

## UTERINE PERFORATION AS A SEQUEL TO REPEATED CURETTAGE FOR MOLAR

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### ABSTRACT

An 18 year old girl was subjected to emergency hysterectomy and unilateral salpingo-oophorectomy for uterine perforation because of repeated dilatation and curettage for persisting vaginal bleeding following molar evacuation.

As significant proportion of molar do progress into Gestational trophoblastic Neoplasia which in this case was choriocarcinoma; directs our attention to the fact that proper follow up of post molar cases using at least urinary beta HCG and instituting chemotherapy whenever necessary should be advocated in order to avoid such a drastic management.

**Key Words:** *Uterine perforation, molar, Gestational Trophoblastic Neoplasia (GTN)*

### INTRODUCTION

Early recognition and evacuation of abembryonic pregnancy, may reduce its' progression to molar formation.<sup>1</sup> If this concept holds true, this may further help to lower the burden of persistent Gestational Trophoblastic Disease (PGTD), as 10% of molar may persist as invasive mole or choriocarcinoma that requires further treatment, metastatic GTD occurring in 4% of the patients after evacuation of complete molar.<sup>2-3</sup> A free beta HCG may be able to predict those cases that are most likely to progress from molar to choriocarcinoma.<sup>4</sup>

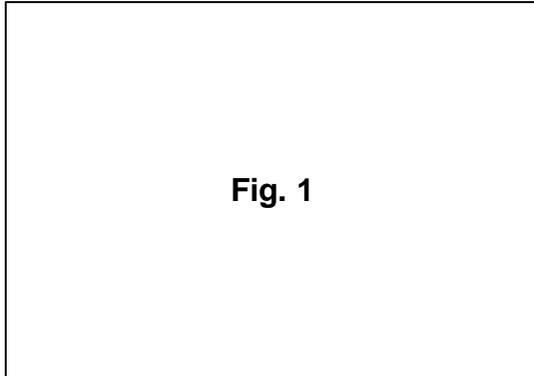
Gestational trophoblastic disease poses a significant problem in our country because the potentiality of every mole developing to persistent GTD is less recognized. The place of serum beta HCG as a guideline to measure the state of the disease, either progression – regression or chemotherapeutic effectiveness has yet to be practiced apart from the clinical symptoms. We therefore report a case of molar pregnancy, which progressed to choriocarcinoma within a short period, complicated also by uterine perforation and severe sepsis due to repeated curettage performed six times for persistent vaginal bleeding.

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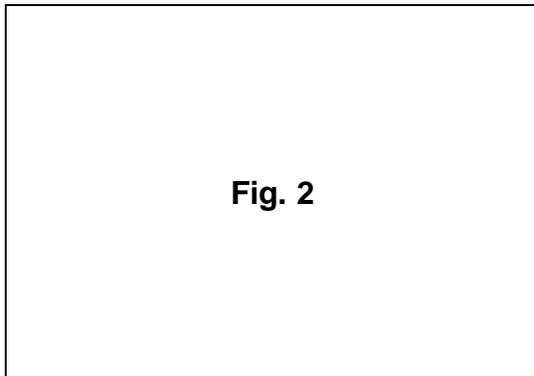
**CASE**

An 18 year old girl was admitted in shock with features of intraperitoneal bleeding as the peritoneal aspirate, obtained under USG guidance, revealed blood. The mass along with uterus could not be properly delineated in USG (fig.1), or clinically

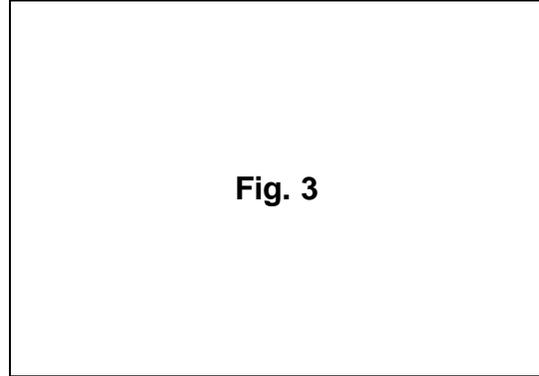
**Fig. 1**

*Fig. 1 : USG picture showing ill defined mass.*

due to abdominal distension. Even in the presence of severe anaemia (Hb 4 Gm %) and leukocytosis of 26,000 we performed laparotomy because of the suspected uterine perforation. There were multiple perforations, few of them which were sealed partially by omentum and dense adhesions with formation of pyoperitoneum in the morrison's pouch and paracolic gutters. Subtotal hysterectomy with unilateral salpingo-oophrectomy was performed. The uterus measuring 14x10cm had multiple perforations (fig.2) and on cut section was packed with greenish material looking like fresh cow shit (fig.3). For the first three post operative

