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Case Study

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A RARE CASE OF BICORNUATE UTERUS WITH MOLAR PREGNANCY

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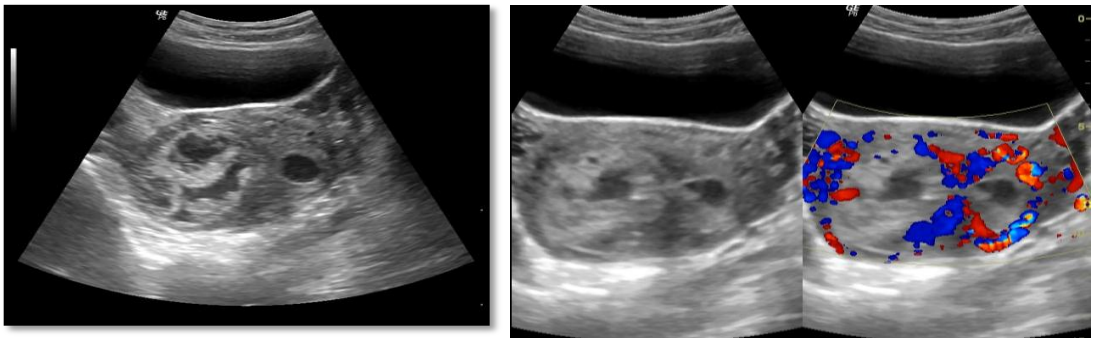
KEYWORDS: Mullerian duct anomalies; Bicornuate uterus; Molar pregnancy; Hydatiform mole; Gestational trophoblastic disease (GTD)

INTRODUCTION

Bicornuate uterus results from abnormal development of paramesonephric ducts and accounts for approximately 20% of all mullerian duct anomalies. The most common symptomatic presentation is early pregnancy loss and cervical incompetence. Hydatiform mole is a type of molar pregnancy which can be partial or complete. Molar pregnancy with uterine anomalies is a rare entity and there is high risk of rupture of uterine horn with advanced gestation. Ultrasound and magnetic resonance imaging play crucial role in early detection of uterine anomalies and type of molar pregnancy.

CASE REPORT

We report a case of 30 year old female, para 0101, was planned for laparoscopic sterilization. She had previous history of first trimester spontaneous abortions and one cesarean section. During the pre-operative workup, urine pregnancy test was positive and ultrasound pelvic organs was done to rule out pregnancy.

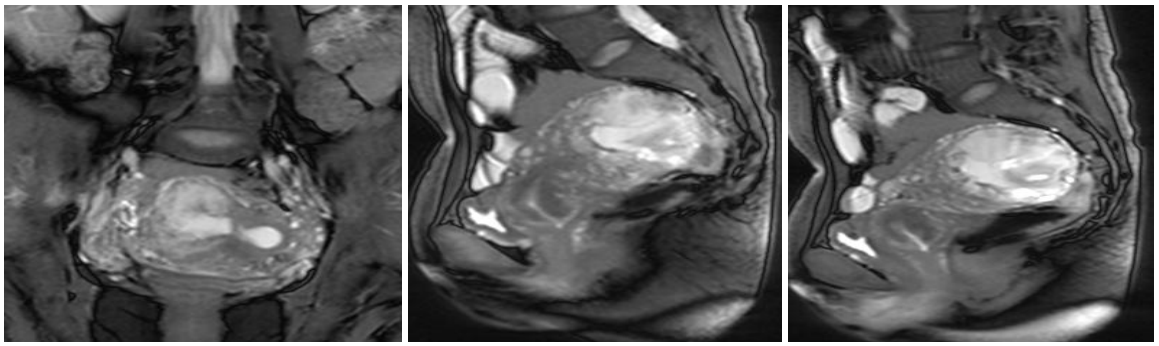


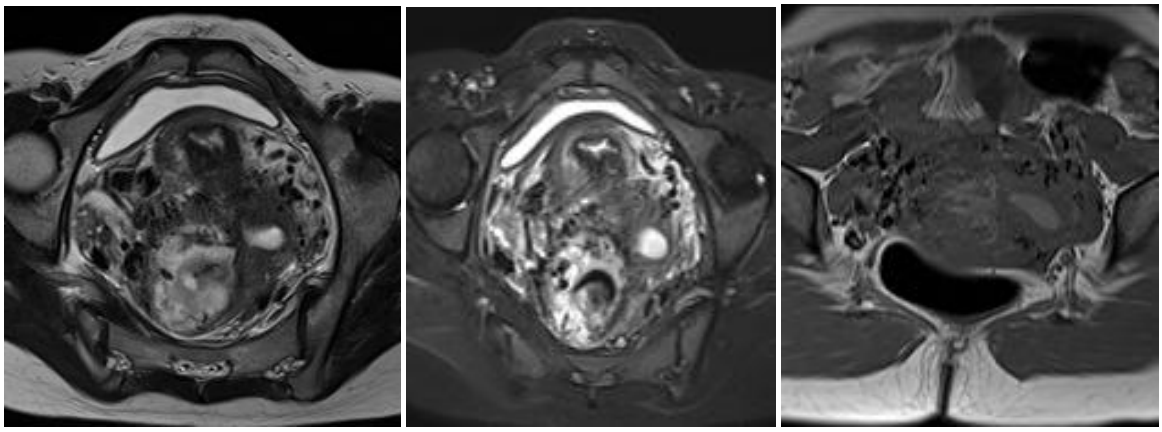
Ultrasound pelvic organs showed two separate endometrial cavities. Right cavity showed presence of heterogenous cystic lesion with loss of endo-myometrial definition and raised peripheral vascularity. Left endometrial cavity showed fluid in canal.

A diagnosis of bicornuate uterus with right sided invasive molar pregnancy was kept.

Serum beta-HCG was 2650 mIU/ml on day 1 of admission and 3490 mIU/ml day 3.

For further evaluation, MRI pelvic organs was requested.





MRI images showed presence of two endometrial cavities with single cervical canal suggestive of bocornuate uterus.Thick walled cyst at cornual end of right cavity with hetrogenous mass and cystic areas extending into myometrium suggestive of invasive type molar pregnancy. Multiple flow voids were seen in the periphery of myometrium on right side.

Patient underwent hysterectomy and histopathology confirmed presence of gestational trophoblastic disease i.e. invasive mole.

DISCUSSION

Molar pregnancy also known as gestation trophoblastic disease, can be classified into

Hydatiform mole (partial or complete);
Invasive hydatiform mole;
Placental choriocarcinoma;
Placental site trophoblastic tumor.

Invasive molar pregnancy develops after evacuation of molar pregnancy in 10 -20 % cases and infrequently after normal pregnancy. It arises from hydatifrom mole and is characterized by invasion of myometrium by hydropic chorionic villi. There is proliferation of trophoblasts and invasion of parametrium and blood vessels. Such moles are locally invasive however lack tendency to develop widespread metastases.

Mullerian duct anomalies are associated with increased risk of pregnancy loss, malpresentation and intrauterine growth restriction. Bicornuate uterus has 39% increased risk of preterm birth and other complications as early pregnancy loss. Magnetic resonance imaging is the investigation of choice for evaluation of mullerian duct anomalies and surgical planning for proper management of pregnancy.

CONCLUSION

Ultrasound and MRI play key role in diagnosis of mullerian duct anomalies and GTD, guiding their management and early detection of complications. Surgical treatment with chemotherapy has shown to achieve remission.

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