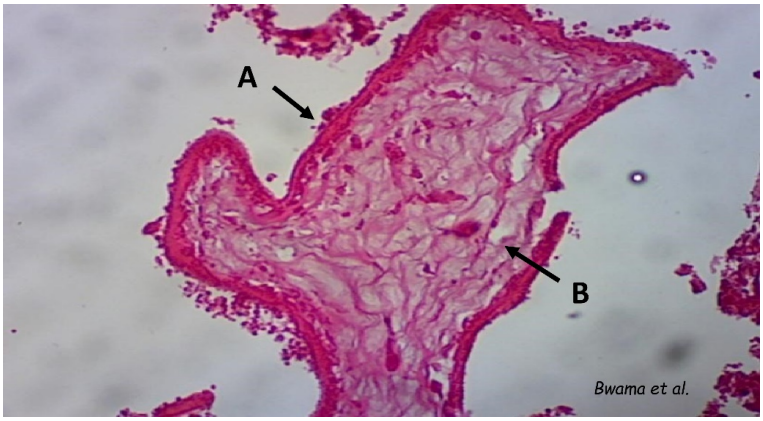


Figure 6. Histological section of achorionic villus. (A): Layerof peripheral cytotrophoblastic cells; (B): Central oedematous connective tissue.

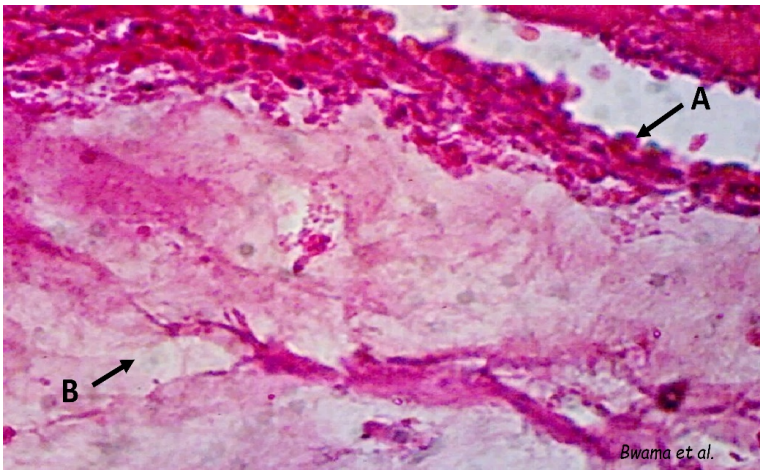


Figure 7. Histological section of a Chorionic villus. (A): Representation of the Peripheral cytotrophoblastic layer; (B): Edema of the underlying connective tisslue.

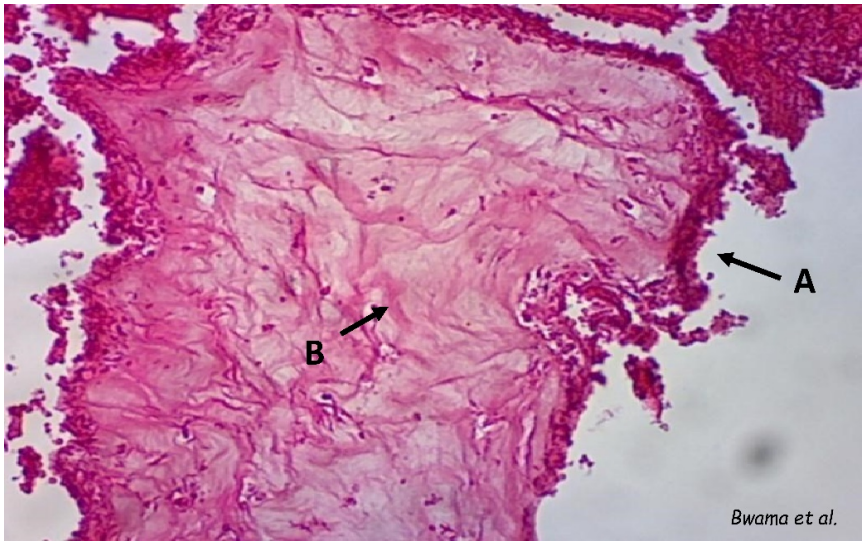


Figure 8. Histological section of a Chorionic villus. (A): Representation of the peripheral cytotrophoblastic layer; (B): Edema of the underlying connective tissue.

The chromosomal study for karyotyping was not performed due to lack of resources.

The rest of the treatment consisted of antibiotic therapy with ampicillin and analgesics. The patient's general condition improved, she was discharged within 72 hours of the operation, and she was given a series of appointments to monitor her b-HCG kinetics. The first check at one week showed a b-HCG level of 337.93 mIU/mL, then at week 2, a level of 95.43 mIU/Ml. At the follow-up visit 8 weeks later, her serum levels of beta-human chorionic gonadotropin (hCG) were no longer detectable.

4. Discussion

Hydatidiform mole is a benign tumour with malignant potential. Malignant progression occurs in 15% of complete moles, and in 1.5% of partial moles [4]. The risk of progression to invasion is greater in multiparous patients than in those with a history of spontaneous abortion or previous mole [2].

The patient's age and history of hydatidiform mole are the two most established risk factors. At ages < 21 and >35, the risk of having complete hydatidiform mole is 1.9 times higher, and at ages > 40, the risk increases 7.5 times [5]. The patient was well within the predisposed age range, but had no history of hydatidiform mole.

Pelvic ultrasound is the most sensitive method of diagnosis, showing a characteristic vesicular pattern due to complete or partial hydropic degeneration of the chorionic villi known as "snow". Stormy appearance [6].

To date, isolated cases of benign hydatidiform pregnancy in postmenopausal women have been reported in the literature in patients over 50 years of age [7]. In our case, the patient was 56 years old and had been post-menopausal for 6 years. The average age of menopause in the Democratic Republic of Congo is

between 46 and 47 years [8]. Clinically, the patient had already been menopausal for 6 years.

Pregnancies at an advanced age are rare and may result in spontaneous abortion or molar pregnancy, which could have occurred in our patient. The risk of post-molar malignant sequelae after vacuum curettage is 56.3% in women over 50. Hysterectomy offers the advantage of simultaneous treatment and sterilisation, and further reduces the risk of postmolar gestational trophoblastic tumour (GTT) [9].

However, there remains an 8% - 20% risk of post-molar GTT in older patients after hysterectomy, so regular monitoring with serum β-HCG is indicated [9]. Our patient, being postmenopausal, had no possibility of future fertility, which is why we opted for hysterectomy.

5. Conclusion

The diagnosis of gestational trophoblastic tumour should be raised in any patient of childbearing age presenting with a typical or atypical clinical picture with or without a recent post-partum context. However, although it is rare, it can still occur in post-menopausal women. Consequently, a high index of suspicion of gestational trophoblastic tumour must be borne in mind, and great vigilance is required when evaluating postmenopausal women presenting with bleeding, in order not to miss hydatidiform mole.

Conflicts of Interest

The authors state that they have no conflicts that could influence the data in this study.

Ethical Considerations

The authors obtained free and informed written consent from the patient's partner for the publication of this case.

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