Archive of Obstetrics, Gynecology and Reproductive Medicine
AOGRM, 2(1): 35-37
www.scitcentral.com

ISSN: 2640-2297

Case Report: Open Access

An Unusual Presentation of Partial Hydatidiform Molar Pregnancy with Live Birth

Sandeepkumar AG, Sujatha Prabhu, Sreelatha S*, Chandushree, Shruthi K

Department of Obstetrics & Gynaecology, ESIC-MC & PGIMSR, Bengaluru, Karnataka, India.

Received July 19, 2018; Accepted August 07, 2018; Published January 29, 2019

ABSTRACT

Partial molar pregnancy is a rare entity in which there is usually triploid abnormal fetus associated with large placenta with cystic changes. Incidence of normal live fetus and partial molar placenta is extremely rare with incidence of 0.005% to 0.01% of all pregnancies. A fetus with normal karyotype can survive in case of partial molar pregnancy. Patient requires β-hCG follow up as there is increased chance of developing malignancy. Here we are reporting a case of primigravida with 29 weeks period of gestation presented with preterm active labor and delivered a live preterm male baby of weight 1.05 kg, placenta appeared unhealthy with cystic changes, whose histopathology reported as partial mole. Baby was in NICU for 45 days and was appearing normal. Karyotyping was done which was reported as normal. Patient and baby were discharged after 45 days.

Keywords: Partial mole, Large placenta, Normal fetus, Karyotyping, β-hCG, Triploidy

INTRODUCTION

Hydatidiform mole is characterized by abnormal fetopla central development and trophoblastic hyperplasia, resulting from genetically abnormal conception when there is excessive paternally derived genetic material [1]. A partial molar pregnancy is a variation of a molar pregnancy in which an embryo either develops incompletely or with multiple structural anomalies [2]. In this kind of abnormal pregnancy, the egg usually receives two sets of chromosomes from the father, usually because two sperm have fertilized the egg. The egg now has 69 chromosomes, instead of the normal 46 [2]. Excluding cases of multiple conceptions with molar pregnancy and coexisting fetuses, partial molar pregnancy in which a live fetus is carried to term is very rare. We report a case of singleton pregnancy in which placental molar change was associated with normal appearing fetus.

CASE REPORT

20 years old primigravida with 29 weeks period of gestation presented with preterm active labor. On examination she was normotensive, pulse rate was normal, with no pallor or pedal edema. Uterus was acting with 3 to 4 contractions lasting for 30 s with cephalic presentation and fetal heart rate was 140 beats/min. On per vaginal exam, cervix was soft, 5 cm dilated; bag of membranes present, vertex was at -2 Station. Investigations revealed hemoglobin of 10 g%. All the biochemical parameters were normal. APLA and TORCH profile were sent which was reported as normal. Patient delivered a live preterm male baby of weight 1.05 kg, placenta and membranes were expelled in toto which appeared unhealthy with cystic changes. Placenta was sent for histopathology which was reported as partial mole. Baby was in NICU for 45 days and was appearing normal. She was followed as per the standard protocol and beta human chorionic gonadotrophin became undetectable after about 8 weeks. Karyotyping was done which was reported as normal. Patient and baby were discharged after 45 days **(Figures 1 and 2)**.

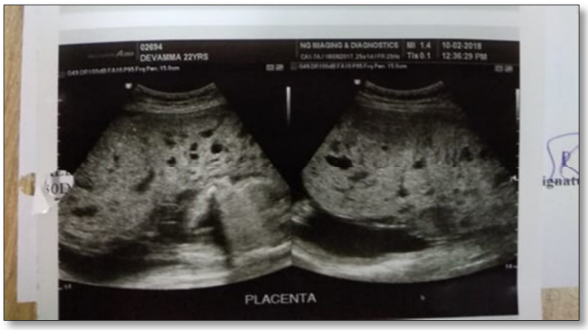

Figure 1. USG image showing cystic changes.

Corresponding author: Dr. Sreelatha S, Professor, Department of OBG, ESIC MC and PGIMSR, Rajajinagar, Bengaluru, Karnataka, India, E-mail: dr.sreelatha2011@gmail.com

Citation: Sandeepkumar AG, Prabhu S, Sreelatha S, Chandushree, & Shruthi K. (2019) An Unusual Presentation of Partial Hydatidiform Molar Pregnancy with Live Birth. Arch Obstet Gynecol Reprod Med, 2(1): 35-37.

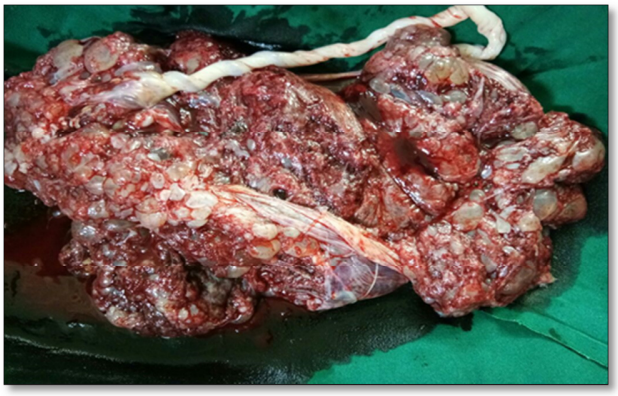

Figure 2. Placenta with cystic changes.

