

# GESTATIONAL TROPHOBLASTIC DISEASE IN A 54-YEAR OLD WOMAN - A CASE REPORT

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## ABSTRACT

A rare case of gestational trophoblastic disease (GTD) in a 54-year old Malay woman is described. A total abdominal hysterectomy with bilateral salphingo-oophorectomy was done. She was given methotrexate therapy as she had persistent high levels of serum B hCG.

**Keywords:** Gestational trophoblastic disease (GTD), Women over 50 years.

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## INTRODUCTION

Women over the age of 50 rarely become pregnant and when pregnancy does occur it is frequently abnormal. Stanton (1) estimates an abortion rate of 80% in women over the age of 47 years and a 20-fold increase in the incidence of hydatidiform mole in women over 45 years of age. Jequier and Winterton (2) reviewed world literature and found only 109 cases of trophoblastic disease in women over the age of 50 years.

## CASE HISTORY

This 54-year old Malay, para ten, was seen with complaints of per vaginal bleeding of twenty days duration following twelve weeks of amenorrhoea. Prior to this she had menstruation regularly, every thirty days with normal flow of seven days duration. She also had swelling of both her feet.

She had undergone ten pregnancies with no complications, all resulting in spontaneous vaginal deliveries at term. There were no postpartum complications. Her last child birth was eleven years ago. She was not on any form of contraception. She had no history of hypertension.

On examination, her general condition was fair. Her blood pressure was 160/100 mm of Hg and pulse 74 per minute. There was pedal edema. Systemic examination was normal. On abdominal examination, there was a mass corresponding to 16 weeks gestational size. The uterus was uniformly enlarged, soft and non tender. The findings were confirmed on vaginal examination.

Her haemoglobin, total white differential count, platelets and renal profile blood sugars were normal. Chest radiograph showed cardiomegaly with no other abnormalities. Urine gravindex was positive in 1:128 dilutions. Ultrasonography confirmed a molar pregnancy.

The patient was informed of the diagnosis and consented to a total abdominal hysterectomy with bilateral salphingo-oophorectomy which was done on 16 Aug 1986 under methotrexate cover. Fifty mgm of methotrexate as infusion was started half an hour before the operation. Her hypertension which persisted post operatively was controlled with prazosin. Histopathology revealed a hydatidiform mole. There was no evidence of invasion or choriocarcinoma. Her urine gravindex was negative by two weeks of the date of operation.

On follow-up, her blood pressure was normal and the urine gravindex remained negative but 3 months later her serum B hCG was more than 400 IU/L. All other investigations were normal. She was admitted for chemotherapy. She was given intramuscular methotrexate 2.5 mg six hourly along with intramuscular folic acid 6 mg daily for five days.

She had no complications during chemotherapy. After completion of three courses of chemotherapy at intervals of three weeks, her serum B hCG was normal. She has been regularly followed up with no complications or evidence of trophoblastic disease.

She is well, three and half years after the initial diagnosis, surgery and chemotherapy. She is on a six monthly regular follow-up.

## DISCUSSION

The incidence of gestational trophoblastic disease (GTD) at Seremban General Hospital has been around 1:420 deliveries. The incidence of invasive mole and choriocarcinoma was 10% of the total number of GTD. This patient was the only one above the age of 50 years. A high degree of suspicion is thus required to diagnose GTD in this age group.

Though this patient was 54 years old, she had been menstruating regularly. She had amenorrhoea of 12 weeks with an uterus corresponding to 16 weeks gestation.

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The uterus was soft and no foetal parts were felt. The associated pedal edema and hypertension strengthened the suspicion. The ultrasound confirmed the diagnosis. However, these very signs can lead to a host of other diagnoses rather than GTD as revealed by Jequier and Winterton (2).

This patient was considered a high risk patient as the interval between the current diagnosis and the antecedent pregnancy, which was a full term pregnancy, was a long eleven years (3). In these high risks patients, primary hysterectomy and adjuvant chemotherapy significantly reduces the number of courses of chemotherapy alone especially in patients with tumour load in the uterus (4). The hysterectomy was done under methotrexate cover by an intravenous infusion as a prophylactic measure against the development of metastatic choriocarcinoma as it has been shown by Chan (5) and others (6,7) that trophoblastic deportation during treatment of molar pregnancy may result in subsequent malignant transformation after a variable latent period.

The histopathology of the specimen revealed no evidence of invasive mole or choriocarcinoma. The urine gravindex which was positive in 1:128 dilutions before the operation was negative within 2 weeks of the hysterectomy. She was nevertheless closely followed-

up and this revealed the caution was not unfounded when her serum B hCG began to rise 3 months later. Tsukamoto et al (8), in their report of twenty cases of GTD in women over 50 years of age, gave an incidence of secondary trophoblastic disease in their 16 hydatidiform mole patients to be as high as 56.3%. Jequier and Winterton (2) in their review of 109 cases of GTD in women over 50, found a malignancy rate of 25%.

The primary hysterectomy and the prophylactic chemotherapy in our high risk patient were beneficial to the patient as shown by subsequent response to chemotherapy. She only needed 3 courses of chemotherapy for serum B hCG to return to normal and she has been free of the sequelae of GTD for the last 3 1/2 years.

## CONCLUSION

GTD is an extremely rare condition in women over 50 years of age and a high level of suspicion is needed for its diagnosis. The malignant sequelae of hydatidiform mole in this age group is high. Thus primary hysterectomy with prophylactic chemotherapy with strict follow-up with serum B hCG assays are indicated.

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