CASE REPORT

Partial Hydatidiform Mole with a Live Fetus—A Rare Entity

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Abstract

Partial hydatidiform mole (PHM) with a singleton live fetus is a rare condition. A live baby of 2000 grams with many external congenital anomalies like hydrocephalus, bilateral congenital talipus equino varus (CTEV), meningomyelocele and spina bifida was delivered. Placenta weighed 700 grams and PHM was confirmed by histopathological examination. Baby expired one hour after birth. Baby was sent for autopsy which documented various anomalies. Partial hydatidiform mole is a histopathological entity characterized by focal trophoblastic hyperplasia with villous hydrops together with identifiable fetal tissue. PHM with a single live fetus is a rare condition which is reported by very few authors. Not all the cases of partial mole can be detected by USG/Doppler. If any anomalies are detected, PHM should be thought among the conditions possible. MShCG and karyotyping can be done to rule out this condition. Placenta has to be sent for histopathological examination to confirm the diagnosis of PHM. These patients are prone to go in preterm labor and preterm premature rupture of membranes (PPROM). There is possibility of malpresentations like transverse lie among these cases.

Keywords: Partial hydatidiform mole, pregnancy, histopathology, karyotyping, molar pregnancy.

INTRODUCTION

Partial hydatidiform mole (PHM) with a singleton live fetus is a rare condition. It is commonly seen with twin gestation and it is rare with singleton pregnancy.[1] Incidence is 1 in 20000 to 1 in 100000.[2] Most of the women present with early onset of hyper emesis, pre-eclampsia, intrauterine growth restriction (IUGR), or a fetus with anomalies. We are reporting a rare case of PHM with a live anomalous preterm fetus.

CASE REPORT

A twenty two years old lady was referred from a private hospital to KLES Dr Prabhakar Kore Charitable Hospital. She was not a booked case of the hospital. She had visited the antenatal clinic at private hospital only once at twenty-five weeks period of gestation. An ultrasound examination was done at this period of gestation which showed no anomalies. She had no other antenatal visit to hospital during this pregnancy. Her other antenatal history was uneventful. She was second gravida with 31 weeks period of gestation (calculated from last menstrual period). Her first pregnancy was uneventful with delivery of single, live healthy baby.

She presented with pain abdomen since 4 hours prior to admission and PPROM since 6 hours prior to admission. She had records of only one antenatal visit at twenty-five weeks of gestation at a private hospital and an ultrasound report showed no anomalies. On examination, we found the uterus was acting with strong uterine contractions and fetus was in transverse lie. She had active leak per vagina and was in active labor. Fetal heart sound was normal and admission cardiotocography was reassuring. Ultrasonography (USG) was done in our hospital which revealed hydrocephalus due to aqueductal stenosis. Though the prognosis of baby was poor, emergency cesarean section was performed in view of transverse lie in active labor after counseling and informed written consent.

A live male baby of two kilograms with many external congenital anomalies like hydrocephalus, bilateral CTEV deformity (Fig. 1), meningomyelocele and spina bifida (Fig. 2) was delivered. Morphological examination of placenta revealed multiple vesicles of various size and shape (Fig. 3). Placenta was unduly enlarged and weighed 700 grams. PHM was suspected clinically and was confirmed by histopathological examination. Baby developed respiratory distress and expired one hour after birth. Baby was sent for autopsy which

