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Case Report

Invasive Hydatid Cyst In An Elderly Patient: A Case Report.

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Abstract

Introduction: Gestational trophoblastic disease encompasses conditions resulting from abnormal trophoblast proliferation following abnormal fertilization, including hydatidiform mole, trophoblastic neoplasia, and trophoblastic tumors. Invasive hydatidiform mole infiltrates the myometrium and uterine vessels, exhibiting malignant and metastatic behavior; its incidence is 10%. Clinical suspicion arises from persistently elevated human chorionic gonadotropin levels following curettage for molar disease, especially in women of extreme reproductive ages. The definitive diagnosis is histological, showing villi with molar changes infiltrating the myometrium. Treatment is dual, consisting of hysterectomy and chemotherapy.
Clinical case: A 54-year-old female patient with a history of systemic hypertension, hyperthyroidism, and uterine fibroids. Allergic to naproxen. G2 C1 (1994). She presented transvaginal bleeding that had been ongoing for one month, progressively increasing in volume, requiring the use of 10 wet pads, with abundant clots, and colicky pain rated 9/10 on the EVA scale in the hypogastrium, accompanied by asthenia and adynamia. Ultrasound findings were suggestive of uterine myomatosis; therefore, a hemostatic uterine curettage was performed, with endometrial tissue biopsy, requiring a blood transfusion of three red blood cell concentrates. A positive pregnancy test and a progressive elevation of the beta-hCG level were noted, suggestive of a complete molar gestational trophoblastic disease, confirmed by biopsy and a Berkowitz score of 9. Following persistence of human chorionic gonadotropin for 3 weeks thereafter, she was referred to surgical oncology, where a total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed. The final diagnosis was invasive hydatidiform mole, with no evidence of metastasis, and an adequate response to treatment.

Keywords: Invasive hydatidiform mole, advanced age.

INTRODUCTION

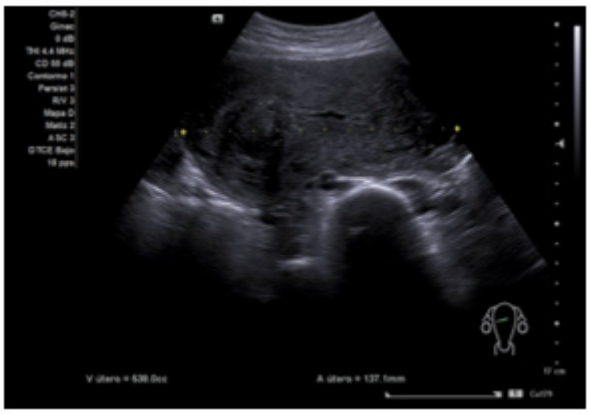
Gestational trophoblastic disease includes complete and incomplete hydatidiform moles, invasive moles, choriocarcinoma, and placental-site or epithelioid trophoblastic tumors. The invasive mole, also known as chorioadenoma destruens, is distinguished by its invasion of the miometrium or uterine vessels. It possesses high malignant potential due to its ability to infiltrate and metastasize to the vagina, vulva, broad ligament, or lungs. Incidence rates vary globally: approximately 1 per 500 pregnancies in Asia compared to 1 per 1,500 in Western countries. In Mexico, the incidence is estimated at 2.4 per 1,000 pregnancies, though this is likely underestimated.

CLINICAL CASE

The patient is 54 years old with a history of hypertension (enalapril 10 mg/day) and recently diagnosed hyperthyroidism (thiamazole 10 mg three times/day). She is allergic to naproxen and dexamethasone. Her last menstrual period was in September 2025. She sought care at Hospital General ISSSTE Ignacio Zaragoza for one month of heavy transvaginal bleeding (using 10 pads per day), intense abdominal pain, and fatigue. Physical examination revealed tachycardia, pallor, a painful abdomen, and an open cervical os with heavy bleeding. An initial ultrasound suggested large-element uterine myomatosis. (16 x 18 x 8 cm). (**Figure 1**)

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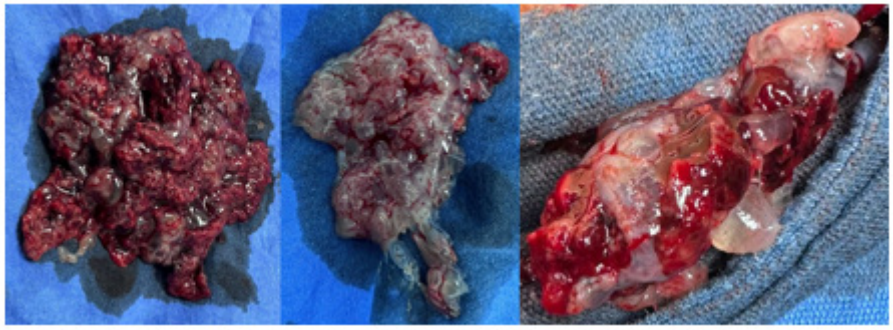
Figure 1. Initial ultrasound.



