

CASE REPORT

PARTIAL HYDATIDIFORM MOLE ALONG WITH TERM GESTATION AND ALIVE BABY

Zahida Parveen, Rubina Bashir, Taimur Jadoon, Iftikhar Qayum

Department of Obstetrics and Gynecology, Ayub Teaching Hospital Abbottabad

Gestational trophoblastic disease consists of a broad spectrum of conditions ranging from an uncomplicated partial hydatidiform molar pregnancy to stage-IV choriocarcinoma with cerebral metastases. We describe a partial molar change in the placenta that was associated with a normal female fetus that was delivered at term and is alive and healthy.

INTRODUCTION

Gestational Trophoblastic disease encompasses a diverse group of lesion with specific pathogenesis, morphological characteristic and clinical features.¹ The modified world health organization classification of Gestational Trophoblastic disease includes complete and partial hydatidiform mole, invasive mole, choriocarcinoma, placental site trophoblastic tumor, epithelioid, trophoblastic tumor, exaggerated placental site and placental site nodules.² Molar pregnancy is significantly more common in extremes of age.³ The usual management of gestational Trophoblastic disease is evacuation of the uterus and follow up because of higher chances of patient to develop choriocarcinoma.¹ But some time when molar change is there in the placenta along with an alive fetus than expectant management can be performed under strict surveillance.^{4,5} We describe a case of partial molar pregnancy along with normal fetus who was managed and delivered at term.

CASE REPORT

A 23 years old patient who was G4P1+2 was referred from periphery and was admitted with Gestational amenorrhea of 18 weeks along with mild vaginal bleeding and lower abdominal pain. She was sure of her dates.

Previously she had one child and had two spontaneous abortions and she had evacuation and curettage for her abortion. Her periods were regular previously. When she was admitted her vitals were stable and on abdominal examination the height of the fundus was 20 weeks and FHS was present. On vaginal examination she had mild bleeding and cervix was closed. On ultrasound scan she had single viable fetus of 18 weeks along with big placenta showing molar changes. She had her pregnancy test which was performed 4 weeks earlier and were positive directly and also in 1:100 dilution.

As we had no facility of β HCG in our hospital so urinary HCG was measured. Her Hb level was low and she was transfused two unit of A + blood. All other tests which were performed were within normal limits.

She was diagnosed as a case of partial mole along with viable pregnancy. It was decided with patient consent to prolong this pregnancy under strict surveillance. Her bleeding subsided and she was discharged home.

She was followed regularly in antenatal clinic and fetal growth and placental size was monitored by ultrasound every 15 days. She was prescribed iron and Folic Acid during her antenatal period. She remained well except for mild abdominal pain and recurrent anemia till 36 weeks. Her hemoglobin was found again low at 36 weeks and 2 units blood was again transfused.

On ultrasound scan the baby was alive but had sign of intrauterine growth restriction for which she was advised rest.

Fig-1: Ultrasound at 23rd week indicative of a partial molar pregnancy

Fig-2: Gross Appearance of the molar tissue

Fig-3: Partial Hyaditiform mole on histopathology H & E stain x 100

Fig-4: Alive baby born (photograph was provided by the parents)

At 39th week she presented with labour pain and admitted. Labour monitored normally and a partogram was maintained. After 6 hours she delivered a baby girl of 2.7kg with good APGAR score. Placenta was delivered by Brandt Andrew's methods. Weight of the placenta was 800gm and almost 1/3 of placenta had molar tissue. Cord was normal and having 3 vessels. Histopathology of placenta showed molar changes.

The baby was kept with mother and breast fed and remained well till 5th day and was discharged home. The chest X-Ray after delivery was normal and urine pregnancy test after delivery was negative.

After 6 weeks patient had post natal check up and was fine. X-Ray chest was again normal and urine pregnancy test was negative. After 4 months mother and the baby both were fine.

DISCUSSION

We have studied partial molar pregnancy and we have searched the literature. One case reported by Zhang et al University of California San Diego where female fetus died in utero at 26 weeks.⁶ Another study was reported by Bruchim et al in Israel,⁷ they delivered one woman at 41 week of gestation with partial mole and another at 26 weeks but those cases were of complete hydatidiform mole alongwith a normal fetus which was a twin pregnancy. Such patients have risk of developing persistent gestational Trophoblastic disease.

Any pregnancy along with molar change in placenta has definite risk of preterm delivery as obvious from many case reports. The other problem which our patient had was recurrent anemia and requirement for blood transfusion which need further evaluation and research.

The follow up of patient with partial hydatidiform mole have been questioned by some authors that whether they need follow up by serum β HCG. Such patient can develop choriocarcinoma and one death has been reported in the study conducted by Seckl et al.⁸ However partial hydatidiform mole rarely requires chemotherapy.

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Address for Correspondence:

Dr. Zahida Perveen, Department of Gynae/Obst, Ayub Medical College, Abbottabad – Pakistan.

Tel: 92-992-381907-14 Ext: By name