SUSPECTED ECTOPIC MOLE: A CASE STUDY

Dr Amatulnoor Saba Aslam[1], Dr David Baartz[2], Shona Morrison[3], Dr Andrea Garrett[4]

[1]Principal house Officer, Royal Brisbane and Women's Hospital, Queensland, Australia; [2]Director Queensland Trophoblast Centre (QTC), Queensland, Australia ; [3]Clinical Nurse Consultant QTC; [4]Deputy Director QTC

Introduction:

The incidence of a molar ectopic pregnancy is rare; it is about 1-5/200,000 (1). Diagnosis is dependent on tissue histopathology (2). Current treatment is dependent on location, and, whether the ectopic pregnancy is live. Beta-human chorionic gonadotropin (β-hCG) is followed up until negative. At times patients can be lost to follow-up and this carries a risk of unresolved ectopic pregnancy or in rare cases the development and sequelae of gestational trophoblastic neoplasia (GTN).

GTN can occur in 50% of molar pregnancies and are highly responsive to chemotherapy with a cure rate over 90% (3). However, this requires early diagnosis and treatment. In rare cases Epithelioid trophoblastic tumour (ETT) can develop, whereby the mainstay of treatment is hysterectomy (4), with a significant risk of metastasis and death (5).

Case:

Table 1: B-hCG trend

At diagnosis of ectopic and first methotrexate treatment (18 months prior)	At second dose of methotrexate	Last B-hCG prior to patient being discharged against medical advice	At emergency presentation with chest symptoms	One month after hysterectomy	B-hCG level post two cycles of chemotherapy
623 IU/L	484 IU/L	599 IU/L	35000 IU/L	8398 IU/L	21 IU/L

We present the case of a 34 year old female who presented to the Emergency Department with chest symptoms. On imaging she was found to have lesions on her lung. Her Bhcg was elevated at 35,000. The lung lesions were suspected to arise from a lobulated mass within the anterior uterine fundus on a whole body CT scan. Given her elevated B-hCG, no pregnancy identifiable on imaging and a previous ectopic pregnancy, she was referred to the Queensland Trophoblastic Centre (QTC).

Her ectopic pregnancy occurred 18 months prior and was treated with Methotrexate. She had 2 doses and her B-hCG fell to 599 IU/L. She was lost to follow up with no knowledge of normalisation of her B-hCG. Although she reported ongoing vaginal bleeding after defaulting on her follow-up, it wasn't until she developed chest symptoms that she presented for care.

Her MRI showed a 96mm lobulated mass in the fundus with at least 4 pulmonary nodules, the largest of which was 35mm. Subsequently she underwent a hysterectomy, and a tissue diagnosis of Epithelioid Trophoblastic Tumour (ETT) was made.

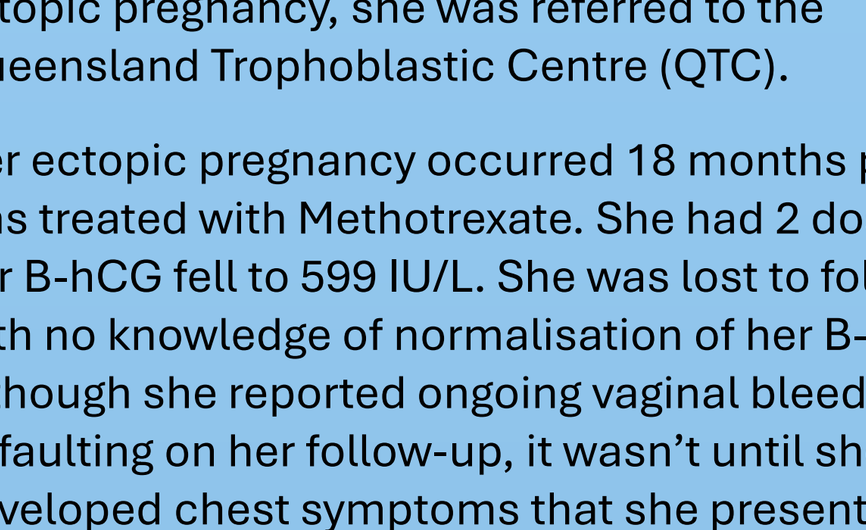


Figure 1: MRI imaging of pelvic mass – T2; Sagittal

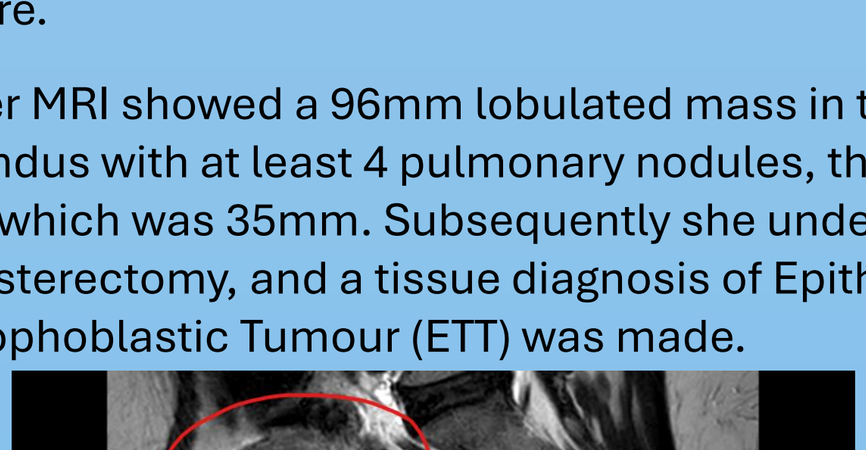


Figure 2: MRI imaging of pelvic mass – T2: Coronal

She commenced multi-agent chemotherapy (EP/EMA) and her B-hCG dropped to 21 IU/L after 2 cycles. Unfortunately, she has again been lost to follow up without knowledge of normalisation of her B-hCG.