During the physical examination, the patient maintained a perfusional mean arterial pressure but presented with tachycardia, pallor, and abdominal tenderness upon palpation. The uterine fundus was located at the level of the umbilicus. Digital vaginal examination revealed an open external cervical os and heavy bleeding with clots.

As a result, admission was decided on March 18, 2024, with laboratory workup initiated and administration of crystalloid solutions. An instrumental sharp curettage (D&C) was performed 30 minutes after admission, including an endometrial tissue biopsy. An initial hysterometry of 20 cm was noted; abundant translucent, vesicular, and hemorrhagic tissue was obtained and sent to pathology (**Figure 2**).

Figure 2. Instrumented uterine curettage material with multiple translucent vesicles and hemorrhagic tissue.



Estimated blood loss was approximately 500 cc, superimposed on severe anemia (5.5 g/dL), requiring a blood transfusion of two units of packed red blood cells. Additionally, with a positive pregnancy test (PT) and a clinical suspicion of gestational trophoblastic disease, the following auxiliary diagnostic tests were requested (**Table 1**).

Table 1. Auxiliary Diagnostic Tests.

	QUANTITATIVE B-HCG	BLOOD COUNT (CBC)	BLOOD CHEMISTRY	THYROID FUNCTION TESTS (TFTS)	IMAGE
18.03.26		HB 5.5 PIE POSITIVE			
19.03.26	236 623	HB 6.4 HTO 20.2 VCM 86.8 HCM 27.4 PLAQ 237	GLU 84 UREA 50.4 BUN 23.6 CR 0.79 BD 0.1 BT 0.12 BI 0.02 AST 19.2 ALT 6.57 FA 56.5 DHL 339 TP 10.3 INR 0.94 TTPA 22.6 TT 30.5	TSH 0.01 T4 TOTAL 9.8	USG hígado y vías biliares Sin evidencia de actividad tumoral o metastásica a nivel hepático
21.03.26		HB 6.5 HTO 20.4 VCM 86.2 HCM 27.6 PLAQ 311			

23.03.26		HB 8.6 HTO 26.1 PLAQ 418			
23.03.26	41 138				
01.04.26	16 500				
08.04.26	21 804				
	"Ultrasound (USG) of the uterus and adnexa: Anteverted uterus measuring 80 x 90 x 70 mm with heterogeneous myometrium. Simple, non-complex cyst in the left adnexa. Probable recurrent gestational trophoblastic disease; small to medium-sized uterine leiomyomas (myomatosis)."				
09.04.26	TAC Thoraco-abdomino-pelvic CT: solid and heterogeneous endometrial tissue with extension into the myometrium, suggestive of a primary endometrial neoplasm. Pulmonary nodules and micronodules suggestive of secondary deposits (metastases). The remainder of the study shows no evidence of tumor activity or lymphadenopathy.				
13.04.26	3 701	HB 8.5 HTO 26.8 PLAQ 312	GLU 89 UREA 20.6 BUN 9.6 CR 0.57		

Source: Data obtained by the author from the clinical record. Medical Records Department, ISSSTE Ignacio Zaragoza General Hospital. Hb: hemoglobin; Hct: hematocrit; PT: pregnancy test; MCV: mean corpuscular volume; MCH: mean corpuscular hemoglobin; PLT: platelets; GLU: glucose; Cr: creatinine; DB: direct bilirubin; IB: indirect bilirubin; TB: total bilirubin; AST: aspartate aminotransferase; ALT: alanine aminotransferase; ALP: alkaline phosphatase; LDH: lactate dehydrogenase; TSH: thyroid-stimulating hormone; T4: thyroxine; USG: ultrasonography; CT: computed axial tomography.

