Case Report

Complete hydatidiform mole presenting as placenta previa in a twin pregnancy with a coexisting normal foetus: Case report

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Abstract

We present a case of a patient with a complete hydatidiform mole co-existing with a normal foetus (CMCF) who had a caesarean section in week 32 of gestation, resulting in a live female infant weighing 1590 grams. The mother, with a normal bleeding pattern, did not require any surgical intervention. She was discharged from hospital on the third post-operative day. Premature termination is recommended in this type of pregnancy because of the risks associated with molar pregnancies. However, with the close follow-up of these pregnancies, good maternal and perinatal results may be obtained. (J Turk Ger Gynecol Assoc 2014; 15: 256-8)

Key words: Twin pregnancy, complete hydatidiform, placenta previa

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Introduction

A complete hydatidiform co-existing with a live foetus (CMCF) is extremely rare. It is difficult to estimate the incidence of such pregnancies because the diagnosis can only be made by histological examination (1). Pre-eclampsia, hyperemesis gravidarum, intrauterine foetal demise and increased risk of persistent trophoblastic disease are the most common complications (1-4). Careful clinical assessment, detailed ultrasound examination and chromosome analysis are essential for prenatal diagnosis. Patients with CMCF may have an increased risk of persistent trophoblastic disease. These pregnancies may have an aggressive biological course even after they have been terminated. The rate of trophoblastic tumours after such pregnancies has been reported to be 50 to 60% (1). However, there is no consensus on the diagnosis and management of such pregnancies. We present here a case of a CMCF who was delivered at 32 weeks of gestation.

Case Presentation

A 21-year-old nulliparous woman suffering from vaginal haemorrhage in the early second trimester of her pregnancy was referred to the Obstetrics and Gynecology Department of Ege University Hospital. Gestational age was 17 weeks and 4 days according to her last menstruation date at the time of admission. A live foetus and a placenta with multi-cystic, heterogeneous appearance and increased anteroposterior diameter were observed on ultrasound examination (Voluson e8 Ultrasound Device, Buckinghamshire, United Kingdom) (Figure 1). Serum levels of β-hCG and haemoglobin were 77.509 mIU/mL and 11 g/dL, respectively. The thyroid function tests, amniotic fluid volume, umbilical artery Doppler flow velocimetry, foetal growth and the maternal blood pressure were all within normal limits. A normal karyotype (46, XX) was found based on the results of amniocentesis. The pregnant woman and her family were informed about molar pregnancy and written informed consent was obtained from the patient for this study. The termination of the pregnancy was recommended as an option because of the probable risks of molar pregnancy; however, with the close follow-up of these pregnancies, good maternal and perinatal results may be obtained. (J Turk Ger Gynecol Assoc 2014; 15: 256-8)
of gestation. The patient was hospitalised with the diagnosis of placenta previa totalis and preterm labour. Antenatal betamethazone for foetal lung maturation and intravenous MgSO₄ as a tocolytic agent were administered to the patient. The patient was taken urgently to the operation room for labour due to excessive vaginal haemorrhage at the gestational age of 32 weeks on the fourth day of hospitalisation. A female infant weighing 1590 g was successfully delivered by caesarean section. APGAR scores at the 1st and 5th minutes were 7 and 9, respectively. The surgery took place smoothly and none of the expected complications, such as significant uterine bleeding, were encountered during the operation. The serum β-hCG and haemoglobin levels were 30.134 mIU/mL and 9.7 g/dL, respectively, on post-operative day 1. Placentomegaly, hydropic degeneration and many vacuoles were observed to be compatible with complete hydatidiform mole in the placenta (Figure 3). The pathological examination confirmed the initial diagnosis of CMCF. The infant was admitted to the newborn intensive care unit because of prematurity. The mother was discharged on the third post-operative day. Serum β-hCG levels were both zero on the sixth post-operative week and on the monthly follow-up, until six months after delivery.

Discussion

In several studies, the incidence of CMCF has been reported to be between 1/10000 and 1/100000 (1-4). Diagnosis is usually made by first-trimester ultrasound examination (2). In those cases, vaginal haemorrhage was found to be most common complaint at admission to the hospital (1-4). Serum levels of β-hCG are usually high at the time of admission, but it should be kept in mind that β-hCG levels may be high in multiple gestations (2). A high level of β-hCG at the time of admission may be an indication of poor prognosis of the disease (1).

Partial and complete molar pregnancies have obvious foetal and maternal risks (2). Thus, such pregnant women should be followed more carefully in specialised centres. It is usually recommended to terminate a partial or complete hydatidiform mole if it is detected early in the course of pregnancy (1, 2).

Ongura et al. (5) presented a case who had a complete mole coexistent with a twin foetus. Her pregnancy was terminated by hysterectomy due to massive haemorrhage. The second patient published by Suri et al. (6) presented to hospital in the 28th week of gestation with signs of intrauterine infection. Her pregnancy was terminated in week 28 of gestation by hysterectomy following the development of systemic inflammatory response and a live male infant was born. Pathological examination supported molar pregnancy and bacterial abscess. Klatt et al. (7) reported a case in the third gestational week with vaginal haemorrhage. Her pregnancy was terminated on the 31st gestational week by hysterectomy upon increasing vaginal haemorrhage and foetal distress; an intrauterine balloon was inserted prophylactically for postpartum haemorrhage.

It is appropriate to evaluate the placenta by Doppler ultrasound examination in early gestational weeks to exclude placenta accreta; occasionally, MRI may be needed for the posterior side placenta and it may be necessary for the assessment of the depth of myometrial and parametrial involvement (8).
The optimal management of CHCF is controversial, especially when the pregnancy is desired. The management may be altered due to coexisting complications, such as hypertension, pre-eclampsia, thyrotoxicosis and vaginal haemorrhage. The aim of the management should be to avoid complications and to plan delivery at the most appropriate time for both maternal and foetal well-being. Performing the surgical intervention by an experienced surgical team would be more appropriate for avoiding complications that could occur during operation. One should be alert for severe and serious postpartum haemorrhage that may be caused by placenta previa as well as molar pregnancy and the necessary surgical instruments and materials should be prepared prior to operation.

In conclusion, we can say that it should be advised to terminate such pregnancies in order to prevent maternal and foetal risks. However, one should keep in mind that such pregnancies may result in live births with careful follow-up. Also, one should be alert for the possibility of gestational trophoblastic neoplasia following termination of the pregnancy.

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**References**


