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RUPTURED TUBAL COMPLETE HYDATIDIFORM MOLE MIMICKING ECTOPIC PREGNANCY AND ADNEXAL MALIGNANCY: A CASE REPORT

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BACKGROUND

Tubal molar pregnancy is an exceptionally rare form of gestational trophoblastic disease resulting from the coexistence of ectopic implantation and molar trophoblastic proliferation. It has been estimated to occur in approximately 1.5 per 1,000,000 pregnancies. Its clinical presentation is usually indistinguishable from conventional tubal ectopic pregnancy, and preoperative diagnosis remains difficult because symptoms, β-human chorionic gonadotropin levels, and imaging findings are nonspecific.

INDEX CASE

A 45-year-old, Gravida 3 Para 2 (2-0-0-2) woman presented with 1-week history of severe hypogastric pain and vaginal bleeding.

On arrival, the patient was in severe abdominal pain and noted with generalized pallor. The patient was hypertensive, with rest of the vital signs within normal limits. Chest and cardiovascular examinations were unremarkable. Abdominal examination revealed generalized tenderness. On internal examination, the cervix was closed with scant vaginal bleeding with cervical motion tenderness, and bilateral adnexal tenderness.

Whole abdominal ultrasound done 5 days prior to admission showed:

- Normal-sized anteverted uterus
- An irregular, lobulated, heterogeneous pelvic mass of 7.4 × 7.0 × 6.8 cm adjacent to the uterus showing intralesional vascularity
- Free fluid collections

Pertinent Laboratory results on admission:

Laboratory	Result	Reference range
Hemoglobin	54.0 g/L	115 - 160
β-hCG	203,743.84 mIU/mL	< 1.2 - negative
CA-125	367.40 U/mL	0 -37

MANAGEMENT

Patient underwent EXPLORATORY LAPAROTOMY, BILATERAL SALPINGECTOMY

INTRAOPERATIVE FINDINGS

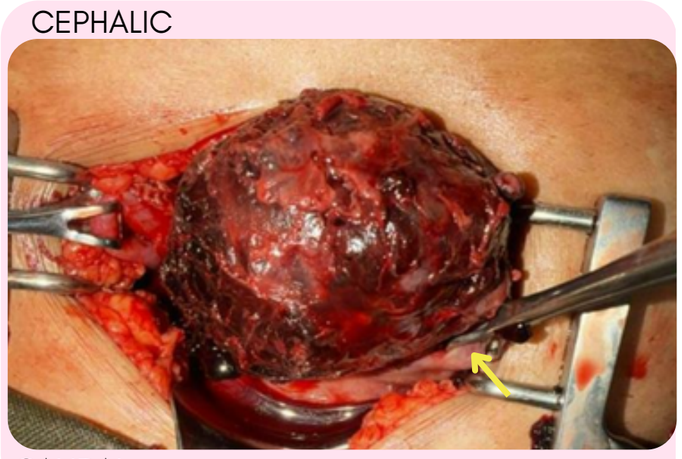


Figure 1. Ruptured ampullary segment of the left fallopian tube with products of conception (yellow arrow, left fallopian tube)



Figure 2. Post-bilateral salpingectomy view showing a grossly normal uterus

HISTOPATHOLOGY REPORT

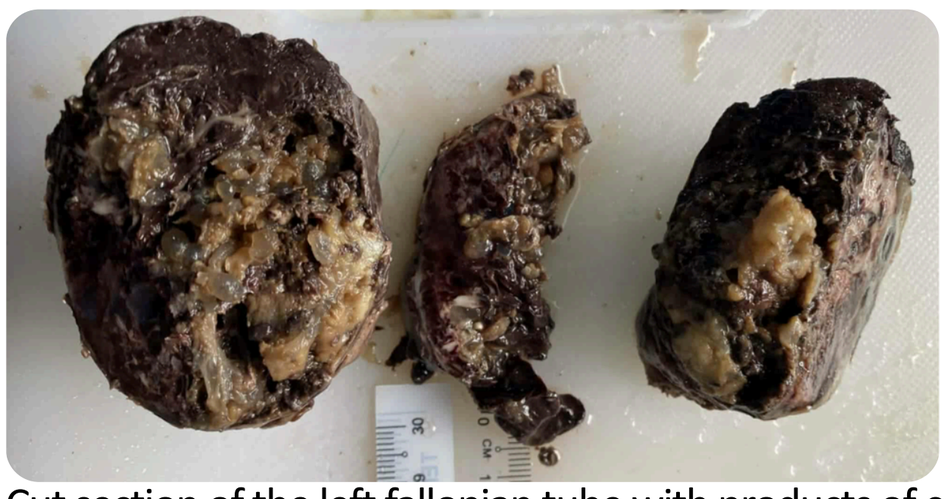


Figure 3. Cut section of the left fallopian tube with products of conception. Consisted of tubular shaped, brown tissue measuring 7.5 x 6 cm. Its outer surface is rough with ruptured wall and extravasated blood clots, Section show a dilated lumen filled with blood clots and meaty, tan and vesicular tissues.

