

Twin Pregnancy With Complete Mole and Co-Existing Partial Mole

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Abstract

Twin gestation with coexisting complete and partial is a rare entity. Many cases have been reported in literature that resulted in alive births in case of twin pregnancy with co-existing mole. A G3P2 presented at 18+ weeks gestation with gravid uterus of 28 weeks. On ultrasound, there was one alive intrauterine fetus of 15 weeks and other mass lesion that was suspected to be a complete mole. Beta HCG on admission was 924,500 mIU/ml. Emergency Hysterotomy performed for deteriorating maternal condition. Histopathology confirmed twin gestation with both partial and complete mole.

Keywords: Gestational trophoblastic disease, Molar pregnancy, Hysterotomy, Gonadotropin.

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Introduction

Gestational trophoblastic disease (GTD) is a group of rare diseases in which abnormal trophoblast cells grow inside the uterus after conception. Instead, these tumors start in the cells that would normally develop into the placenta during pregnancy.¹ The term gestational refers to pregnancy. In rare cases a normal fetus can develop with a coexisting molar tissue. The reported incidence for such cases is about one in 22,000-100,000 pregnancies.¹ This is a significant clinical challenge for treating Gynaecologist. Keeping a balance between conservative management and immediate intervention is a significant dilemma.³ The optimal management is not clear. Here we report a case of twin pregnancy with existing partial and complete mole together

Case Report

A 36 years old woman gravida 3 para 2, with two previous normal deliveries at term, was referred from Rawalakot at 18+ weeks of gestation with twin pregnancy. On ultrasonography one sac had alive fetus with normal looking placenta and other was suspected to be a complete mole. She presented with complaints of per vaginal bleeding, shortness of breath and

palpitations. On physical examination her Pulse was 110/minute, BP of 180/100 mmHg, respiratory rate of 20 /minute. Her urine dip stick showed +1 urine albumin. Abdominal palpation revealed mild tenderness and a uterine size corresponding to 28 weeks gestation. On vaginal examination cervical os was closed with mild bleeding.

On investigations, she had A-ve blood group and Haemoglobin was 8.9g/dL. Her liver function tests and renal function tests were within normal limits except for uric acid which was 6.8mg/dL. Thyroid function tests showed hyperthyroidism with raised free T3 -14.0 pmol/L, T4-30.3 pmol/ and TSH of 0.005uIU/ml. An ultrasound examination confirmed a twin pregnancy, including one normal fetus with a biometry of 15+ weeks gestation and other twin with complete mole. Chest X-ray and ECG were normal. Serum human chorionic gonadotrophin levels (β -hCG) was 924500 mIU/ml.

The patient and her husband were counselled in detail regarding the risks associated her condition. They requested expectant management initially. She was started tab Propranolol 40mg B.D, tab nifedipine 20mg B.D, tab Neomercazole 5mg B.D. She was given

Injection Anti-D. Meanwhile she was also transfused two units RCC.

She had worsening dyspnoea over the next 48 hours .She was transferred to HDU and consented for hysterotomy. Under general anaesthesia, lower segment hysterotomy and bilateral tubal ligation was performed .On hysterotomy, complete mole(Figure 2) delivered first followed by delivery of intact sac with fetus and unhealthy looking placenta (Figure 1) .The fetus was alive male 100grams and no gross anomaly could be identified .Fetus died after 10 minutes and was handed over to parents. It was a dichorionic gestation. Both pacentae were sent for histopathogy. The intra-operative blood loss was 800 mL. Histopathological examination was consistent with twin pregnancy complete molar pregnancy and fetus with partial mole in second sac.

In post-operative period, She developed severe shortness of breath at rest with fever of 101 *F. Repeat chest X ray showed pleural effusion. CTPA was normal. On strong clinical suspicion of pulmonary embolism she was given LMWH in therapeutic dose. Patient became stable in next 48 hours.

Her post -op serum β -hCG was 29,872.43mIU/ml after 1 week. She was discharged in a stable condition on tenth post-operative day with proper follow up counseling. Her β -hCG levels after 3weeks of surgery was 363.6mIU/ml. Three months after the surgery, the patient's serum β -hCG level had returned to normal without any cytotoxic therapy and patient is doing well.



Figure 1. Photograph of the normal fetus and partial mole



Figure 2. The complete molar tissue following a hysterotomy in a pregnant patient with a complete hydatidiform mole and a coexisting live fetus with partial mole.

Discussion

We have studied molar pregnancy and we have searched the literature. We are unable to find any such case .Twin gestation with a molar pregnancy is a relatively rare entity. They can be classified as for better management like

- 1) Twin pregnancy ,one twin is a diploid fetus with normal placenta and second complete hydatidiform mole
- 2) Singleton pregnancy with triploid fetus with partial hydatidiform mole(that mimics twin gestation)
- 3) Twin pregnancy , one twin is diploid fetus with normal placenta and second twin is a triploid fetus with partial mole placenta
- 4) Co-existing partial and complete mole(as in our case)

Management of twin molar pregnancy with coexisting fetus remains controversial.² The chances of fetal survival are weighed against the risk of maternal complications and for this reason, many cases were managed by immediate termination in past.⁵ In our case , as the initial diagnosis was twin pregnancy with one complete mole and with coexisting alive fetus and normal looking placenta ,it was on patients request that pregnancy was continued. She counselled for risks associated with such types of pregnancies Conservative management can be planned in a tertiary care setting where complications can be picked earlier and managed accordingly.⁵ It is recommended to

closely monitor patient to detect early signs of maternal and fetal complications.⁵

The management of these cases with multiple gestation along with molar pregnancy remains problematic.² Such pregnancies should be terminated if mother develops severe pre-eclampsia, thyrotoxicosis, excessive vaginal bleeding or there is clinical evidence of trophoblastic embolization.³ There are distinct fetal and maternal complications in partial and complete moles. In partial hydatidi form mole, the fetus is almost always triploid and hence non viable ,so pregnancy should be terminated.⁴ In our case partial mole was a retrospective diagnosis.

Amniocentesis is a procedure for obtaining fetal cells and doing karyotyping and antenatal diagnosis. Both complete and partial mole can be differentiated by this way. If there is aneuploidy, one can proceed with termination.⁵ In our case , patient was operated in emergency before we could go for amniocentesis.

P57 ,a marker for differentiating between a complete and partial mole could not be done as the facility is not available at our hospital. RCOG guidelines 2013 recommend prenatal invasive testing for fetal karyotype in cases where it is unclear if the pregnancy is a complete mole with a coexisting normal twin or a partial mole. Karyotyping of our was not done in our case because of reason already mentioned.

In conclusion, management of multiple pregnancy with a molar change still remains uncertain, In the past, most molar gestations were terminated immediately following diagnosis because of poor information concerning clinical features and natural history. We managed our patient conservatively with an initial diagnosis of twin pregnancy with one complete mole and another normal fetus with normal placenta and with a different retrospective diagnosis.

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