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Case Report

Twin pregnancies with complete hydatidiform mole: A case report

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ABSTRACT

Objective: The association between twin pregnancies and hydatidiform mole is a rare clinical condition. With the development of ultrasonography devices, prenatal diagnosis has become easier.
Case Report: A 21-year-old patient with gravidity 1 parity 0 applied to our clinic with the complaint of vaginal bleeding at week 16 of her pregnancy according to her last menstrual period. A pregnancy termination option was offered to the patient who was diagnosed with twin pregnancy consisting of a complete hydatidiform mole and a co-existent fetus as a result of the examinations and tests. Emergency laparotomy was planned for the patient who did not accept the pregnancy termination option due to severe vaginal bleeding at week 21 of pregnancy.
Conclusion: Although live births are reported in the literature in cases where twin pregnancy and hydatidiform mole are seen together, pregnancy termination due to vaginal bleeding may be required in earlier weeks.

Keywords: hydatidiform mole; hysterectomy; twin pregnancy; ultrasound; vaginal bleeding

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Introduction

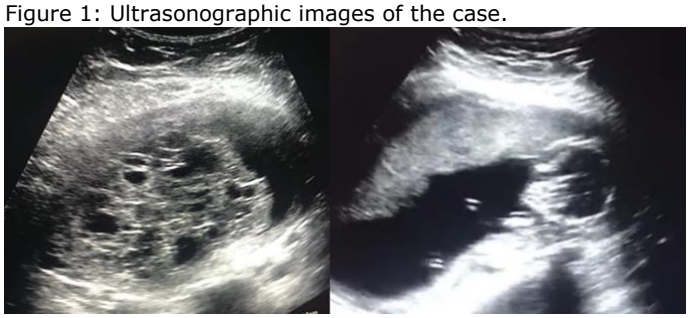
Hydatidiform mole is a rare pregnancy complication, however it can turn into forms that require systemic or surgical treatment. Hydatidiform mole has two histopathological subgroups: partial (PM) and complete mole (CM) [1].
Twin pregnancy consisting of a complete hydatidiform mole and a co-existent fetus (CHMF) is rare clinical condition [2]. The incidence of this clinical situation ranges from 1 22.000 to 1 in 100.000 pregnancies [3].
The presented case was followed up with the diagnosis of abortus imminens in an external health center until the 16th gestational week and admitted to our clinic with complaint of vaginal spotting. Transabdominal ultrasound examination revealed a pregnancy of 16 weeks gestation with live fetus. One of the placentae was separate and the sonoluscent areas were interpreted as molar tissues at the level of the uterine isthmus. This case reported aimed to share this rare condition and our clinical experiences gained from this case.

Case Report

A 21-year-old patient with gravidity 1 parity 0 applied to our clinic with complaint of vaginal bleeding at week 16 of her pregnancy according to her last menstrual period.
The patient was followed up by another center with the diagnosis

In the ultrasonographic examination, a live and anatomically normal fetus compatible with 16 weeks of pregnancy was observed. Also, a normal placenta observed on the anterior wall of the uterus and a 7.5 x 12-cm-molar placental tissue at the level of the uterus isthmus were observed accompanying a single fetus in a single amniotic cavity (Figure-1).

Figure 1: Ultrasonographic images of the case.



The patient was hospitalized with the preliminary diagnoses of partial mole and CHMF. In the examinations performed, maternal serum β human chorionic gonadotropin (MS-βhCG) was found to be 340,000 mIU / mL, thyroid-stimulating hormone (TSH) 0.01 μU / mL, and free thyroxine (T4) 1.11 ng / dL. Other laboratory values were found to be within limits.

