



**ORIGINAL RESEARCH PAPER**

**Obstetrics & Gynaecology**

**AN UNUSUAL CASE OF TWIN MOLAR PREGNANCY**

**KEY WORDS:**

**Dr Prajakta Deshmukh**

Junior Resident Department of Obgy

**Dr D Y Patil\***

Medical College Navi Mumbai\*Corresponding Author

**Dr Ashvini Deshmukh**

LECT

**Dr Yogeshwar Nandanwar**

Prof & Hou

**Dr Sriram Gopal**

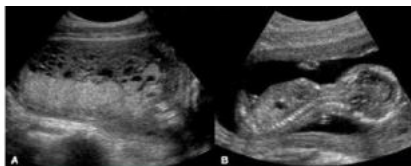
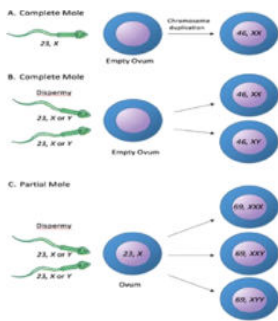
Prof &HOD

**ABSTRACT**

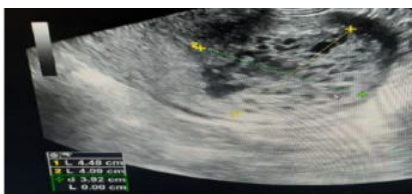
- Molar pregnancies belong to the group of diseases classified as gestational trophoblastic diseases(GTD) which result from altered fertilization.
- Molar pregnancy with a live fetus is very rare (0.005% to 0.01% of all pregnancies).
- Its diagnosis is challenging when clinical signs are almost absent. Management of these cases is also challenging due to antepartum and postpartum complications.
- We are reporting a rare case of 26-year primigravida presented at 18 weeks of gestation with inevitable abortion and USG demonstrated single live intrauterine pregnancy with concurrent hydatiform mole.

**INTRODUCTION**

- Molar pregnancy constitutes a benign spectrum of gestational trophoblastic disease(GTD).
- Molar pregnancy is caused by a cytogenic anomaly in fertilization and may lead to 2 clinical forms: a complete mole and a partial mole based on distinctive histopathological features and genetic abnormalities
- Partial mole is usually derived from dispermic fertilization with haploid normal oocyte and produces a triploid set of chromosomes(69XXX,69XXY,69XYY)
- Complete mole consists of 46 paternal chromosomes and does not have any fetal structures.



Transabdominal image at 15 weeks gestational age show (A) a heterogeneous placenta with multiple cysts and (B) a live fetus. Findings are compatible with partial molar pregnancy.



Transvaginal image at 18 weeks gestational age shows a heterogeneous placenta with multiple cysts and a fetus within the uterine cavity. Findings are compatible with complete molar pregnancy.

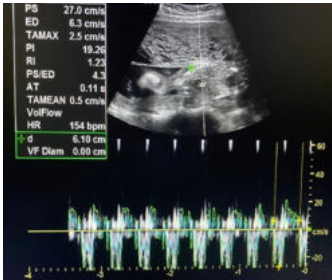
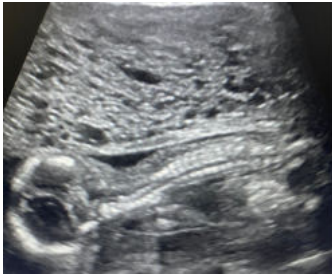
- Most common symptom of early molar pregnancy is heavy vaginal bleeding (passage of grape-like vesicles).
- Other associated symptoms and risks include severe nausea, hyperemesis gravidarum, hyperthyroidism, hypertension, anaemia, thromboembolism, uterine rupture, development of GTN, or persistent gestational trophoblastic disease.
- Serum beta HCG levels in partial molar pregnancy are generally lower than in complete molar pregnancy.
- Diagnosis is usually made with USG and sensitive measurements of serum beta HCG levels in the first trimester.

**CASE PRESENTATION**

- A 26 years old primigravida married for 8 years unregistered at our hospital presented at 18 weeks of gestation with complaints of vesicle discharge and heavy vaginal bleeding and lower abdominal pain since 1 day. History of nausea and vomiting episodes 7-8 per day since 5-6 days
- No signs of preeclampsia,HELLP syndrome
- On examination, the patient was averagely built, tachycardia present, normotensive, and maintaining saturation on room air
- Pallor present.
- UPT test was positive.
- Per abdomen uterus 24 weeks of gestation, irritable.
- Per speculum findings-bleeding present.
- PV findings-internal os 2 cm dilated,50% effacement present, a bag of membranes bulging, vertex, the station at 0.
- Serum beta HCG levels were 2 lacs mIU/ml.
- Moderate anaemia haemoglobin 8
- Deranged thyroid function test.
- LFT, RFT, COAGULATION PROFILE, and other ANC investigations within normal limits.