- Ectopic Hydatidiform Mole, Complete Type, Involving the fallopian tube
- Positive wall and/or serosal rupture, Left
- Positive lymphovascular invasion
- Reactive mesothelial hyperplasia, right fallopian tube

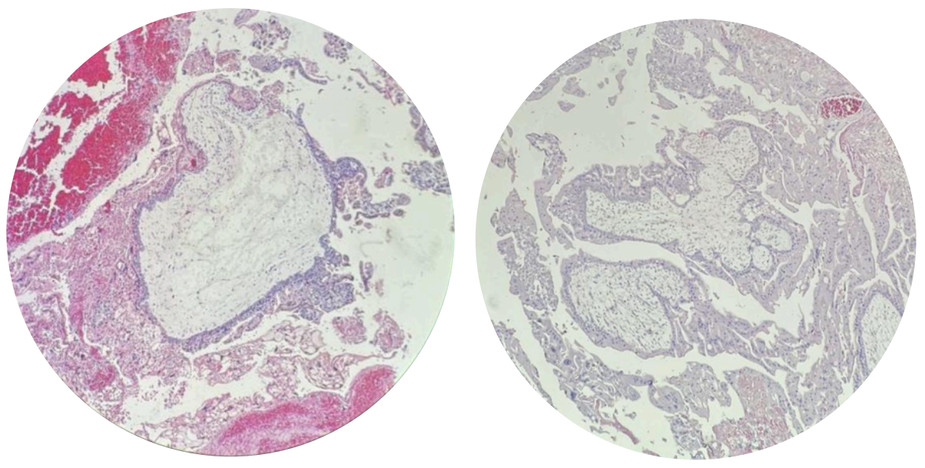


Figure 4. Histopathologic sections of the left fallopian tube showing hydropic chorionic villi and diffuse trophoblastic proliferation, consistent with complete hydatidiform mole (H&E, 100x).

β-hCG SURVEILLANCE

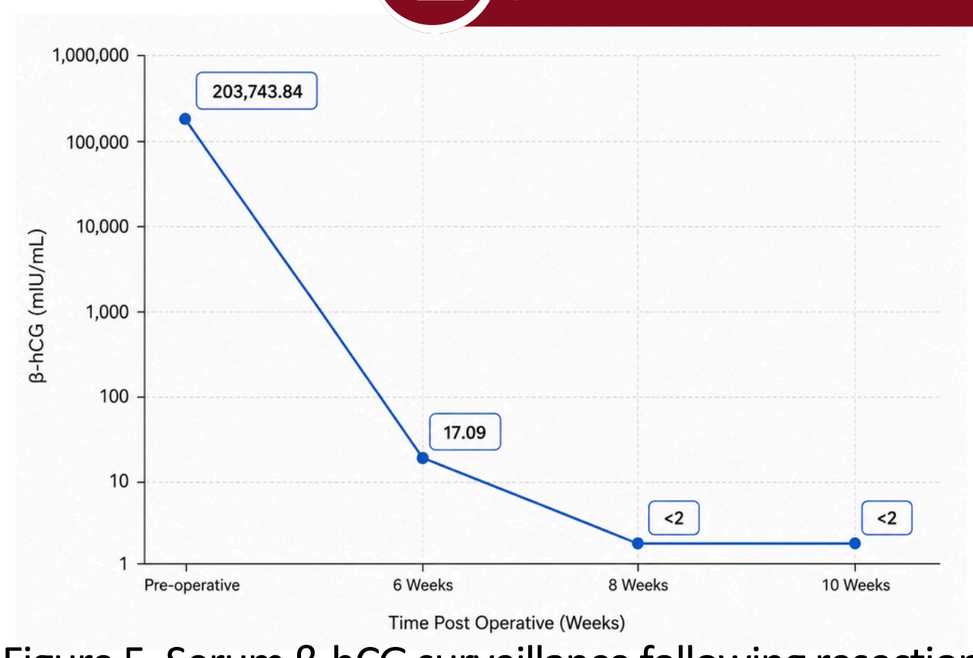


Figure 5. Serum β-hCG surveillance following resection of an ectopic complete hydatidiform mole.

At follow-up, β-hCG levels declined from 203,743.84 mIU/mL preoperatively to 17.09 mIU/mL at six weeks postoperatively; repeat measurements at eight and ten weeks were both <2 mIU/mL, consistent with biochemical remission, and continued surveillance was advised.

CONCLUSION

This case illustrates that tubal complete hydatidiform mole may masquerade as both ruptured ectopic pregnancy and adnexal malignancy. A β-hCG disproportionately high for the clinical picture should raise suspicion, every ectopic specimen warrants histopathologic examination, and confirmed molar histology mandates structured β-hCG surveillance to detect post-molar gestational trophoblastic neoplasia, particularly when lymphovascular invasion is present.