Case Report

Cornual Molar Ectopic Pregnancy: A Case Report with Difficult Management in Poor Resources Settings

Bruno Kenfack,1,3 Zacharie Sando,2 Grace Nganwa,1 Ambe Gilbert Che,3 Philip Njotan Nana,2 and Emile Mboudou2

1Department of Biomedical Sciences, University of Dschang, P.O. Box 67, Dschang, Cameroon
2Faculty of Medicine and Biomedical Sciences, University of Yaoundé I, P.O. Box 1364, Yaoundé, Cameroon
3Reproductive Health Unit, Dschang District Hospital, P.O. Box 67, Dschang, Cameroon

Address correspondence to Bruno Kenfack, brunokenfack@gmail.com

Received 25 October 2012; Accepted 3 November 2012

Abstract Molar pregnancy is a rare entity and ectopic location of pregnancy in the uterine horn represents the least frequent site of implantation. This paper presents a rare case of molar cornual ectopic pregnancy at advanced gestational age with a particular difficulty in diagnosis and management. A 35-year-old woman, gravida 4 para 3 with a history of 12 weeks amenorrhea, was operated for presumed ruptured ectopic pregnancy. Per-operative findings showed swollen villi in clusters that looked like bunches of grapes, characteristic of a complete hydatiform mole, located at the left horn of the uterus. Histopathologic examination confirmed the diagnosis. Bleeding could not be controlled with suturing and hysterectomy was eventually done. Although rare, molar pregnancy can be ectopic. If it is located at the uterine horn, bleeding may be difficult to control if at a gestational age of 12 weeks or more.

Keywords ectopic molar pregnancy; diagnostic; treatment; hysterectomy

1 Introduction

Molar pregnancy is a rare entity, with an incidence of approximately 1 in 1000 pregnancies in most parts of the world [7]. Among ectopic pregnancies, molar changes may be rarely found [1,8]. Therefore, ectopic molar pregnancy is a very rare occurrence and consequently not often considered as a diagnostic possibility. The final diagnosis is made on histopathology. The uterine horn is the least frequent site for location of ectopic pregnancies, with 2.4% of cases [9]. Ectopic pregnancies located at the uterine horn are difficult to treat because bleeding is not easy to control, especially if they are at an advanced gestational age [6].

2 Case presentation

A 35-year-old woman, gravida 4 para 3 referred from a neighboring health center for a suspected ruptured ectopic pregnancy, was admitted at the Dschang District hospital, in the West Region of Cameroon. She had a 12 weeks history of amenorrhea with 2 months of abdominal pain and discomfort, but no episode of per vaginal bleeding. Her last pregnancy ended with a normal vaginal delivery of a live male baby three years ago. She had not used any contraceptive method in the past and had not been exposed to any potentially teratogenic substance during the last four months. No history of pelvic inflammatory disease, diabetes, hypertension or tobacco use was found. She was a farmer and housewife, married at the age of 23. Her 49 years old husband was a farmer, and both of them were living in the village.

Her main complaints were asthenia and swollen painful abdomen.

On physical examination at entry, her blood pressure was 110/65 mmHg, heart rate 104 per minute, weight 67 Kg, and temperature 37.3 °C. The conjunctivae were pale, and the abdomen distended, with shifting dullness, suggestive of the presence of fluid in the abdominal cavity. Ultrasound exam was not done for technical reasons. The machine was not functioning, and the nearest referral hospital was at 50 km. The patient being hemodynamically unstable, it was risky to refer her. She could have died on the way. A pregnancy test done was positive, and paracentesis revealed non-clotting blood. The diagnosis of a ruptured ectopic pregnancy was made and the patient prepared for emergency laparotomy. Her blood group was A positive, hemoglobin at 7 gms/dl, and a hematocrit of 18%. Her bleeding and clotting times were normal.

