TWIN MOLAR PREGNANCY:

A CASE REPORT OF COMPLETE HYDATIDIFORM MOLE COEXISTING WITH NORMAL FETUS

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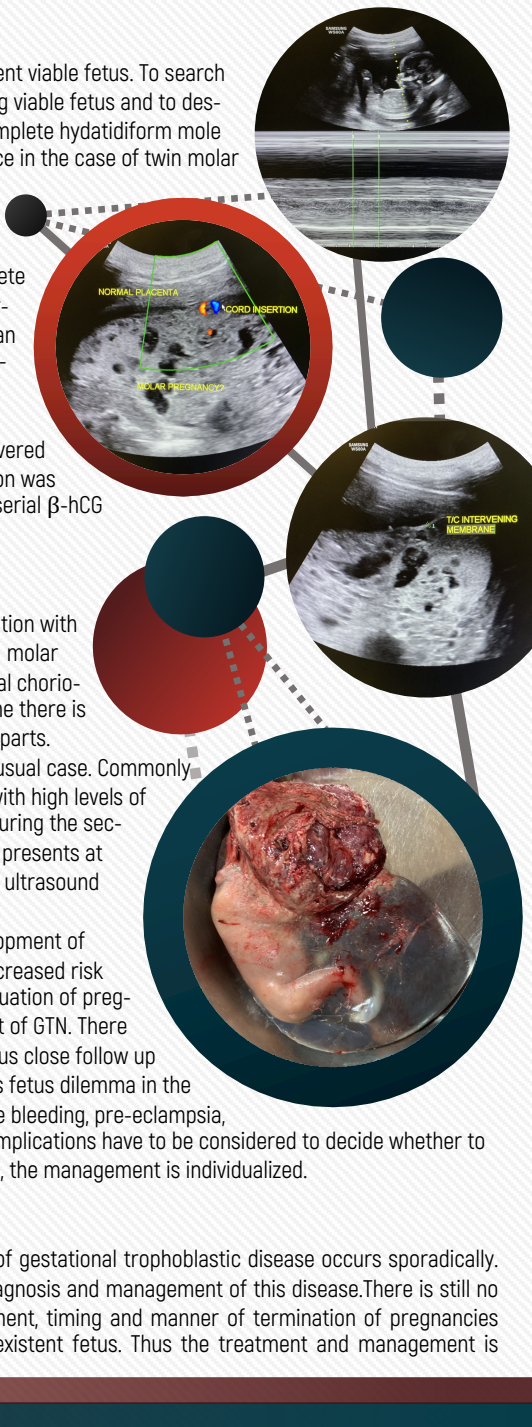
INTRODUCTION

Complete hydatidiform mole coexisting with normal fetus (CHMCF) has a rare occurrence with an incidence rate of 1/22,000 to 1/100,000 pregnancies. These uncommon cases pose several diagnostic and management challenges. During the early pregnancy it is crucial to distinguish between partial mole vs complete mole with coexisting fetus since the management of these conditions differ.

OBJECTIVES

To report a case of Twin molar pregnancy with coexistent viable fetus. To search for local incidence of twin molar pregnancy with coexisting viable fetus and to describe the clinical, diagnostic and therapeutic aspect of complete hydatidiform mole with coexisting fetus. Lastly to discern the fetal surveillance in the case of twin molar pregnancy with coexisting viable fetus.



CASE

Presented is a case of a 22-year old female with complete hydatidiform mole with coexisting fetus, with known hyperthyroidism. Serial ultrasonographic studies and beta-human chorionic gonadotropin (β-hCG) was done to confirm presence of the complete hydatidiform mole. Pregnancy was carried up to 20 3/7 weeks age of gestation. Due to heavy vaginal bleeding and imminent abortion the fetus was delivered followed by suction curettage. Methotrexate administration was done post correction of anemia. And close follow up with serial β-hCG monitoring was done as outpatient basis.

DISCUSSION

Molar pregnancy is an abnormal trophoblastic proliferation with villous stromal edema. Classified into complete and partial molar pregnancy. Histologically a complete mole has an abnormal chorionic villi that looks like a clear vesicles, while partial mole the there is a focal villous edema and often with the presence of fetal parts.

Complete hydatidform mole with coexisting fetus is unusual case. Commonly presented with delayed menstruation with accompanied with high levels of β-hCG, and vaginal spotting. CHMCF is usually diagnosed during the second trimester, sonographic features of hydatidiform mole presents at 2nd trimester. But combined with high levels of β-hCG and ultrasound impression of CHMCF can be done.

CHMCF predisposes many complications such as development of hyperthyroidism, theca lutein cyst, vaginal bleeding and increased risk of development of GTN. According to Imafuko et.al, continuation of pregnancy in CHMCF does not increase the risk of development of GTN. There is a 40% chance of fetal survival in patients with CHMCF thus close follow up and prenatal checkup is important. There is mother versus fetus dilemma in the management of CHMCF. Risk for mother include excessive bleeding, pre-eclampsia, hyperthyroidism and development of GTN hence, these complications have to be considered to decide whether to continue or terminate the pregnancy. Therefore, in CHMCF, the management is individualized.

CONCLUSION

Complete mole with coexisting fetus in the spectrum of gestational trophoblastic disease occurs sporadically. There are limited reports and studies pertaining to the diagnosis and management of this disease.There is still no standard guideline regarding fetal surveillance, management, timing and manner of termination of pregnancies complicated with partial, complete, and mole with a coexistent fetus. Thus the treatment and management is suggested to be individualized.