On questioning during her admission, she related her non-attendance to a lack of understanding of her original ectopic diagnosis and follow up required and that the repeated blood tests felt overwhelming. There were also limitations due to significant social and cultural barriers.

This case is rare but has had a life altering outcome and potential of a terminal diagnosis for a young woman in the prime of her fertile age.

This highlights the necessity of tenacious management of atypical ectopic pregnancies and a patient centred focus with emphasis on patient autonomy with appropriate education and culturally safe care for timely diagnosis and management.

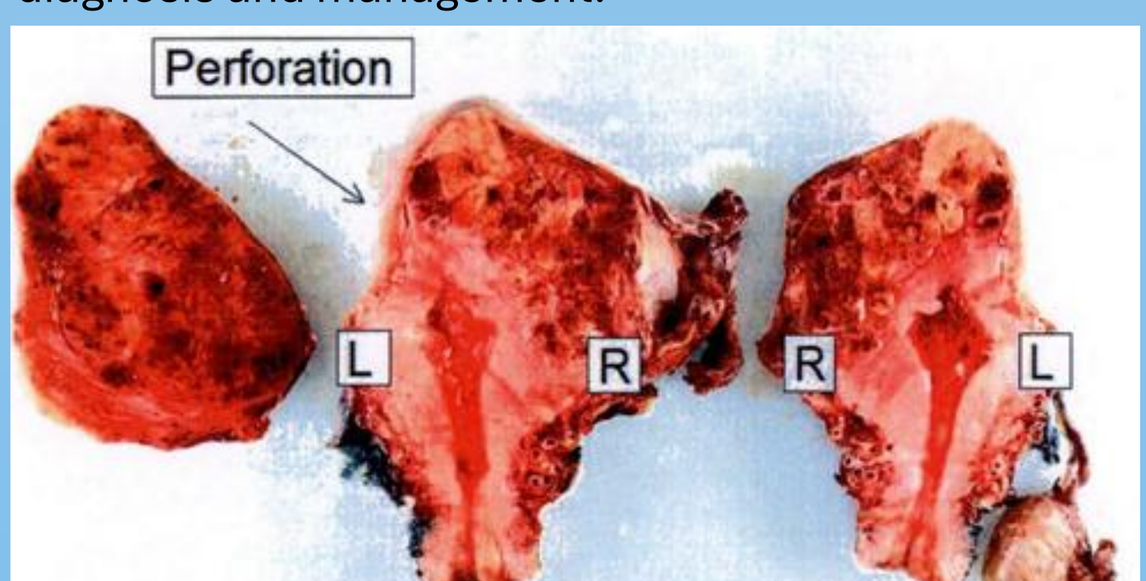


Figure 3: Macroscopic histopathology of hysterectomy specimen

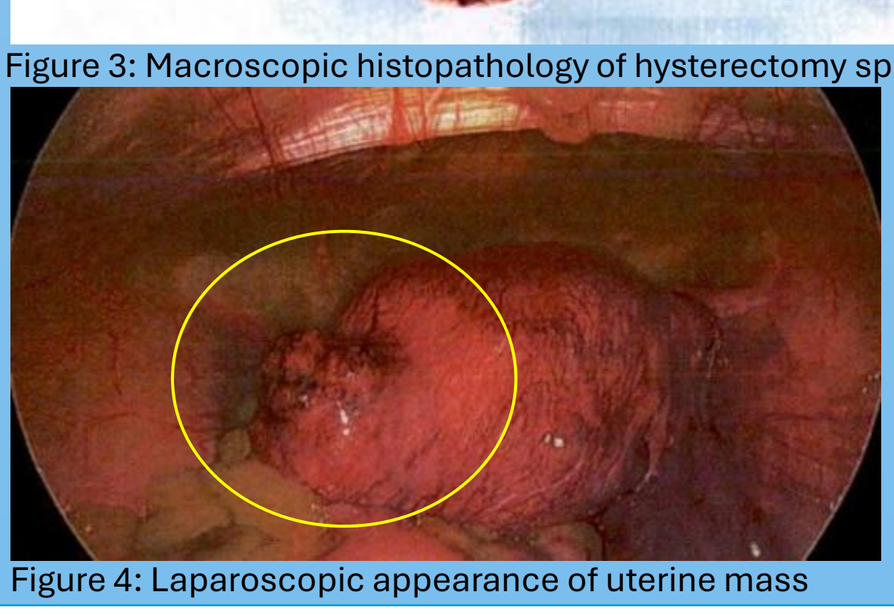


Figure 4: Laparoscopic appearance of uterine mass

CONCLUSION:

Protocols for the management of ectopic pregnancies should emphasize the importance of follow-up, the risk of GTN and the importance of escalating ectopic pregnancies that do not respond to treatment as expected. More research is needed to assess the incidence of this rare cancer in our population, especially when looking at culturally and linguistically diverse populations.

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Patient consent has been obtained by the Queensland Trophoblastic Centre at the Royal Brisbane and Women's Hospital via an Opt-out system.

XXIII World Congress on Gestational Trophoblastic Disease