Case Report

Molar Pregnancy with Co-Existing Live Fetus Delivered Preterm at 34 Weeks Gestation

Rahman MT[1], Sobhan SA[2]

Conflict of Interest: None
Received: 15.08.2023
Accepted: 01.09.2023
www.banglajol.info/index.php/JSSMC

ABSTRACT:

Background: *Molar pregnancies are rare and pose unique challenges when a live fetus coexists. This case report sheds light on the intricacies of managing such cases and highlights the scarcity of literature on this subject. The introduction provides an overview of molar pregnancies, emphasizing the rarity of cases involving a live fetus and the challenges in their management.*

Case: *The patient, a 23-year-old gravid woman, exhibited symptoms at 28 weeks, including per vaginal spotting. Following thorough investigations and careful consideration of risks, she opted to continue the pregnancy. The case culminated in a preterm delivery at 34 weeks, resulting in a healthy male baby, weighing 1.8 kg, with no congenital abnormalities.*

Conclusion: *Pregnancy with a hydatidiform mole and a live fetus has a high chance of poor fetal outcome. However, this case indicates that a hydatidiform mole may coexist with a live pregnancy and result in the live birth of a normal fetus.*

Key Words:
Gestational trophoblastic, live fetus, hydatidiform mole, multidisciplinary management.

[J Shaheed Suhrawardy Med Coll 2023; 15(2): 45-48]
DOI: https://doi.org/10.3329/jssmc.v15i2.81866

Authors:

1. Dr. Milia Tamanna Rahman, Registrar, Department of Obstetrics and Gynecology, Sylhet MAG Osmani Medical College Hospital, Sylhet.
2. Dr. Syed Abdus Sobhan, Assistant professor, Department of Orthopedics, Sylhet MAG Osmani Medical College, Sylhet.

Correspondence:

Dr. Milia Tamanna Rahman, Registrar, Department of Obstetrics and Gynecology, Sylhet MAG Osmani Medical College Hospital, Sylhet.
Mobile: 01714328005. Email: miliatamanna123@gmail.com

Introduction

You can get gestational trophoblastic disease when you have a molar pregnancy. Having a hydatidiform mole and a healthy baby at the same time is very uncommon and is thought to be a high-risk pregnancy [1]. Ultrasonograms show that a hydatidiform mole without a fetus happens once every 2000 pregnancies. On the other hand, they show a hydatidiform mole with a live coexisting fetus between 1 in 10,000 and 1 in 100,000 pregnancies [2].

When molar changes happen during a healthy pregnancy, there are many risks for both the mother and the baby [3]. There are different opinions on whether it is better to end the pregnancy or help the mother have a normal birth. As of now, there have only been a few reports of this happening in the books. In this case report, we describe a molar pregnancy with a living fetus that had a good result for both the mother and the baby.

Case Summary

A 23-year-old lady presented on 4th February 2023 at her 28 weeks of pregnancy with per vaginal spotting for 10 days. She was 2nd gravida, para 1(cesarean section). She received her 1st antenatal checkup at 20 weeks of gestation in a private clinic. After proper history taking and examinations, she was advised to undergo some investigations. She had a USG at 20 weeks of pregnancy and an anomaly scan, which revealed a single live fetus with

uterine cavity partially filled with soft tissue and numerous vesicle-like structures in the anterior fundal location. Her β HCG was 65065miU/ml. Her renal, liver function, and thyroid function tests were normal. After fully understanding the risks, the patient decided to continue the pregnancy.

At her 34 weeks of pregnancy, she noticed profuse per vaginal bleeding and also developed scar tenderness.

Emergency cesarean section was done on 14th March 2023 in a well-equipped center. A male baby weighing 1.8 kg was delivered with no congenital abnormalities. There were two separate placentas; one was normal and the other showed molar changes.