**Fig. 2**

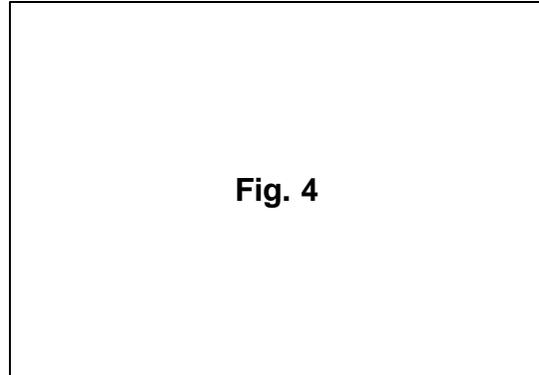
*Fig. 2 : Gross picture seen are (m) metastatic deposit with perforation.*

**Fig. 3**

*Fig. 3 : Cut section of uterus filled up with greenish collection.*

days invasive monitoring was done to combat the septic shock with Dopamine and Dobutamine along with antibiotics. However there was no renal shut down or DIC. Unfortunately relaparotomy was needed to drain the pyoperitoneum after the second week of the primary surgery.

Multiple rounded discrete densities were noted on chest x-ray (fig.4) and CT Scan (fig.5). WHO

**Fig. 4**

*Fig. 4 : Chest X ray : coin shadow.*

prognostic scoring was 5 but single agent chemotherapy; methotrexate and folinic acid rescue was started from the 3<sup>d</sup> day of relaparotomy. A small gap noticed in the abdominal wound was resutured after the removal of tension sutures.

Meanwhile, the urinary HCG which was positive in 1/128 dilution before instituting chemotherapy was negative in the neat sample after completion of the third course of chemotherapy.

**Fig. 5**

**Fig. 5 : CT Scan, which clearly defines the metastasis.**

### DISCUSSION

To summarise, this is a patient who subsequently underwent dilatation and curettage number of times in various centers and received 13 units of blood transfusion for persistent vaginal bleeding following evacuation of complete mole in a 18 weeks size uterus at 10 weeks period of gestation. Finally, she had to undergo emergency sub total hysterectomy for multiple uterine perforation and intraperitoneal bleeding. Her haemoglobin was 4 Gm % and total leucocyte count 26,000. A relaparotomy was needed for pyoperitoneum. All this could have been avoided if careful monitoring had been done, suspecting it as a case of persistent GTD when she repeatedly presented with acute bleeding episodes. She was curetted repeatedly and not once was she thought to be a case of PGTD. This teaches us a stitch in time saves nine. There was no choice left other than removal of the uterus in this young girl. Although the surgery has been claimed to play a important part in primary disease as well, she is not a case one likes to perform this drastic procedure.

Methotrexate with Folinic acid rescue, has lowered the urinary HCG but this is not a reliable method to monitor sufficiently. Even in tertiary center like ours unavailability of serum beta HCG causes difficulty in proper management of these cases. As 80 % do have lung involvement, even in this case there were multiple lung metastases seen as discrete rounded densities and HCG remission may not

coincide with the radiological resolution, this may pose another problem.

### CONCLUSION

The concept that non embryonic pregnancy should be evacuated once diagnosed to evade the proliferation of the developing mole can hardly be practiced in our set up, as the patient usually report with full blown picture.

Moreover, the whole aetiological process involved to a larger extent on the spontaneous regression and death of the trophoblast following molar evacuation with the possibility of yet leaving behind 10% of the cases where the disease progresses or recurs as an invasive mole or choriocarcinoma requiring further treatment for PGTD is less understood. And that either being unaware of, which is hard to believe, follow up is left aside. Those who know that the Metastatic GTD occurs in 4% of the patient after the evacuation of the complete mole, thereby needing a follow up do not also take this seriously.

This case of an 18 year girl who underwent six D and C and subtotal hysterectomy for uterine perforation is an example, which should alert everyone of us in essence of follow up in the proper management of GTD.

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