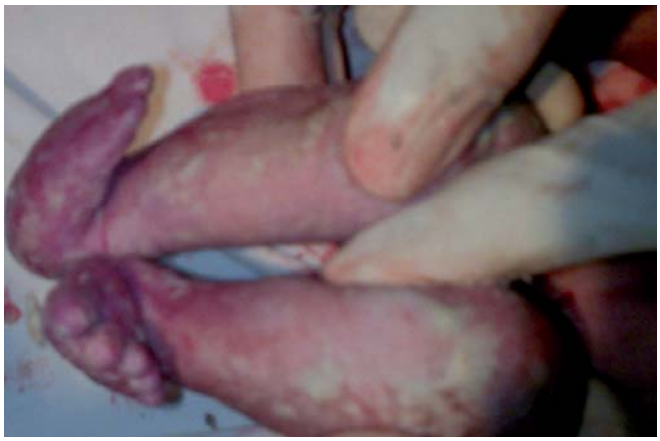

Fig. 1: Bilateral CTEV of the foot

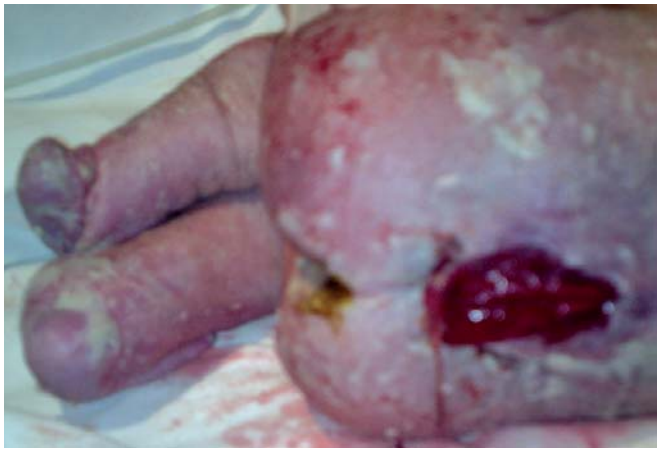

Fig. 2: Meningomyelocele and spina bifida

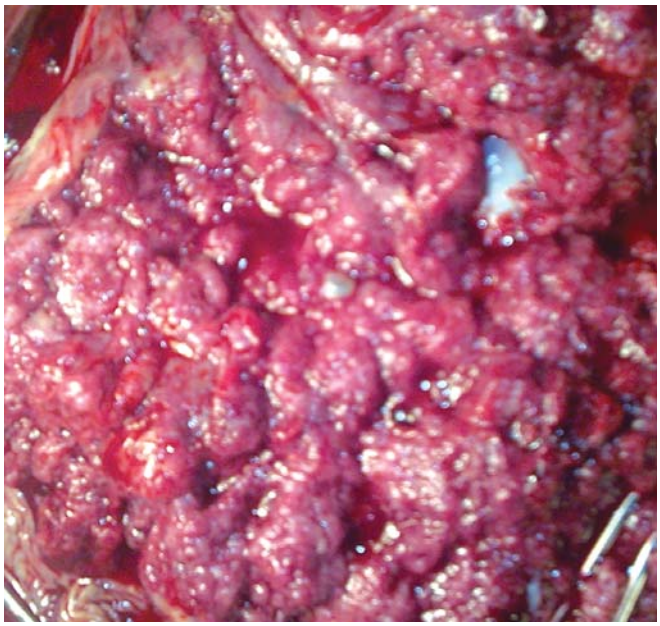

Fig. 3: Placenta with multiple vesicles

documented various anomalies like hydrocephalus, hydronephrosis, restrictive emphysema and spina bifida. Post-operative period was uneventful.

DISCUSSION

Partial hydatidiform mole is a histopathological entity characterized by focal trophoblastic hyperplasia with villous hydrops together with identifiable fetal tissue.[3] Complete hydatidiform mole and PHM are two abnormal conceptus that may be identified by clinical, USG, gross morphological, histological and genetic characteristics.[4] Among these criteria, the specific diagnosis is generally confirmed by histopathological view.[4] PHM with a single live fetus is a rare condition which is reported by very few authors.[5] These patients are known to presents with early onset pre-eclampsia,[6] but not all patients present with this condition as in our case. Most of the cases present with IUGR, oligohydramnios, congenital anomalies.[3,7] We also have similar observation of multiple congenital anomalies in our case. Specific diagnosis is confirmed by histopathology only.[4,8] We got the diagnosis confirmed by histopathological examination of placenta. Some authors say a placental cyst may be visualized on USG and Doppler which is difficult to diagnose.[9] On ultrasound examination, if congenital anomalies are present with symmetrical intrauterine growth restriction and a placental cyst, PHM has to be suspected. The diagnosis of partial hydatidiform mole should be based on pathological examination, since most cases still elude clinical detection.[10] A reliable and complimentary method to the pathologic interpretation is a genetic study of the conceptus.[4] MShCG level and cytogenetic results have to be correlated with the histopathological examination.[3] These women should have postpartal MShCG done in order to rule out gestational trophoblastic disease/persistent gestational trophoblastic disease.

Malpresentation like transverse lie in our patient could be due to large placental area occupying the uterus which compromises the space available for baby. Congenital anomalies and hydrocephalus might also be responsible for the mal-presentation.

Women with this pregnancy complication should be offered immediate termination and specific follow-up.[3] Early termination of pregnancy was not possible in our patient as diagnosis was not made earlier. Single undetectable MShCG after termination of pregnancy is sufficient to ensure remission in these patients.[11] Follow-up period in patients with PHM should not be more than a year, because of the rarity of postevacuation sequelae.[12,13]

CONCLUSION

Diagnosis of PHM has to be made by histopathological examination of placenta. Various congenital anomalies are associated with PHM. It is not possible to diagnose all the cases of partial mole by antenatal USG/Doppler. These patients

are prone for preterm labor and PPROM. There is possibility of malpresentations like transverse lie among these cases due to increased placental surface area.

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