MOLAR PREGNANCY IN TUBAL ECTOPIC PREGNANCY
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• Ecstatic pregnancies occur in 1-2% of all pregnancies and partial or complete hydatidiform mole occur in approximately 0.1-0.2% of all pregnancies.
• The incidence of hydatidiform mole in tubal pregnancy is a therefore very rare entity and not one that will immediately occur to one’s mind when faced with an ectopic pregnancy.
• We described 2 such cases which varied in its presentation, diagnosis and management processes; and conveyed the importance on following up on histological examination of products of conception to provide an appropriate diagnosis in order to aid the clinician in offering appropriate counselling and follow-up for the patient.

CASE ONE
This is a 35 years old Irish Caucasian Para 1 (SVD) woman with no significant medical history and does not drink or smoke. Her period cycle is irregular ranging from 28 to 32 days. LMP was known. This is a spontaneous conception.
1st EPU: 7 weeks – 5mm structure that was identified as a gestational sac though had no yolk sac or fetal pole within it (Figure 1). No abnormal adnexal structure. Comfortable throughout scan. Labelled as PUV. Planned for review 2 weeks later.
2nd ER: 8 weeks 2 days – Abdominal cramps and PV spotting. Examination was deemed reassuring although a transabdominal ultrasound showed an empty uterus.
3rd ER: 8 weeks 3 days – BIBA for 2 episodes of vasovagal attacks and abdominal pain. TVUS: 2cm left adnexal mass with haemoperitoneum (Figure 2).

Treatment:
Laparoscopic left salpingectomy with uncomplicated post-op.

Histology:
Combined p57 (kip2) imprinted gene analysis and chromosome 17 silver in-situ hybridisation (SISH) confirmed the ectopic gestation tissue to be a partial mole.

Follow-up:
Pre-op BhCG : 17, 408 IU/L. Took 3 weeks to reduce to <5 IU/L before she was finally discharged with another blood test 4 weeks later.

CASE TWO
This is a 25 years old woman of Nigerian origins with a previous history of left live ectopic pregnancy. Her period cycle is irregular ranging from 30 to 60 days. LMP was unknown.
1st ER: Right iliac fossa pain and brown PV spotting. Reassuring clinical assessment. Declined offer of admission (previous history of ectopic). BhCG was done and followed up. 1st BhCG: 115 IU/L. 2nd BhCG (48 hours later): 332 IU/L. Arranged for an early pregnancy ultrasound 6 days later in view of doubling of low BhCG levels.
1st EPU: BhCG: 1063IU/L. Empty uterus. No suspicious adnexal mass. Planned for BhCG levels every 48 hours.
2nd EPU: BhCG: 1660IU/L. 1.6mm right fallopian tubal pregnancy with a 9.7mm gestational sac and yolk sac (Figure 3). Asymptomatic and comfortable throughout scan. Planned for further BhCG levels.

Treatment:
Laparoscopic right salpingostomy (as already had left salpingectomy). Methotrexate was not likely to be successful with a developing ectopic and increasing BhCG (2949IU/L prior to surgery).

Histology:
Combined p57 (kip2) imprinted gene analysis and chromosome 17 silver in-situ hybridisation (SISH) confirmed the ectopic gestation tissue to be a partial mole.

Follow-up: BhCG levels to ensure resolution of ectopic post salpingostomy and as part of partial molar protocol.

DISCUSSION
• It is important that routine histological examination be performed on all ectopic pregnancy to raise suspicion of molar changes and to follow-up with gene analysis to confirm or exclude diagnosis.
• Early suspicion of hydatidiform mole is important in order to commence BhCG levels follow-up as malignant potential in tubal pregnancy is similar to that in an intrauterine pregnancy.
• In the case of a small sac seen in the uterus that does not have a yolk sac or fetal pole, it is best to assume it as a pseudosac and supplement the investigation with BhCG levels; which should be interpreted cautiously.

CONCLUSION
• Doubling of BhCG indicate that the pregnancy is only likely located intrauterine and does not confirm it as an intrauterine pregnancy.
• Molar pregnancies in intrauterine location often present with elevated BhCG levels.
• It would be interesting to have studies assessing BhCG levels rising trends in ectopic molar pregnancies.