IJABR

International Journal of Advanced Biotechnology and Research (IJABR)
ISSN 0976-2612, Online ISSN 2278–599X,
Vol-9, Issue-4, 2018, pp63-67
http://www.bipublication.com

Research Article

Molar pregnancies: experience at rural health centre

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ABSTRACT

Objective: To study the prevalence of molar pregnancies at Rural Health Centre, AhmedpurLamma.

Material and Methods: This was an observational study conducted at Rural Health Centre, AhmedpurLamma from February 2018 to August 2018 over the period of six months. During the study period total 52 cases of molar pregnancy were diagnosed and clinical presentation was also studied.

Results: During study period, total 52 were found with molar pregnancy. Mean age of cases with molar pregnancy was 21.56±2.93 years. Most of the cases (51.9%) were belonged to age group 15-20 years. Amenorrhea was the commonest symptom seen in 51(98.08%) patients and majority (59.62%) of the patients had pre evacuation beta hCG values between 1,00,000-10,00,000 IU/L with mean value of 2.30 ± 2.30 lakhs. Patients with Partial hydatidiformmole (PHM) was 28(53.8%) and with Complete hydatidiform mole (CHM) was 23(44.2%).

Conclusion: Findings of present study showed that 15-20 years age group was the most prevalent group of molar pregnancies and most common clinical symptom was amenorrhea. Majority of the patients had pre evacuation beta hCG values between 1,00,000-10,00,000 IU/L with mean value of 2.30 ± 2.30 lakhs.

Key Words: β-hCG, GTD, Hydatidiform mole, pregnancy

INTRODUCTION

Gestational trophoblastic disease (GTD) includes a series of disorders that are characterized by an abnormal proliferation of trophoblastic tissue with varying tendency to spontaneous remission, local invasion and metastasis. The variation in worldwide incidence rates results in part from discrepancies between population based and hospital-based data. In addition, incidence rates may be based on the total number of pregnancies, deliveries or live births. Furthermore, under registration of GTD might occur.[1]

Hydatidiform moles have been diagnosed at younger gestational ages in the past 10 years owing to the widespread use of routine first-trimester ultrasound detection and ultrasound investigation of threatened miscarriage. High number of complete hydatidiform mole patients is diagnosed co-incidentally at routine first trimester ultrasound examination without any classical symptoms. The clinical presentation of partial HM is less marked, with fewer clinical symptoms than complete moles.[2]

The majority of cases can be cured by simple surgical intervention. Those cases requiring chemotherapy are generally cured with very low toxicity regimen. Unlike other gynaecological malignancies, fertility can be preserved and normal pregnancy outcome anticipated. The curability of this condition is a milestone of success in the history of modern medicine.[2]

Gestational Trophoblastic Neoplasia (GTN) is highly curable, yet there are many patients succumbing to GTN in our country due to lack of proper organised follow up programmes. It is important to have the regional registries for the proper understanding of this unique malignancy. This will help making decisions and optimizing management, and preventing treatment failure.[3]
Regular monitoring is essential to ensure full regression of disease.
However, a lengthy timeframe for follow-up may result in poor compliance and an increased number of defaulters. Women are highly recommended to continue with follow-up for up to 6 months to enable detection of relapse or persistent gestational trophoblastic disease (pGTD).
Unfortunately, in reality, women often default and do not complete the recommended protocol. The long protocol may create a significant burden to the woman and her family and may also delay future conception.[4]
GTD is a discrete pool of epidemiological and clinico-pathological entities. Some predisposing factors have a geography specific character. Therefore, every geographical region should be studied separately. The Indian subcontinent is underreported for this disease. The Asian descent has been reported as a risk factor for GTD. This indicates that emphasis on detailed study of GTD and its follow up in Asian countries may help in revealing its geographical distribution in a clearer way.[5]

MATERIAL AND METHODS

This was an observational study conducted at Rural Health Centre, AhmedpurLamma from February 2018 to August 2018 over the period of six months. During the study period total 52 cases of molar pregnancydiagnosed with hydatidiform mole clinically and sonologically were selected.
Demographic data of the patients was taken. Blood sample was taken from every patent for serum beta-hCG. This test was performed on Beckman Coulter, fully automated chemistry analyser and by using Beckman coulter regaent on immunoflourscent technique. As a primary mode of management suction and evacuation done for all patients followed by gentle curettage. Oxytocin infusion started at the end of the evacuation to minimize bleeding. The samples obtained sent for histopathological examination with recommended lab protocols, findings were noted on pre-designed proforma. Frequencies and percentage was calculated for categorical data. Data was presented in the form of tables.

