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Case Report

Twin pregnancy with a complete hydatidiform mole and coexisting foetus

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ABSTRACT

Coexistence of a viable foetus with a complete hydatidiform mole is a rare entity. Traditionally, termination of pregnancy was recommended because of severe maternal and foetal complications. Here we report a case of a 30 year old G2A1 at 27 weeks with a twin pregnancy with a complete hydatidiform mole and coexisting normal foetus who took home a healthy baby without any persistent trophoblastic disease. This case is presented for the rarity of occurrence and good outcome.

Keywords: Twin pregnancy, Complete hydatidiform mole, Coexisting normal foetus, G2A1, Trophoblastic disease

INTRODUCTION

Twin pregnancy with a complete hydatidiform mole and coexisting foetus is a rare entity, its incidence being 1:22000 to 1:100000.[1,2] Due to high rates of maternal and foetal complications, clinicians are wary of a conservative approach. Here we present a case of a complete mole with coexisting twin which was conservatively managed, due to the rarity of occurrence and good maternal and foetal outcome.

CASE REPORT

A 30 year old G2A1 at 26^{+4} weeks of gestation with early onset preeclampsia on tablet α methyl-dopa 250 mg BD since 22 weeks was referred to us with uncontrolled blood pressures. Her first pregnancy had been medically terminated at 20 weeks of gestation due to severe Intrauterine Growth Restriction (IUGR) and oligohydramnios on ultrasound and absent end diastolic flow on Doppler. With married life of 4 years, she had conceived spontaneously a second time. Her first trimester and anomaly scans of the present pregnancy were normal (nuchal translucency being 1.4mm at 13 weeks). An ultrasound done at 22 weeks revealed a live foetus, without anomalies, appropriate for gestational age, alongside a normal looking placenta at the posterior uterine wall. A completely vesiculated mass resembling molar tissue was also noted in the anterior uterine wall, suggestive of a partial mole. A repeat ultrasound at 26 weeks confirmed the findings. Early diastolic notching in both uterine arteries was noted on Doppler. β hCG done at 17 weeks as part of triple marker test was 286878mIU/ml and at 20 weeks was 415200mIU/ml.

After admission, her anti-hypertensive dose was stepped up. Investigations revealed raised creatinine levels (1.4mg/dl) and moderate anaemia while thyroid function tests were normal. Couple was counselled regarding maternal and foetal prognosis and conservative management with close monitoring was done with informed consent.

As she developed preterm contractions, antenatal steroids were given for foetal lung maturity and magnesium sulphate started for foetal neural protection. After 5 days of conservative management, decision for termination of pregnancy was taken because of worsening maternal albuminuria and rising creatinine levels. She was induced at 27^{+2} weeks with one dose of Prostaglandin E2 gel. During the course of labour, she developed abruption and foetal distress for which option of Caesarean delivery was given. Since she refused Caesarean section, vaginal delivery was allowed and a live baby girl weighing 885g with APGAR 1'-6/10 and at 5'-8/10 was born. The normal placenta as well as the mass of molar tissue was spontaneously expelled (Figure 1). Retroplacental clot of 200g was noted. There was no postpartum haemorrhage.

A normal healthy looking neonate without gross congenital defects, a normal healthy placenta as well as a separate mass of molar tissue led to suspicion of a complete hydatidiform mole with coexisting twin. This was confirmed by histopathological examination of placenta (Figure 2) and karyotyping (46XX) of the neonate.

The baby had respiratory distress syndrome, sepsis, shock, necrotising enterocolitis, apnoea and recovered from all these problems, was on ventilator for 11 days and discharged after 84 days of NICU stay with a weight of 1.4kg

β hCG fell from 113119mIU/ml on postnatal day 2 to 80mIU/ml 24 weeks after delivery, on serial monitoring. Following this, patient came for a follow up only after 6 months, by when the β hCG had fallen to < 2mIU/ml. Patient is still under follow up.

Figure 1: A normal placenta and molar tissue are seen separately along with a normal preterm foetus.

DISCUSSION

Twin pregnancy with complete hydatidiform mole coexisting with a live foetus is very rare with only 200 documented cases of which only 56 resulted in live birth.[1] The rising incidence is due to widespread use of ovulation induction, In vitro Fertilisation and advances in ultrasound.[2,3]

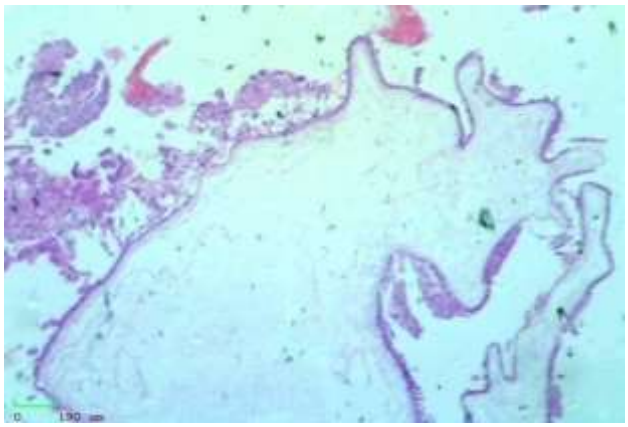

Figure 2: Histology of molar tissue showing avascular oedematous villi with circumferential trophoblastic proliferation.

It is difficult to differentiate a complete hydatidiform mole with coexisting live foetus from a partial mole by ultrasound as both have the same vesicular pattern.[4] Often invasive tests for foetal karyotyping are required to distinguish between the two entities.[1] Partial moles with a triploid foetus have poor prognosis as they are usually aneuploid with severe congenital malformations and tend to die in early pregnancy.[1,4] In contrast, a complete hydatidiform mole with a live diploid twin without anomalies has a better chance of survival (29% - 38%).[1,2,4]

Counselling the couple regarding maternal complications like hyperemesis gravidarum, early onset preeclampsia (30%), vaginal bleeding (30%), anaemia, hyperthyroidism, development of theca lutein cysts, respiratory distress due to trophoblastic embolisation to lungs is essential for making an informed choice.[1,2,4] Foetal complications like IUGR, foetal distress, preterm delivery before 32 weeks (50 – 60%) may decrease foetal survival rates.[1,2]

Traditionally, termination of pregnancy was advocated to avoid maternal or foetal complications.[3] Recent studies have reported a pregnancy termination rate of 4% to 71% due to complications.[2] 60% of pregnancies go beyond 28 weeks with a foetal survival rate of 70%.[5]

Risk of persistent trophoblastic disease after complete mole varies from 19% to 50%.[3] Hence the need for follow up with β hCG. Favourable response to chemotherapy in Gestational Trophoblastic Disease favours a conservative approach.

Conservative management, after good counselling, in a tertiary centre could result in good outcome.

CONCLUSION

Twin pregnancy with a complete hydatidiform mole and coexisting normal foetus can result in a good obstetric and neonatal outcome following a conservative approach in a tertiary care centre after good counselling and follow up of the couple.

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available with the corresponding author.

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