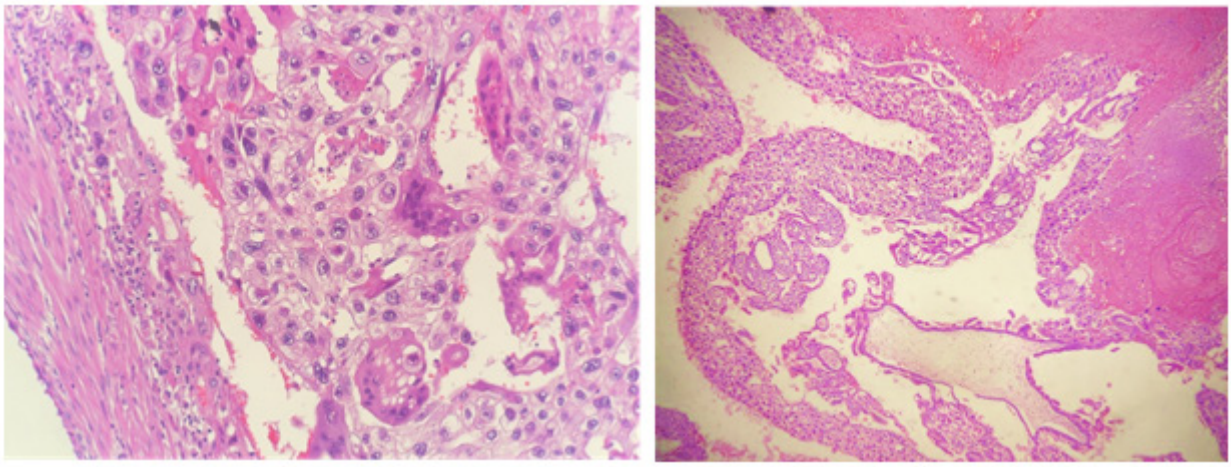
"During follow-up studies on the second and third days, the patient required packed red blood cell transfusions and the administration of 500 mg of iron dextran, resulting in improved hemoglobin levels. Discharge was granted on the 5th day of hospitalization following a decrease in quantitative β-hCG levels.

A new β-hCG quantification was requested 22 days after the surgical intervention, showing a significant increase compared to previous values. Consequently, the patient was evaluated by the Oncology service and readmitted on April 9, 2026. A computed tomography scan (Figure 3) was requested, and the biopsy results were retrieved (Figure 4), reporting a molar pregnancy. Additionally, an ultrasound (USG) concluded a probable recurrent gestational trophoblastic disease. However, despite a decrease in the Berkowitz score from 9 to 6, the upward trend in β-hCG levels led to a diagnosis of persistent gestational trophoblastic disease.

Figure 3. Computed Axial Tomography.

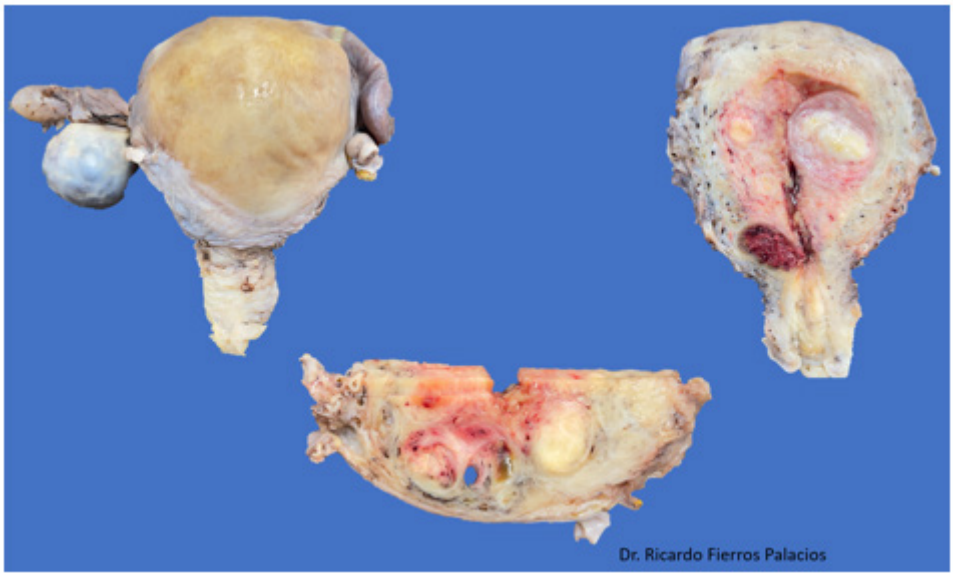


Figure 4. Histological sections. Trophoblast cells with marked atypia associated with hydropic villi infiltrating the uterine wall are identified.