RESULTS

During study period, total 52 were found with molar pregnancy. Mean age of cases with molar pregnancy was 21.56±2.93 years.Age of the patients ranged from 18 to 30 years. Most of the patients were belonged to age group 15-20 years, followed by 20 patients to age group 21-25 years, 5 patients to age group 26-30 years.
Table 2 shows the presenting symptoms of patients. Amenorrhea was seen in 51(98.08%) patients.
Bleeding per vaginum in 34(65.38%) patients was the commonest symptom apart from amenorrhea which was present in all cases except one. 5(9.61%) had vomiting out of which one also had headache, 3(5.76%) had pain abdomen and only 1(1.92%) had classic symptom of passage of vesicles. 12(23.07%) patients did not have any symptoms and were diagnosed on routine antenatal ultrasonography.
Majority (59.62%) of the patients had pre evacuation beta hCG values between 1,00,000-10,00,000 IU/L with mean value of 2.30 ± 2.30 lakhs. 36.54% of the patients had beta hCG values between 10,000-1,00,000. Shown in table 3.
The table 4 summarises the histopathology diagnosis. 28(53.8%) were PHM giving incidence of 1.3 PHM per 1,000 deliveries, 23(44.2%) were CHM with incidence of 1.1 CHM per 1,000 deliveries.
The specimen of uterus of one patient (1.9%) who underwent hysterectomy showed hydropic villi invading myometrium suggestive of invasive mole. No cases of choriocarcinoma, PSTT or ETT were seen in the study.

Table 1: Age wise Distribution at Presentation

Age group	Number of patients	Percentage
< 15 years	0	0
15-20 years	27	51.9
21-25 years	20	38.5
26-30 years	5	9.6
> 30 years	0	0

Table 2: Presenting Clinical Symptoms

Clinical features	Number of patients	Percentage
Amenorrhea	51	98.08
Bleeding per vagina	34	65.38
Vomiting	5	9.61
Pain abdomen	3	5.76
Passage of grape like vesicles per vaginum	1	1.92
Headache	1	1.92
Hypertension	1	1.92
No complaints (Diagnosed on routine antenatal USG)	12	23.07

Table 3: Baseline Beta hCG Levels

Baseline beta hCG levels(IU/L)	Number of patients	Percentage
1000 – < 10,000	0	0
10,000 – <1,00,000	19	36.54
1,00,000 – <10,00,000	31	59.62
≥ 10,00,000	2	3.8

Table 4: Histopathology Diagnosis (n=52)

Histopathology Diagnosis	Number of patients	Percentage
Partial hydatidiform mole	28	53.8
Complete hydatidiform mole	23	44.2
Invasive mole	1	1.9

DISCUSSION

There is a wide variation in the epidemiology of molar pregnancy around the world.[6] Possible ethnic, racial, genetic or cultural differences have not been attributed to an increased incidence of molar pregnancy.[7]

The incidence of GTD in the present study is 2.4 HM per 1000 pregnancies, 2.5 per 1000 deliveries and 2.6 HM per 1000 live births. This is consistent with rates found in previous studies. In a study in India by Kumar N et al at[5] showed a lower incidence of 1.31 per 1000 live births and in the same year a study by Sekharan P[8,] showed a very high incidence of 5 per 1000 deliveries.The findings of the present study concur with many others that Asian women are more likely to develop molar pregnancies than non-Asians when compared with historical data.[9]

In the present study majority (51.9%) of patients belonged to age group15-20 years. Mean age of the patients was 21.56 ± 2.93 years with the age

ranging from 18 to 30 years. The median age was found to be 20 years. In a study by Kumar N et al had majority of their patients (66%) in the age group of 20-25 years with the mean age 24.6 ± 4.4 years.[5]

The incidence of gestational trophoblastic disease for women under 20 was 1.58 per 1000 live births falling to 1.18 in the age group 30–34 rising to 5.49 in the >40 age group.[9] In the present study 98.08% had presented with history of amenorrhea. Vaginal bleeding was a symptom in 65.38% of patients. Fatima et alreported bleeding per vaginum as commonest symptom seen in 94.2%.[10] This was also reported as the commonest symptom by a study conducted in China as 83.2% of the patients with hydatidiform mole.[11] However, contrastingly a clinical study from Dubai reported incidence of vaginal bleeding only in 29% of patients.[2] The classic symptom of passage of grape like vesicles per vaginum was seen in 60% of patients in a study by Ocheke AN et al which was seen in only 1 (1.92%) patient in our study.[12] Routine antenatal USG detected symptomless GTD in 6.5% of study population in study by Kumar N et al.[5]Tasneem et al detected 51% with no symptoms on early pregnancy scan.[2] In our study USG detected 23.07% of patients without symptom. This may be because of the early diagnosis during routine antenatal scans in first trimester as majority of patients in the current study presented during first trimester.

In the present study histopathology examination (HPE) of 53.8% of the patients showed partial mole, and in 44.2% HPE showed complete mole. These proportions were consistent with the published literature. In a study from Malaysia, 46.1% observed to have CHM compared to 53.9% having PHM.[4]Lybol C et al observed 30.2% having CHM, 44.5% of patients having PHM and in rest 11.6% the HPE was unspecified.[1]

CONCLUSIONS

Findings of present study showed that 15-20 years age group was the most prevalent group of molar pregnancies and most common clinical symptom was amenorrhea. Majority of the patients had pre evacuation beta hCG values between 1,00,000-10,00,000 IU/L with mean value of 2.30 ± 2.30 lakhs.

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