Per-operative findings were hemoperitoneum estimated at 2500 mL, swollen villi in clusters that looked like bunches of grapes, characteristic of a complete hydatiform mole, located at the left horn of the uterus (Figure 1). The distal part of the tube was normal. Both ovaries were polycystic and very enlarged, measuring 60 × 60 × 30 mm for the left side and 85 × 50 × 40 mm for the right side. After removal
of the molar tissues, it was not possible to control the bleeding, because the uterine corn was very soft and fragile to support the least tension from suturing. The only solution was to remove the uterus. We then did a total abdominal intrafacial hysterectomy, with left side annexectomy. On the right side, only a 20 × 10 × 10 mm ovarian tissue was left. Transfusion of 1000 mL of blood was done during the operation and 500 mL the following day.

Histopathology examination confirmed the diagnosis of a complete hydatiform mole, with cystic endometrial hyperplasia, polycystic Stein Leventhal ovaries, and a low grade cervical dysplasia (CIN 1).

There were no post operative complications, and she was discharged on day 8. Reviewed 6 weeks post operatively, she was clinically normal, and a qualitative \( \beta \)hCG test done was negative. The following year, she was fine, with a negative \( \beta \)hCG test.

3 Discussion

The diagnosis of molar tubal ectopic pregnancy is difficult clinically and by ultrasound because it mimics normal tubal pregnancy [2]. In developing countries the most cases are diagnosed late, mostly at the ruptured stage leading to a complex situation [3]. Our case was at a late stage, with massive hemoperitoneum but with a normal blood pressure, suggestive of chronic hemorrhage. However, ultrasonography was not done. It might have at least revealed the huge polycystic ovaries which are common in molar pregnancies [5] and therefore incited us to check for it.

Cornual location of ectopic pregnancy is rare, estimated at 2.4% [6], and bleeding is not easy to be stopped as sutures involve the uterus which is particularly fragile at this moment when reproductive hormones are secretly abundant. In case of a molar pregnancy, the secretion of these hormones is even greater than in a normal pregnancy [5]. This may explain the difficulty we encountered in controlling the bleeding, which eventually motivated hysterectomy. According to some authors, mortality in uterine horn located pregnancy is twice that of any other type of Fallopian tube ectopic pregnancy [9]. Bunch of grapes’ appearance is usually seen when the complete mole is present in the second trimester, and is due to swelling of chorionic villi [5]. Our case was typical (Figure 1), usually described at an advanced stage of the pregnancy.

Total intrafacial hysterectomy was done because the surgeon had a good experience and did not face any particular difficulty during the intervention. Otherwise, a subtotal hysterectomy would have been the better alternative in such an emergency situation.

Polycystic ovaries common in molar pregnancies often regress after the evacuation of the products of conception [7]. On this basis, oophorectomy is not necessary. We did a total left side ovariectomy and left only a bit of ovarian tissue on the right side for hormonal functions. We were motivated by the fact that the ovaries were very large and liable to complications and they were no longer needed for procreation.

Molar pregnancy can be treated by uterine evacuation followed by monitoring of \( \beta \)hCG [5]. Some authors associate chemotherapy with Methotrexate [4,5]. In our case, it was not technically and financially possible to do a quantitative monitoring of \( \beta \)hCG. Only a qualitative test was done. We abstained from chemotherapy, because the most molar pregnancies resolve spontaneously after evacuation only [5]. Moreover, the patient was unable to pay for medication and follow-up serial \( \beta \)hCG tests which were not possible to be carried out in our semi rural area.

4 Conclusion

Molar pregnancy can be ectopic. If the implantation site is in the uterine horn, bleeding into the peritoneal cavity may be chronic, without associated per vaginal blood loss and the patient may consult at an advanced stage of pregnancy, especially in poor African communities. Surgical control of bleeding at the uterine horn may be very difficult and hysterectomy is the only solution to save the patient’s life. Histological examination of the hysterectomy specimens is mandatory.

References


