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Hydatidiform mole in the fallopian tube

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Introduction

Hydatidiform mole (HM) is a very rare disease of fallopian tube. It is a gestational trophoblastic disease and till 1993, 26 cases have been presented in the literature. Twenty four of 26 cases were complete type and 2 were partial type (1). We report a case of ruptured partial tubal hydatidiform mole which to our knowledge is the first case reported in the world literature.

Case report

A 24 years old woman with regular menstrual cycles who did not have any pregnancy was admitted to our hospital with right abdominal pain and hypovolemia. She informed that her menses was delayed, and pregnancy test was found positive. On pelvic examination, right adnexal region was tenderful. In pelvic ultrasonography, a great amount of liquid in the abdomen and findings implying a hemorrhagic mass in right fallopian tube (FT) were seen. No fetus and chorion were seen in the right FT. No abnormalities were found in the bilateral ovaries, the left FT, and the uterus. In laparotomy, about 1.5 liter dark-red uncoagulated blood was found in the peritoneal cavity and themorrhagic mass in ruptured right FT. The right FT was removed. The postoperative course was uneventful. Macros-copically, numerous vesicular (hydropic) villi which were 1-1.5 cm in diameter placed next to the clots were seen. Pathologic examination revealed a ruptured FT with a lumen filled with blood, decidualized tissue, and distended chorionic villi. Fetal stromal blood vessels were absent. The appearance of the trophoblasts were variable; some of the hydropic villi trophoblasts had flattened appearance, but in most villi both cytotrophoblast and syncytiotrophoblast proliferations were seen. There was no infiltration into the muscular layer of the FT, and no fetus or fetal components were detected. Because of these findings, the mass was histopathologically diagnosed as partial hydatidiform mole (Figure 1). The blood beta-HCG level was found to be normal on the 16th day after the operation. Physical and radiological examination of the lungs and other systems, revealed no pathology, and beta-HCG levels remained normal.

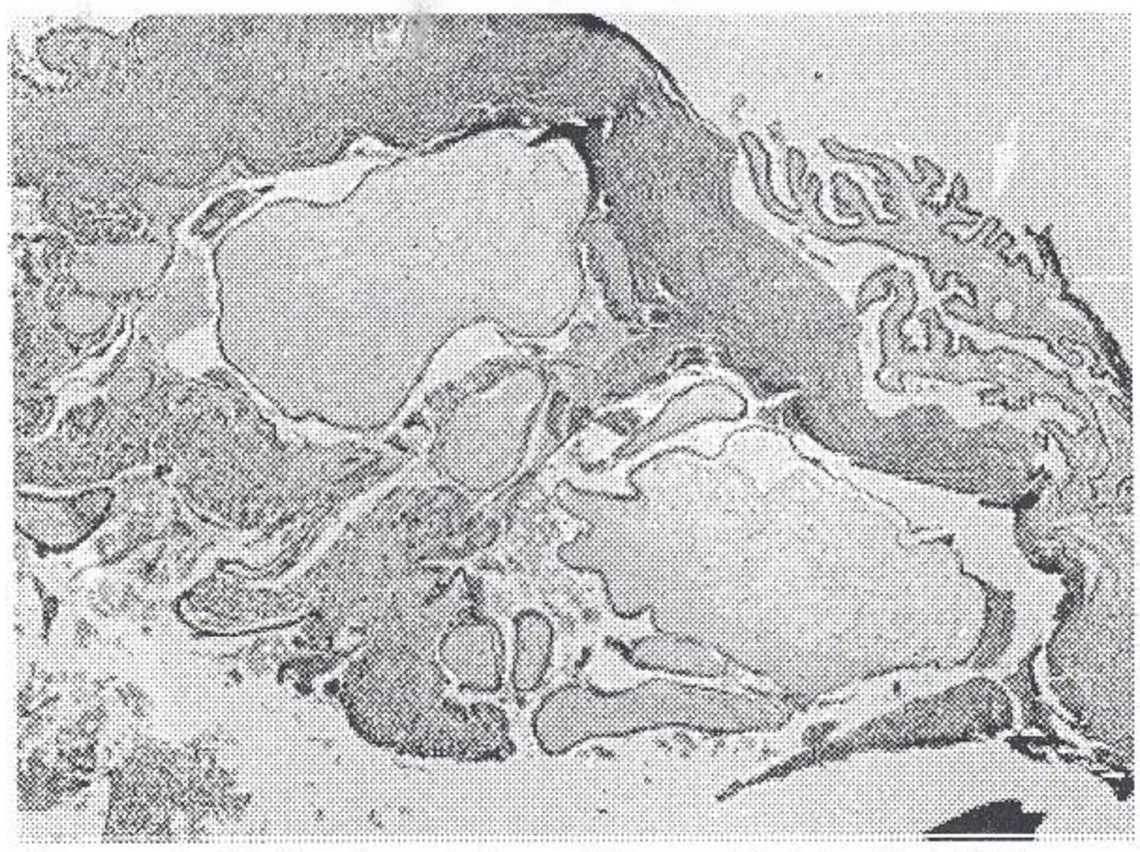

Figure 1. Fallopian tube with partial hydatidiform mole showing fallopian tube mucosa (arrow), and mild trophoblastic proliferation, marked hydropic degeneration of stroma without blood vessels in some villi (Hematoxylin-eosin stain, original magnification, X 10)

Discussion

The preoperative dignosis of HM in FT is indeed difficult (1). The high beta-HCG activity and a mass in FT, in addition to ruptured FT findings as in our patient are sufficient to suspect from HM.

Rewieved 2100 women having gestational trophoblastic disease have shown that 0.8 % (16 patients) had the disease in FT (2). Of these patients, 5 were partial mole, 5 complete mole and 6 choriocarcinoma. Four of the complete mole patients had high HCG levels which decreased to normal levels within 2-7 weeks and one patient had postoperative lung metastasis. Our patient had normal HCG levels on the 16th day and afterwards.

Generally, all localization of HMs are classified in two groups as complete and partial. Complete and partial HMs have

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different properties. Complete mole has no fetal parts, edema is present in all villi, trophoblast proliferation is diffuse and circumferential, atypia is often present. Serum HCG level is highly elevated, and so is strongly stained in tissue. Choriocarcinoma development rate is reported to be 2 %. Conversely, in partial mole fetal parts may be present, villous edema is present in some villi, trophoblast proliferation is focal and slight, atypia is absent. Serum HCG level is less elevated, and HCG is weakly stained in tissue. Choriocarcinoma development is rare in this type (3). The cytogenetic studies revealed out that etiology of these two conditions were quite different. The complete type always carries chromosomes of diploid karyotype which is usually 46, XX and occasionally 46, XY (1,3,4). The partial type, carries chromosomes of triploid karyotypes. These are usually 69, XXY, occasionally 69, XXX and rarely 69, XYY (1).

A tubal HM can be treated simply by the excision of the tubal lesion, similarly to the treatment of tubal ectopic pregnancy (2)

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