

بسم الله الرحمن الرحيم





شبكة المعلومات الجامعية التوثيق الالكتروني والميكروفيلم



جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

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بعض الوثائق الأصلية تالفة



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GESTATIONAL TROPHOBLASTIC DISEASE **A HISTOPATHOLOGICAL** **AND ELECTRON MICROSCOPIC STUDY**

THESIS

Submitted for Partial Fulfillment of
Master Degree of Pathology

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Dedication

To my *Father*

**I will always believe that you are the
greatest man in the whole world.**

To my *Mother*

**Thank you for all what you have
done for me, it was
much more than I deserve .**

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List of Abbreviations

FIGO

GTD: Gestational Trophoblastic Disease.

HM: Hydatidiform mole.

CHM: Complete Hydatidiform mole.

PHM: Partial Hydatidiform mole.

IM: Invasive mole.

PSTT: Placental Site Trophoblastic Tumour.

hCG: human Chorionic Gonadotropin.

hPL: human Placental Lactogen.

RER: Rough Endoplasmic Reticulum.

SER: Smooth Endoplasmic Reticulum.

GTT: Gestational Trophoblastic Tumour.

CT: Cytotrophoblast.

ST: Syncytiotrophoblast.

IT: Intermediate Trophoblast.

H&E: Haematoxylin and Eosin.

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INTRODUCTION

INTRODUCTION

Gestational Trophoblastic Disease encompasses a heterogeneous group of lesions characterized by an abnormal proliferation of trophoblast. Traditionally, the GTD have been divided into three overlapping morphological categories that have complex pathogenic interrelationship, these are : hydatidiform mole, invasive mole and choriocarcinoma [Barber, 1989 & Rosie, 1995].

The World Health Organization International Society of Gynecologic Pathologists defined and comprised several different entities of GTD:

Complete hydatidiform mole (CHM), Partial hydatidiform mole (PHM), invasive mole (IM), Placental site trophoblastic tumour (PSTT), Choriocarcinoma, and other Miscellaneous trophoblastic lesions which are exaggerated placental site, placental site nodule and plaque and Unclassified trophoblastic lesions [Damjanov & linder, 1996].

All trophoblastic lesions elaborate human chorionic gonadotropin (hCG) which can be detected in the circulating blood and urine at titer considerably higher than those found during normal pregnancy, the titer progressively rising from HM to IM to choriocarcinoma. In addition to aid the diagnosis, the fall or (*alternatively*) rise in the level of hCG in the blood or urine can be used to monitor the effectiveness of treatment [Cotran et al, 1997].

Lurain (1990), O'Quinn and Barnard (1994) observed that the probability of cure depends on the histologic type, the extent of spread of