Surgical management was offered, and the patient consented. The following day, a total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed (Figure 5), along with peritoneal washing for cytological and cytochemical analysis, which was negative for malignancy. The patient was discharged after a 5-day stay with hematinics; follow-up was conducted through the Oncology outpatient clinic. The biopsy confirmed gestational trophoblastic disease, specifically invasive hydatidiform mole."

Figure 5. Surgical specimen: The cut reveals a well-defined dark red intramural lesion with a hemorrhagic appearance.



One of the primary risk factors associated with gestational trophoblastic disease (GTD) is maternal age, with a higher incidence observed at the extremes of reproductive life—specifically, women under 20 and over 40 years of age. Additionally, factors such as multiparity, a history of molar pregnancy, and recurrent gestational loss have been linked to an increased risk of developing the disease. [5] In the present case, the patient was of advanced maternal age with a history of one previous pregnancy, resolved via cesarean section over 30 years ago due to failure to progress; thus, she fits the clinical profile described in the literature.Correira et al. (2021) reported the case of a 53-year-old woman with hyperthyroidism and a histopathological diagnosis of invasive hydatidiform mole who underwent total abdominal hysterectomy and salpingo-oophorectomy. They identified that elevated levels of β-hCG can cross-stimulate TSH receptors, which may lead to secondary manifestations of hyperthyroidism. [6] Our patient presented a similar case, having a recently diagnosed history of hyperthyroidism that coexisted with the onset of abnormal uterine bleeding and a significant elevation of β-hCG The diagnosis of hydatidiform mole is multifactorial, based on clinical manifestations,

laboratory findings, and imaging data. One of the most significant clinical findings is hypogastric pain, related to increased uterine size or the presence of theca lutein cysts. Currently, due to the routine implementation of ultrasound, it is uncommon for a diagnosis to rely solely on persistent β-hCG quantification greater than 100.000mUI/ml. [7] However, in the case presented, the initial diagnostic suspicion arose from the macroscopic characteristics of the tissue obtained during intrauterine curettage and the persistent serum elevation of β-hCG following the surgical procedure. Furthermore, abdominal pain, coupled with the exacerbation of transvaginal bleeding of one month's duration, constituted the primary reason for hospital consultation. Uterine hemorrhage is the most prevalent complication of hydatidiform mole, caused by the presence of trophoblastic material in the endometrial layer, generally accompanied by the expulsion of vesicular tissue and a high risk of hypovolemic shock. Primary or repeated uterine evacuation is imperative following hemodynamic stabilization with crystalloids and, if necessary, blood transfusion. [8] Consistent with these guidelines, the patient presented with profuse transvaginal bleeding of one month's duration, which led to severe anemia and required multiple units of packed red blood cells with no reported adverse reactions followed by instrumental uterine curettage as initial management. Subsequently, upon evaluation by the Oncology service, total hysterectomy was offered as treatment, followed by monitoring through β-hCG counts and imaging studies to rule out metastatic invasion. This approach is supported in patients with completed childbearing goals; however, surgical treatment alone is not entirely curative, particularly in the presence of invasive disease or extrauterine extension. [9]Finally, it has been reported that the persistence or recurrence of GTD represents a significant medical challenge, particularly in patients with sustained β-hCG elevation after initial treatment. Kong et al. (2020) reported a recurrence rate of 6.5% and noted that complementary surgical management is associated with higher rates of complete remission. [10] In our patient's case, the persistence of elevated β-hCG levels after uterine curettage preceded the performance of a total abdominal hysterectomy with bilateral salpingo-oophorectomy, resulting in an adequate clinical and biochemical response post-treatment.

CONCLUSIONS

Invasive hydatidiform mole is a rare pathology whose diagnosis represents a challenge, especially in perimenopausal women where clinical suspicion is low or non-existent. This case highlights the importance of timely recognition of clinical manifestations—such as abnormal uterine bleeding and abdominal pain and laboratory findings like persistent β-hCG elevation, in addition to performing close follow-up after uterine evacuation. The integration of clinical, biochemical, histopathological, and radiological findings allowed for an accurate diagnosis and timely treatment, leading to a satisfactory clinical outcome.

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