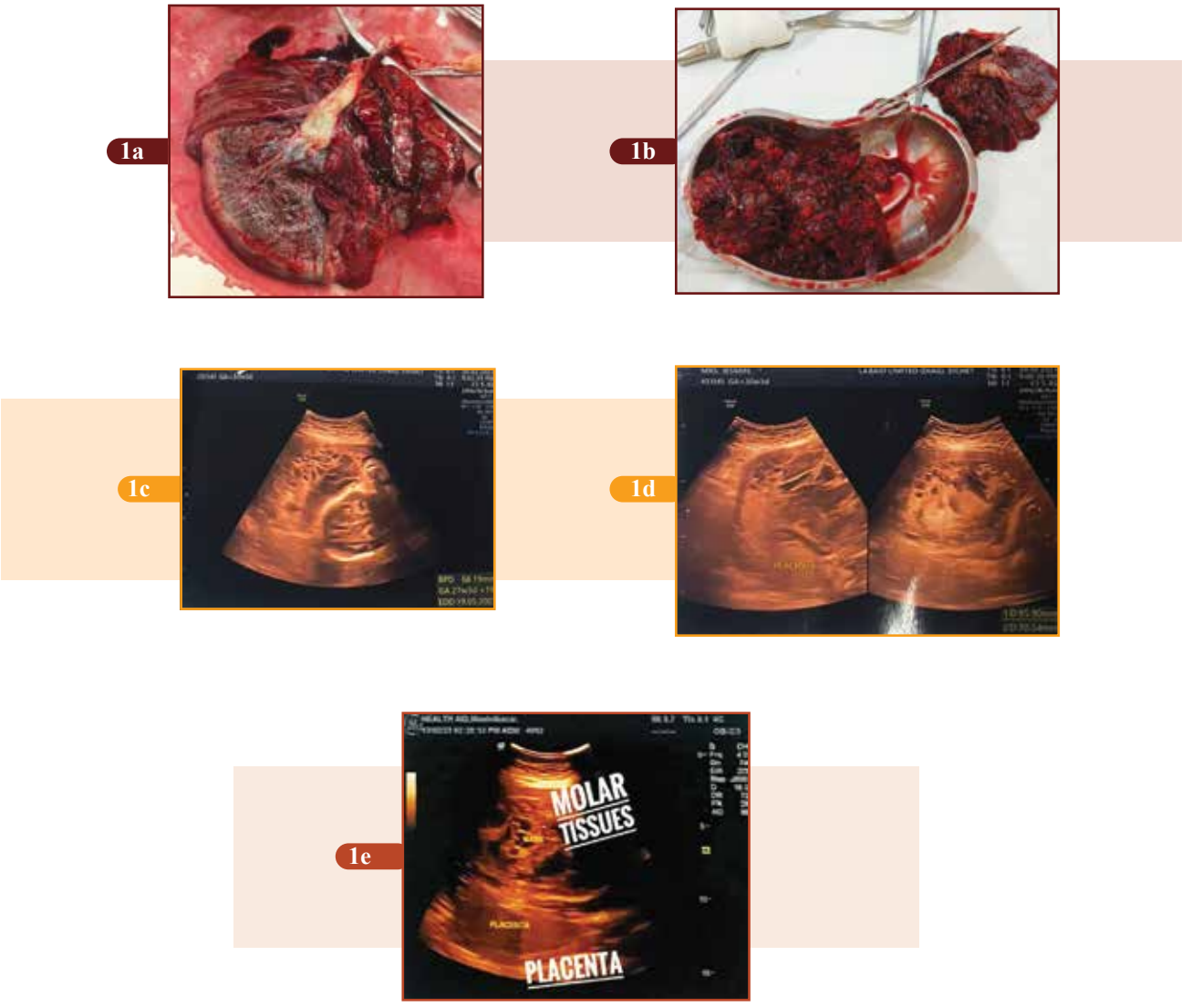

Figure 1: Photographs of Placenta (1a) and Molar tissue after delivery (1b); USG showing the live product of conception (1c); USG showing placenta and molar tissue (1d and 1e)

The baby cried immediately after birth and was shifted to the NICU for observation. She developed PPH, which was managed conservatively. The placenta, molar tissue, and endometrium were sent for histopathology. Histopathology showed normal placenta, endometrium, and hydatidiform mole. The patient and baby

1a

1b

recovered uneventfully and discharged on the 7th post-natal day. β HCG was done weekly and became normal after 6 weeks.

Figure 2: Photographs of the live baby immediately after birth (2a) and 11 days after (2b)

Follow-up continued for one year without any progression to malignant trophoblastic disease, and the baby was also found healthy.

Discussion

When a gynecologist treats a molar pregnancy with a live baby, they should keep in mind that there are three possible outcomes:

1. The most usual is having twins, one of which has a healthy baby and a healthy uterus.

2. The second type is twin pregnancy, where both the baby and the placenta are normal. No PHM is present.

3. The third type, which is also the rarest, is a singleton pregnancy, which has a healthy baby and a placenta that changes during pregnancy [4].

The second type of pregnancy is said to make up between 0.005 and 0.01% of all pregnancies [5]. For this case, one possible reason is that it came from a twin dizygotic pregnancy, in which one twin grew regularly and the other turned into a full mole. A sound placenta and different molar cells show that this idea is correct from a histology and anatomical point of view.

When a couple wants to take the pregnancy to term, it can be hard to tell if there is a molar pregnancy or a live baby. In a study of the literature, Kawasaki et al.[6] found 18 cases of molar pregnancies with live babies present at the same time. There wasn't much hope for the babies because, at an average gestational age of 24.5 weeks at birth, only four (22.2%) were able to survive outside the uterus.

Karyotyping showed that ten of the patients had diploid placentas, which suggests that a CHM could happen in a twin or related placenta mesenchymal dysplasia, as Hojberg et al. [7] also reported. A molar pregnancy with a living child has bad outcomes for both the mother and the baby. There are a lot of prematurities (71.4%). In most of these cases, the pregnancy ends because of serious problems like preeclampsia, missed abortions, vaginal bleeding, or other issues.

In this case, the patient's choice to stay pregnant was respected, and both the mother and the baby did well. We can't ignore the high chance of getting chronic fetal

trophoblastic disease, though. So, a good prenatal assessment should talk about both the result and any problems that might come up during this pregnancy, especially the need for treatment or even a hysterectomy. It is also important to keep in touch with the woman.

Conclusion

To the best of our understanding, there are no worldwide standards on how to treat molar pregnancy with a live baby. Most of the papers that are out there are case studies. So, we need general rules for how to handle these kinds of cases.

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