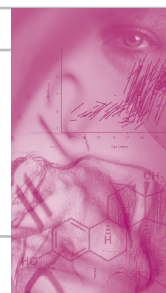


Complete hydatidiform mole in a 57-year-old woman

A case report



Jacqueline Goedhals, MB ChB, MMed (Path)

Department of Anatomical Pathology, National Health Laboratory Service and University of the Free State, Bloemfontein

Michiel C Botha, MB ChB, MMed (Rad Onc)

Department of Oncology, University of the Free State

Magda Theron, PhD

Division of Human Genetics, National Health Laboratory Service and University of the Free State

Catherine A Beukes, MB ChB, MMed (Path)

Department of Anatomical Pathology, National Health Laboratory Service and University of the Free State

Gestational trophoblastic disease represents a spectrum of lesions characterised by an abnormal proliferation of trophoblast. The incidence of pregnancy in perimenopausal women is extremely low, most pregnancies that occur ending in spontaneous abortion. We report on a 57-year-old patient with a complete hydatidiform mole to emphasise that this diagnosis should still be considered at an older age.

Gestational trophoblastic disease (GTD) represents a spectrum of lesions characterised by an abnormal proliferation of trophoblast, including complete hydatidiform mole, partial hydatidiform mole, invasive hydatidiform mole, choriocarcinoma, placental site trophoblastic tumour, epithelioid trophoblastic tumour, placental site nodule and plaque, and exaggerated placental site reaction.¹ Complete mole is characterised by gross hydropic villous swelling with some degree of circumferential and haphazard trophoblast proliferation microscopically.² The incidence of pregnancy in perimenopausal women is extremely low. Most pregnancies that occur will end in spontaneous abortion. In the remaining pregnancies the incidence of GTD is greatly increased.³ Only isolated cases of hydatidiform mole in elderly women have been reported in the literature.^{3,4} We report on a patient aged 57 years with a complete hydatidiform mole to emphasise that this diagnosis should still be considered at an older age.

Case report

A 57-year-old woman, gravida 2, para 3, presented to her local casualty department with a 4-week history of vaginal bleeding, loss of appetite and vomiting.

Because of her age she was initially assumed to be postmenopausal, but it was later found that prior to the onset of these symptoms she had had a regular menstrual cycle. Her first pregnancy had been in 1972, and the second had been a twin pregnancy in 1982. She was not using any form of contraception. On examination vaginal haemorrhage, a yellowish vaginal discharge and an enlarged uterus were noted. The possibility of a myomatous uterus or cervical carcinoma was considered and the patient was referred for an ultrasound scan, which was suggestive of a molar pregnancy. A dilatation and curettage was performed and histological examination revealed chorionic villi with marked hydropic degeneration, cistern formation and non-polar trophoblast proliferation compatible with a complete hydatidiform mole. This was confirmed with genetic studies, which showed a 46XX genotype. The serum quantitative β -human chorionic gonadotropin (β -hCG) level was measured for the first time 2 weeks after the dilatation and curettage and was 909 IU/l. Follow-up showed a steady downward trend in the level, which was undetectable within 2 months. In view of the patient's age she was referred for a hysterectomy, which showed no evidence of residual disease. Beta-hCG levels remain undetectable 1 year after initial diagnosis.

Discussion

Pregnancy is extremely rare in women over 50 years of age, and when it occurs the outcome is frequently abnormal.⁴ As cited by Tsukamoto *et al.*, Stanton estimates an abortion rate of about 80% in women over 47 years of age and a 20-fold increase in the incidence of hydatidiform mole in women over 45, while Shiina and Ichinoe report that the incidence of hydatidiform mole for women over 45 years is 25 times higher than for women under 34 years.⁴ They also state that the secondary occurrence of invasive mole and choriocarcinoma after hydatidiform mole increases significantly after the age of 35, with a 31% occurrence of secondary trophoblastic disease following hydatidiform mole in women over 45 years of age.

Recognition of GTD becomes more difficult in women over 50 years of age, as menopause is expected and the possibility of pregnancy is often overlooked or denied.⁵ GTD is therefore usually not included in the differential diagnosis of perimenopausal bleeding in women in this age group.⁵ Our patient was assumed to be postmenopausal, and the initial differential diagnosis included a myomatous uterus or cervical carcinoma. A molar pregnancy was not suspected and β -hCG levels were not determined. It was only after an ultrasound scan that the possibility of a molar pregnancy was raised.

In women aged over 35 years the risk of post-molar GTD after suction curettage appears to be increased, and

is reported to be as high as 56% in women over 50. In these women, who have completed their child bearing, evacuation via hysterectomy offers the advantage of simultaneous treatment and sterilisation and appears to decrease the risk of post-molar GTD.⁶ However, there remains an 8 - 20% risk of post-molar GTD in the elderly patient after hysterectomy, and close follow-up with serum β -hCG is indicated.⁶ Our patient had completed her family and it was decided that a hysterectomy should be performed. No residual trophoblastic disease was found and to date the β -hCG levels remain undetectable.

This case highlights the fact that patients over 50 years of age should not be assumed to be postmenopausal. Gestational trophoblastic disease can occur in older patients and should be included in the differential diagnosis of perimenopausal haemorrhage to prevent a delay in diagnosis and treatment.

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