**On Transvaginal Sonography:** gravid uterus with a single live fetus with CRL of 7.17 cm corresponding to 14 weeks 5 days was seen, with a thickened decidua at the anterior wall of

the uterus showing multiple heterogeneous anechoic cystic areas within suggestive of twin molar pregnancy.



- Patient was transfused 1 pRBC. After a few hours, the abortus (male) expelled 185gms weight, and the placenta was expelled spontaneously. Check curettage done post spontaneous abortion due to high maternal risk and samples sent for a histopathology examination.
- Patient's serum beta HCG levels were in decreasing trend and returned to normal in 7 weeks
- Histopathology report confirmed the diagnosis of complete mole



Image shows the delivered aborted fetus and the grape like vesicles of the thickened decidua, confirming to the diagnosis of CMCF: complete hydatidiform mole and a coexisting live fetus.

**DISCUSSION**

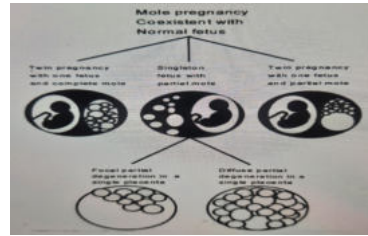
- Twin pregnancy consisting of one fetus and one complete mole (CMCF: complete hydatidiform mole and a coexisting live fetus) a rare occurrence of 0.005%- 0.01%.
- An increase in incidence could be explained by greater use of ART (Assisted Reproductive Techniques).
- Suspected/ confirmed diagnoses of twin pregnancy with a hydatidiform mole can lead to 2 strategies:

1. Elective Termination Of Pregnancy due to high risk to mother: if the preferred technique used is uterine aspiration in <12 weeks but not done in > 12 weeks due to fetal skeletal maturity. Or

2. Comprehensive Prenatal Care in a referral center for GTD.

- Weekly measurements with serum beta HCG levels was

performed during the post-molar follow-up till it were undected and monthly after that.



3 types of molar pregnancy with coexisting normal live fetus:  
 1. A twin pregnancy with normal fetus having a normal placenta and another complete mole

2. Singleton normal fetus with partial molar placenta.  
 Twin pregnancy with regular fetus and placenta and another partial mole

**CONCLUSION**

- Twin pregnancy with complete hydatidiform mole and the coexistent live fetus is a rare condition that can be diagnosed by obstetric ultrasound.
- Twin molar pregnancies presented with a clinical dilemma in deciding between continuation or immediate termination of the pregnancy.
- The potential risk of malignancy in such patients was significantly higher than single complete molar pregnancy, while advanced gestational age was not an independent risk factor for the development of persisting trophoblastic tumor.
- It is associated with an increased incidence of maternal and fetal complications.
- Immediate termination has been recommended after the diagnosis because of the increased risks of developing maternal medical complications.
- Termination versus expectant management should be decided after karyotype and detailed anatomical survey of the live fetus.
- Decision to continue the pregnancy should be taken after weighing the possibility of fetal survival against maternal risk.
- Counselling of the couple and family plays a crucial role in such cases. For those who choose to continue the pregnancy, the management has to be in a tertiary care hospital with strict vigilance on maternal, fetal, and neonatal condition.
- Long term follow-up with serum b-hCG levels is mandatory.

**REFERENCES**

1. J. Fetal Med. (December 2015) 2:171-174 DOI 10.1007/s40556-015-0067-6.
2. Lagare JJC, Lu-Lasala L. Complete hydatidiform mole with coexisting live fetus: case report. SPMC J Health Care Serv. 2019;5(1):6. <http://n2t.net/ark:/76951/jhcsu8d5t>
3. Abidi SMA, Shah TS, Abbas S (2021) Delivering a Live Fetus at 24th Week Gestational Week: A Case of Partial Hydatidiform Molar Pregnancy. Gynecol Obstet Case Rep Vol. 7 No.5:137 <https://pubs.rsna.org>
4. <https://pubs.rsna.org>
5. <https://jmedicalcasereports.biomedcentral.com>
6. <https://obgyn.onlinelibrary.wiley.com>
7. <https://fetalmedicine.org>