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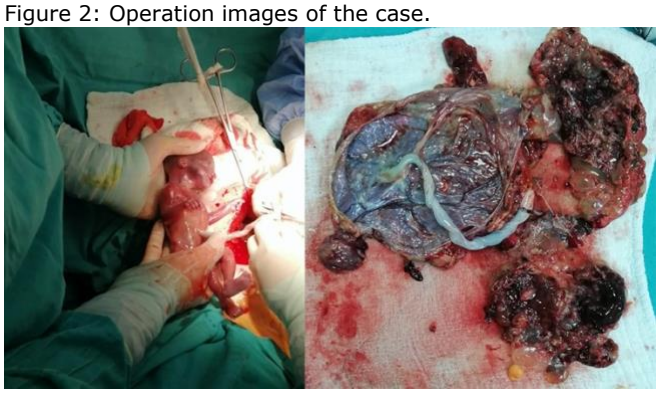
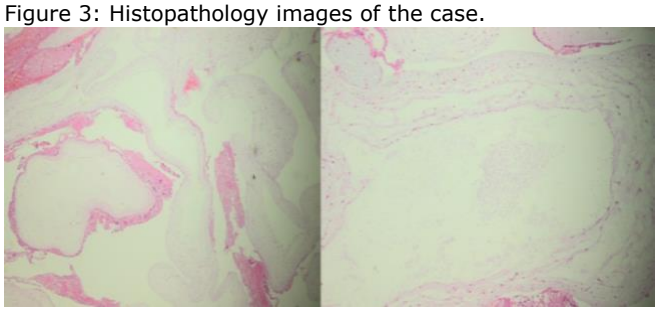
The patient was referred to a perinatology clinic for genetic analysis.
As a result of the amniocentesis, the karyotype of the fetus was reported to be normal. The patient was offered the option of termination of pregnancy, however the family did not accept the termination of pregnancy.
The patient then applied to our clinic with severe vaginal bleeding at the 21st week of pregnancy. In the examination, the cervix was fully dilated and the amniotic sac was prolapsed into the vagina. Emergency laparotomy was planned for the patient in the lithotomy position. Following the Pfannenstiel-Kerr incision, a 350 g female baby was delivered with APGAR 0 (Figure-2).

Figure 2: Operation images of the case.



After the placenta and molar tissues were removed, bilateral internal iliac artery ligation was performed and intrauterine Bakri balloon was placed to stop the uterine bleeding originating from the uterine isthmus level.
During the operation, 3 erythrocyte suspensions and 3 fresh frozen plasma were given. The patient's post-op follow-up was normal. Bakri balloon was removed on the 1st day and the patient was discharged on the 4th post-op day. The patient, who was reported as a complete mole as a result of the pathological examination, was followed up weekly until the negative MS-βhCG value was detected, after which she was followed up for 6 months (Figure-3).

Figure 3: Histopathology images of the case.



Discussion

The incidence of CHMF is reported in the literature between 1 / 10000 and 1 / 100000 [2]. In the ultrasonographic examination, cases with the coexistence of molar appearance and fetus can be encountered in three ways in practice; twin pregnancies in which the first fetus is normal and the second pregnancy is CM, single PM accompanied by triploid fetus and twin pregnancies with normal other fetus accompanied by PM [4].
While the diagnosis of molar pregnancies is usually made during the first trimester ultrasonographic examination, CHMF is often presented with the findings of gestational trophoblastic diseases in the second trimester. The presence of a normal fetus in CHMF may lead to errors in diagnosis [5]. The clinical significance of MS-hCG levels, which are found to be severely high in CM, decreases due to the naturally high detection of this hormone in twin pregnancies. In this case, invasive methods may be preferred for differential diagnosis [6]. In our case, cytogenetic examination was needed for differential diagnosis and the fetus was evaluated as chromosomally normal.

CHMF management has generally been in the form of termination of pregnancy in the past years. However, in recent years, the number of physicians who show a conservative approach and families who do not accept the termination has been increasing. As a matter of fact, our case did not accept the option of termination of pregnancy. When a conservative approach is chosen, the expectant mother may face complications related to pregnancy and an increased risk of persistent trophoblastic disease (PTH) [7]. Values between 19 % and 50 % have been reported in the literature for the possibility of PTH development in the conservative approach [8, 9]. In addition, it is seen that the chance of a live baby is less than 50 % and the probability of developing preeclampsia is 20 % in this approach [10]. Our case ended with emergency laparotomy due to the onset of labor at 21 weeks of gestation and severe vaginal bleeding with a conservative approach.
When a conservative approach is preferred, it is necessary for the clinician to demonstrate the presence of a diploid fetus by amniocentesis [4]. Evaluation with USG and MS-hCG follow-up is recommended every two weeks in the follow-up of pregnancy. It has been reported that increased MS-hCG levels are associated with a high risk of maternal complications and PTH[11]. In addition, due to the risk of developing preeclampsia, it is recommended to regularly monitor arterial blood pressure and to screen for proteinuria in the urine, and to evaluate anemia due to chronic vaginal bleeding and possible hyperthyroidism findings. It is recommended to take a chest X-ray every 3 months for metastasis screening [10].
In conclusion, although the diagnosis of molar pregnancy can be made by ultrasonographic examination, it should be considered that the disease is a progressive disease and molar degeneration cannot always be detected in the first trimester. There are publications in the literature that support both the conservative approach and pregnancy termination. If the family chooses to continue the pregnancy, it would be appropriate to follow up with the patient in a center with a perinatology and oncology unit. In our case, the family preferred the conservative approach, but the pregnancy ended with the onset of severe vaginal bleeding and labor at the 21st week.

Disclosure

Authors have no potential conflicts of interest to disclose.

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