DISCUSSION

Hydatidiform mole can be partial or complete. The Greek word 'Hydatis' meaning a drop of water and the Latin word 'molar' meaning a mass [3]. Partial molar pregnancy with coexisting fetus is a rare complication with the incidence of 0.005%-0.01% of all the pregnancies [4]. It usually derives from dispermic fertilization of a haploid normal oocyte and produces a triploid set of chromosomes. It has a triploid karyotype [5]. Symmetric intrauterine growth retardation is more common with partial mole. Complete mole is more dangerous than partial mole. Moles may progress to persistent trophoblastic disease, placental site trophoblast tumor and choriocarcinoma. The chances of the persistent disease after the partial mole are less than 4% but increase to 20% with the complete mole [6]. The definite diagnosis of partial mole is confirmed by pathological and cytogenetic studies. In Partial molar pregnancy with fetal survival depends upon several factors: (i) normal karyotype of the fetus [8]; (ii) smaller molar placenta compared to normal placenta (iii) the onset of the molar degeneration and its speed of degeneration; (iv) absence of anemia occurring in the partial mole with an anemic fetus; and (v) absence of maternal complications such as pre-eclampsia, thyrotoxicosis, and vaginal bleeding interrupting the pregnancy. Ultrasonography has made it possible a diagnosis of a hydatidiform mole and co-existent fetus in the first trimester. US findings include a greatly enlarged placenta relative to the size of the uterine cavity associated with cystic spaces ("molar placenta") [7]. An amniotic cavity (gestational sac) found, either empty or containing amorphous inappropriately small fetus with multiple structural anomalies. However in some situations molar changes in placenta is associated with a normal diploid fetus. In singleton normal fetus with partial molar placenta, the fetus must have normal karyotype to survive in utero, although its placenta can have some chromosomal variation, from diploidy of the amnion to triploidy of the chorionic villi [8]. From this clinical perspective, there are two different types of US findings in the placenta: the focal and diffuse molar changes. The former shows a normal placenta with a focal area of hydropic changes [9]. Management of molar changes associated with normal appearing fetus still remains challenging. The serum b-hCG level can be a helpful marker, when the serum β-hCG level remains greater than 10^6 mIU/mL, termination of pregnancy should be considered. In contrast, in cases of successful pregnancy outcomes with viable fetuses, the serum β-hCG level usually starts to decline from the beginning of the second trimester and sonography usually reveals a decrease in the size of the molar portion of the placenta [10]. Recent advances in prenatal diagnosis by ultrasound may allow partial and complete molar placenta coexisting with the fetus to be distinguished in many cases. The risk of gestational trophoblastic neoplasia for partial mole is <5-10% and that of complete mole is 20%. The risk of recurrence of hydatidiform mole is 0.5-2.8% with a subsequent greater risk of developing invasive mole or choriocarcinoma. The risk of repeat hydatidiform mole in next pregnancy is 1:76 while the risk after two past hydatidiform mole is 1:6.5 [11].

CONCLUSION

Pregnancy with a normal live fetus and a partial molar placenta is extremely rare because of maternal and fetal complications. Since the fetus was normal at birth and the child continues to be growing normally, the abnormal cell population appears to be confined to the placenta. Complete evaluation of the placental tissue is important even in cases with normal fetal outcome as molar changes which might be unsuspected antenataly might affect the future obstetrical outcome.

REFERENCES

1. Hsieh CC, Hsieh TT, Hsueh C, Kuo DM, Lo LM, et al. (1999) Delivery of a severely anemic fetus after partial molar pregnancy: Clinical and ultrasonographic findings. Hum Reprod 14: 1122-1126.
2. American Pregnancy Association (2015) Molar pregnancy: Symptoms, risks and treatment.
3. Szulman RS, Surti U (1982) The clinico-pathologic profile of the partial hydatidiform mole. Obstet Gynecol 59: 597-602.
4. Suzuki M, Matsunobu A, Wakita K, Nishijima M, Osanai K (1980) Hydatidiform mole with surviving co-existent fetus. Ombt Gynecol 56: 384-388.
5. Vaisbuch E, Ben-Arie A, Dgani R, Perlman S, Sokolovsky N, et al. (2005) Twin pregnancy consisting of a complete hydatidiform mole and co-existent fetus: Report of two cases and review of literature. Gynecol Oncol 98: 19-23.
6. Seckl MJ, Fisher RA, Salerno G, Rees H, Paradinas FJ, et al. (2000) Choriocarcinoma and partial hydatidiform moles. Lancet 356: 36-39.

7. https://radiopaedia.org/articles/partial-hydatidiform-mole

8. Sarno AP, Moorman AJ, Kalousek DK (1993) Partial pregnancy with fetal survival: An unusual example of confined placental mosaicism. Obstet Gynecol 82: 716-719.

9. Vejerslev LO (1991) Clinical management and diagnostic possibilities in hydatidiform mole with coexistent fetus. Obstet Gynecol Surv 46: 577-588.

10. Radhouane A, Aissa BA, Khaled N (2015) Twin pregnancy with both complete hydatiform mole and coexistent alive fetus: Case report. Asian Pac J Reprod 4: 331-333.

11. Sand PK, Lurain JR, Brewer JI (1984) Repeat gestational trophoblastic disease. Obstet Gynecol 63: 140-144.