CASE REPORT: HYDATIDIFORM MOLE WITH ECLAMPSIA

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Mrs. M.B., a 32 year old grand multipara, presented at the Victoria General Hospital bleeding per vagina and convulsing. She had a history of 14 weeks amenorrhea, bleeding p.v. of unknown duration, and convulsions which had been occurring intermittently for several hours. Physical examination per abdomen revealed a uterine fundus two fingerbreadths above the umbilicus and an absence of fetal heart sounds. Peripheral edema was noted and four-plus albuminuria and hematuria were discovered by urinalysis. Her blood pressure was 210/130. Pelvic examination revealed dark blood in the vagina and a long, closed cervix. Her hemoglobin level was 11.3 gm.%.

A clinical diagnosis of hydatidiform mole with eclampsia was made and the patient was immediately sedated with Magnesium Sulphate and Sodium Amytal. On the next day, an attempt was made to induce passage of the mole with a drip containing 10 units of Pitocin. The dosage was increased stepwise until 200 units per bottle of fluid had been tried and had failed. On the third day in hospital, the drip was stopped and a hysterotomy was performed, yielding 1000 c.c.'s of molar tissue. Bilateral lutein cysts, approximately 6 inches in diameter, were noted.

On her fourth day in hospital, an A-Z test was positive in all dilutions. Her subsequent course was uneventful and she was discharged on the tenth day. An A-Z test done then was positive to a 30% dilution

At the patient's first follow-up visit to Outpatient's Clinic one week later, examination revealed that the uterine fundus was at the level of the umbilicus. Two weeks later it was found to be enlarging and she was admitted again, four weeks after leaving hospital. She gave a history of light bleeding daily for the past four weeks, accompanied by slight lower abdominal pain, and a 15 pound weight gain. Physical examination revealed large cystic ovaries and an enlarged uterus, but no other abnormalities. Urinalysis was negative and her blood pressure was 128/80. The A-Z test was positive only when undiluted. Dilatation and curretage produced only necrotic decidua without any chorionic villi.

On the sixth day after admission, treatment was begun with Methotrexate, 5 mg. q.i.d. X 5, but this regime was stopped after two days when her white blood cell count dropped sharply (to a low point of less than 3,000 cells/cu.mm.). When it had risen over 5,000 cells/cu.mm. eleven days later, the treatment was renewed at a lower dosage – 5 mg. b.i.d. . for fourteen days. During this time no side effects developed, her white blood cell count remained within normal limits, her A-Z test went negative, and she resumed menstruation. She was released from hospital on the last day of Methotrexate treatment.

She returned two weeks later for follow-up. She had no complaints, and physical examination revealed no abnormalities except ovarian cysts which were smaller that at previous examinations. Her A-Z Test was negative in all concentrations. She was released in three days to be followed by Gynecology Outpatient's Clinic and the N. S. Tumour Clinic. She was given Ortho-Novum and was followed until she stopped attending Clinic two months later.

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