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A Rare Case of a Partial Mole with a Viable Fetus

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Abstract: Hydatidiform mole is characterized by the abnormal fetoplacental development and trophoblastic hyperplasia which results from genetically abnormal conception because of excessive paternally derived genetic material. Molar pregnancies are associated with potentially life-threatening complications such as heavy vaginal bleeding, preeclampsia, preterm labour and thyroid abnormalities, making management of these conditions more challenging. It is classified into complete mole when there is total replacement of normal placenta by grossly dilated and hydropic villi in the absence of foetus and the incomplete or partial mole showing partial replacement with hydropic villi and visible abnormal fetal parts leading to termination of the pregnancy in first trimester. Fetus in such cases is rarely alive at the time of diagnosis and often shows gross congenital anomalies associated with triploidy and frequently have a grave prognosis owing to limited functional placental circulation and severe intrauterine fetal growth retardation.
Keywords: Molar, partial mole, triploidy , hydropic , trophoblastic.

INTRODUCTION

The incidence of a rare condition like partial molar pregnancy with co-existing fetus is 0.005% to 0.01% of all the pregnancies. Excluding cases of multiple fetuses, co-existing molar pregnancy with normal live fetus as seen in our case is extremely rare.

We present a case of a patient gravida 2 abortion 1 who conceived after Intra Uterine Insemination treatment and was diagnosed to have a partial molar pregnancy with a viable fetus which was diagnosed at 17 weeks and the subsequent complication and termination of the pregnancy.

CASE REPORT

22 year old Gravida 2, Abortion 1 married since four years conceived after Intra Uterine Insemination. Pregnancy progressed normally till 17 weeks, when malformation scan detected presence of partial molar pregnancy with live fetus. Usg suggested 11.8 * 8.8cm of placenta showed multiple cystic lesions suggestive of hydatidiform mole covering the internal os completely. Normal looking placenta was presented adjacent to the cystic placenta without any intervening membrane. Fetus appeared normal except for presence of echogenic bowel. Bilateral Theca Lutein cysts of ovary were seen. Left ovary measured 9.0 * 5.7 cm and Right ovary measured 7.9 * 7.0 cm .Congenital malformations were ruled out by Amniocentesis and FISH (Fluorescence in-situ hybridization). Patient was counselled regarding the condition and she chose to carry the pregnancy. At 22 weeks of gestation, patient suddenly presented with bleeding per vaginum. On clinical examination, patient had tachycardia along with hypotension and severe pallor. On per abdomen examination, uterine size corresponded to 32 weeks and fetal heart sounds were present. On per speculum examination, bleeding from internal os could be seen. Her hemoglobin had dropped to 6.9 gm/ dl from 10 gm/dl and Se. TSH was 0.03 microgram / ml. Liver and renal function tests were found to be normal. Patient and relatives were explained about the condition. Decision to perform hysterotomy was taken as partial mole completely covered the internal os. 430 gm fetus was delivered and multiple vesicles were removed.

Fig-1: 430 gm fetus delivered by hysterotomy in a case of partial molar pregnancy

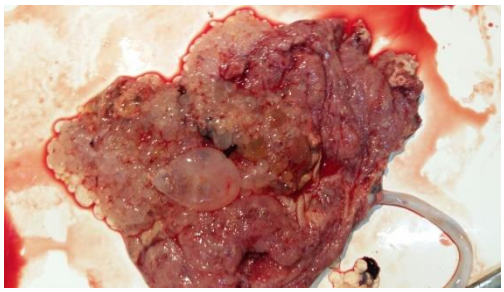

Fig-2: Placenta of Partial Mole showing multiple cystic lesions

Intra – operatively, patient suddenly developed dyspnea with drop in oxygen saturation. Patient was immediately intubated and shifted to the intensive care unit. Chest X-ray revealed pulmonary infiltrates suggestive of pulmonary embolism. D-dimer was raised. Patient also developed transient hypertension. Management of pulmonary embolism was instituted and patient was stabilised. Propranolol and Neomercazole were also started. On histopathology of the placenta, Cystically distended villi with cistern formation and polar trophoblastic proliferation seen. Patient was counselled regarding the need to delay future pregnancy and regular follow-up to rule out persistent trophoblastic disease.

DISCUSSION

Partial molar pregnancy co - existing with normal live term fetus as seen in the above case is an extremely rare occurence excluding cases of multiple conceptions [1].

Three possibilities arise in hydatiform mole with live fetus. The first being a twin pregnancy with one normal fetus having a normal placenta and another complete mole which is the most common. Second type is a twin pregnancy with normal fetus and placenta and another partial mole and the third and most uncommon occurrence is a singleton normal fetus with partial molar placenta.

Such a fetus should have a normal karyotype to survive although placenta may have some variation ranging from diploidy of the amnion to triploidy of the chorionic villi. However placenta in a partial mole with fetus in a singleton pregnancy results from dispermy and it generally has a triploid karyotype [2].

These patients present with complications like bleeding per vaginum , hyperemesis gravidarum, preterm labour, late abortions, severe anaemia in the fetus with congestive cardiac failure, ante-partum hemorrhage, intrauterine growth retardation, congenital anomalies, oligohydramnios etc [3,4].

Final diagnosis should be confirmed by histopathological examination and genetic examination of the conceptus [5,6]. For a singleton normal fetus co – existing with partial molar pregnancy, survival depends upon the following factors:

Normal karyotype, smaller molar area compared to normal placenta, onset and speed of molar degeneration, absence of anemia in the fetus etc.

Postpartum, Maternal Serum hCG should be tested to rule out perstitent gestational trophobladtic disease. However the follow up period need not be beyond one year as the occurrence of post evacuation sequelae are rare [7].

CONCLUSION

Partial molar pregnancies with live viable fetus presents with several dilemmas in management during pregnancy and the woman must be counseled regarding the maternal and fetal complications and the risk of persistent trophoblastic disease in later life. In the past such pregnancies were terminated owing to feto-maternal complications. However, with advances in the medical field, continuation may be considered. The decision to continue the pregnancy should be taken after considering the probable maternal and foetal complications.

In case of continuation, foetal surveillance by chromosomal analysis and serial ultrasonography with close monitoring should be done.

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