CASE REPORT

Term Pregnancy with Partial Molar Changes of Placenta

Amita Gupta, Yudhishter Veer Gupta

Abstract

A rare case report of successful term pregnancy with partial molar changes of placenta is being reported. The patient was 2nd gravida with twin pregnancy with pregnancy induced hypertension (PIH). Patient under went LSCS and gave birth to two healthy looking babies. She was followed up and serum HCG (Human Chorinic Gouadotrophin) level returned to normal within 4 weeks after delivery.

Key Words

Partial mole, HCG

Introduction

In the late 1970, Szulman (1) Lawler (2) and others reported two distinct types of moles based on morphological, histopathological and cytogenestic examination. It was recognized a long ago that in some moles a fetus was present. It is now well accepted that threre are two types of Hydatiform moles, complete and partial. A partial mole exhibits a focal hydatidiform change of the villi, and hyperplasia of the syncytiotrophoblast and an embryo/fetus may be present. The fetus usually dies early in the first trimester but some patients with partial mole give birth to live fetuses. The fetuses are usually retarded in growth and have multi-system abnormalities. Occasionally the partial mole may co-exist with live fetus with abnormal karyotype (3). Partial mole has a triploid XY or XYY karyotype and seems to develop when a normal egg with 23X haploid set is fertilized by two sperms or by one sperm with unreduced genome 46XY. Villi appear to undergo hydatidiform change only when the contribution of the extra haploid set is from the paternal side. If it is from the maternal side, the placenta will not undergo molar change but the fetus will exhibit abnormality. In view of the absence of any abnormality in the babies and a profound molar change confined to one part of placenta we feel the rarity of this case.

Case Report

Patient X (G2P1) with no live issue was under antenatal care in Suvidha Mother & Child Nursing Home as a case of twin pregnancy. General physical examination and systemic examination did not reveal any abnormality. Her routine investigations including haemogram, urine R/E etc. were within normal limits. On routine USG at 36 weeks of pregnancy the placenta showed features of molar degeneration (Fig. 1). The colour doppler study did not show any increase in vascularity in areas of molar degeneration. The patient was taken up for lower segment caeserean section because of over distended abdomen and associated pregnancy induced hypertension at 38 weeks

From Suvidha Mother & Child Nursing Home, Canal Road, Jammu (J&K) India.

Correspondence to : Dr. Amita Gupta, Lecturer, Deptt. of Gynae. & Obst., Government Medical College, Jammu (J&K) India.

pregnancy. She gave birth to a male and a female baby. Placenta was removed manually. There were two placentae. Uterus was flabby but responded to syntocinon drip and uterine massage. Examination of placentae revealed that the molar change was confined to a portion of one placenta. Histopathology of placenta showed hydropic changes of the villi and focal trophoblastic proliferation necrosis. Normal villi were also seen focally. No evidence of malignancy was found.

The patient was followed up for one month. HCG levels were done in the urine weekly by Elisa method and it was negative after 15 days. S. beta HCG levels after 15 days of LSCS were 35·31-m iu/ml. (N<5·0-m iu/ml). S. beta HCG after 30 days were 5·94 m iu/ml. X-ray chest of patient after the caeserean was found normal. Babies have grown nomally till date.

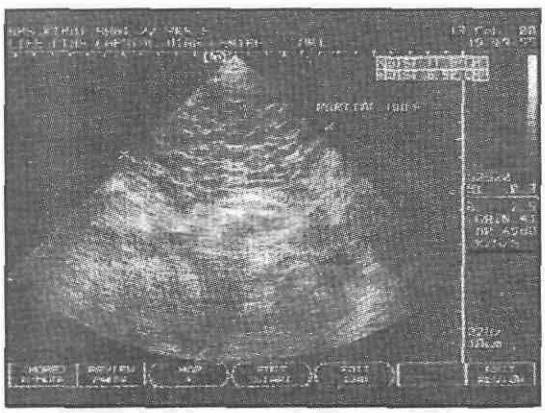

Fig. 1. Ultrasound examination showing partial molar changes in one part of placenta as bunch of grapes appearance.

Discussion

The clinical presentation of partial moles does not differ markedly from that of a complete mole but it tends to present a less florid picture (1). The age, parity and symptoms of partial mole patients are similar to those of complete mole while the duration of amenorrhoea tends to be longer in these patients. Partial mole is usually not as high as that of a complete mole.The ultrasonographic appearances of partial mole was described. Once the diagnosis of a partial mole is made and if there is no live fetus, the treatment is to evacuate the uterus. In the rare situation when there is a live normal fetus, the patient should be warned about the likely adverse fetal outcome. The post evacuation HCG regression pattern is no different from that of the complete mole. It was prevously believed and some still hold the belief that persistent or metastatic trophoblastic diseases very rarely occurred in partial mole patients. Berkowitz 1985 (4) reported that eight of their 81 patients (9.9%) had persistent diseases. Therefore it is important to diagnose partial mole. If a live fetus is present, chorionic villi biopsy can be done to make the diagnosis. In spite of the low incidence of metastatic sequel, partial mole patients should be followed in the same manner as complete mole at least until HCG returns to normal for 3-6 months.

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