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Title: Management of Persistent Gestational Trophoblastic Disease Presenting with Hemorrhagic Shock

INTRODUCTION

Persistent trophoblast refers to the incomplete removal of trophoblastic tissue following surgical treatment.

Case History:
32y/o P3L3A1 presented with heavy bleeding PV and shock. History included vesicular mole with two D&C procedures. Imaging revealed a bulky uterus with an invasive mole and probable arterio-venous fistula. Beta-HCG was 33,588 mIU/ml, confirming persistent GTD. Emergency/ stabilization - IV fluids and blood transfusions.

CASE OPERATION PROCEDURE

1. 10 mm suprapubic and two 5 mm ports placed; pneumoperitoneum established.
2. Dense adhesions between uterus, bladder, and abdominal wall noted.
3. TLH decided due to suspected mole invasion into abdominal wall.
4. Extensive adhesiolysis performed.
5. Bilateral retroperitoneal dissection and uterine artery ligation done.
6. Round ligaments, ovarian ligaments, and fallopian tubes cut; ovaries preserved.
7. Bladder adhesions lysed; bladder flap created.
8. Uterus and cervix removed vaginally via colpotomy.
9. Vault closed with 2-0 Vicryl sutures.
10. Cystoscopy confirmed intact bladder and no invasion.

DIAGNOSIS

1. Clinical Features:
- Persistent vaginal bleeding.
- Soft, enlarged uterus.
- Persistent theca lutein cysts.

2. Hormonal Studies:
- HCG Levels.
  - Failure to normalize.
  - Plateaued levels.

3.Imaging:
- Chest X-ray, CT, MRI: To exclude metastases (brain, liver, lungs).
- MRI Pelvis s/o Lesion at level of LSCS scar
- Extending towards serosal surface, bulging anteriorly, closely abutting the rectus sheath with Indistinct fat planes.

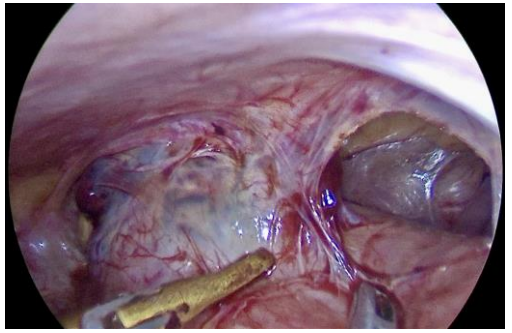
DISCUSSION – TREATMENT MODALITIES

1. Risk Stratification Based on WHO prognostic scoring system:
- Low-Risk Group Single-agent chemotherapy (e.g., methotrexate).
- High-Risk Group - Combination chemotherapy (e.g., **EMA-CO**: etoposide, methotrexate, actinomycin D, cyclophosphamide, vincristine).

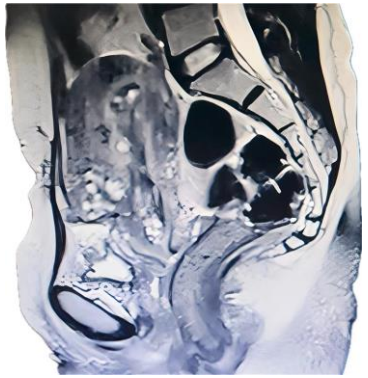
2. Hysterectomy - Indications:
- Age ≥ 40 years., Completed family.
- Persistent disease despite chemotherapy.

Prognosis -
- Outlook: Generally good. Regular follow-up is critical to detect recurrence or progression.

Reference:
Williams Textbook of Obstetrics



- Ventrofixed uterus with invasion of anterior abdominal wall



- MRI Pelvis Sagittal View

Conclusion:
This case emphasizes the importance of early diagnosis, multidisciplinary management, and tailored treatment for GTD. Timely stabilization and appropriate intervention can significantly reduce morbidity and improve outcomes in such high-risk cases.