

## PARTIAL MOLE WITH COEXISTING TERM FETUS- A CASE REPORT

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### ABSTRACT

Partial molar pregnancy is a rare entity in which there is usually abnormal fetus associated with a large placenta with cystic changes. The incidence of a normal fetus at is extremely rare. Here we report a 24-year-old primigravid with gestational age of 39 weeks + five days who present with decrease fetal movement of three days. Ultrasound was done and there was normally appearing fetus, but no measurable fluid. Other biophysical parameters were reassuring. The whole placenta had snow storm appearance and enlarged. Cesarean section was done for the indication of sever oligohydraminosis with unfavorable bishop with the outcome of 2.2 kg alive female neonate with APGAR score of seven and eight in the first and fifth minute respectively. The placenta was sent for histopathology and report as partial hydatidiform mole.

**KEYWORD:** partial hydatidiform mole, Placenta, congenital malformation

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## INTRODUCTION

Hydatidiform mole is characterized by abnormal fetoplacental development and trophoblastic hyperplasia due to excessive paternally derived genetic material<sup>1</sup>. Hydatidiform mole is classified as partial (PM) or complete (CM), on the basis of distinctive histopathological features and genetic abnormalities<sup>2</sup>. In PM there is partial replacement with hydropic villi and visible abnormal fetal parts mostly leading to termination of pregnancy in the first trimester<sup>3</sup>. Partial mole with living fetus without any congenital anomaly or chromosomal stigma is a very rare entity. Singleton living fetus with partial mole is still rarer. Such an occurrence has been found only few times in extensively searched medical literature<sup>4,6</sup>.

The whole placenta had snow storm appearance and enlarged. Fetus showed no obvious congenital abnormality. A cesarean section was done for indication of severe oligohydramnios with unfavorable bishop and the outcome was 2.2 kg alive female neonate with APGAR score of seven and eight in the first and fifth minute respectively. The newborn had wrinkled skin, long nail and hair (Figure 1).

The newborn was stable and with the mother. The gross placenta measures 17 x 11 x 13 cm with associated membrane. The weight of the placenta was 1100gram (including the cord and membrane). There were diffuse solid and cystic components all over the placenta (Figure2).

## CASE REPORT

A 24-year-old primigravida lady with gestational age by date of 39 weeks + five days with no antenatal care present with decrease fetal movement of three days duration. She had no pushing down pain, passage of liquor amni or vaginal bleeding. Pregnancy was uneventful. On physical examination, she was comfortable. Her pulse rate was 78 beats per minute, and Blood pressure was 110\70mmhg. Pertinent finding was on abdomen, where there was 36 weeks size gravid uterus, longitudinal lie and cephalic presentation, with positive fetal heartbeat. On per vaginal examination, cervix was closed, firm and posterior. Obstetrics ultrasound was done and there was no measurable fluid. Other biophysical parameters were reassuring.



Figure 1: Newborn on Immediate Day of Delivery

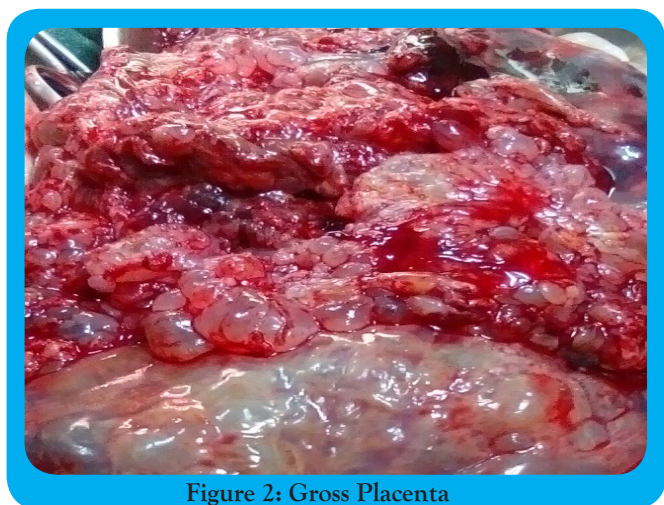


Figure 2: Gross Placenta

On microscopy, there were hydropic chorionic villi with circumferential proliferation of trophoblastic cells. Placental villi show features of chorioamniosis. Final pathologic conclusion was partial hydatidiform mole. The mother and the newborn discharged from the hospital on the 3rd day with appointment for follow up.

## DISCUSSION

The above case of partial hydatidiform mole with singleton living term fetus represents the rarity in obstetric World<sup>1,2,3,4</sup>. Such an association has been divided into three types. The first and most common is a twin pregnancy with one normal fetus having a normal placenta and another complete mole, second type is a twin pregnancy with normal fetus and placenta and another partial mole and the third is a singleton normal fetus with partial molar placenta. The third type of molar pregnancy is the most uncommon occurrence<sup>3</sup>. Such a fetus should have a normal karyotype to survive to term, though placenta may have variation, from diploidy of the amnion to triploidy of the chorionic villi<sup>1</sup>.

The complications of coexisting fetus with molar pregnancy include bleeding, persistent gestational trophoblastic disease, preterm labor, late abortion, pregnancy induced hypertension, and growth restriction of the fetus. In our case, the newborn had birth weight less than 5<sup>th</sup> centile for the gestational age. But there was no other maternal complication.

Several factors influence the outcome of the fetus in partial molar pregnancy most important being karyotype of the fetus. The present case had no obvious congenital anomaly. Other factors include the size of the molar placenta, the speed of molar degeneration and fetal anemia. The cases we report probably had sufficient

placental circulation to sustain through the first and second trimester<sup>1,2</sup>. Antenatal detection of molar pregnancy co existing with a viable fetus should warrant genetic analysis and search for gross malformation of the fetus<sup>6</sup>. Since our cases were un-booked and the diagnosis was made in the last trimester, termination of pregnancy was done by caesarian section to deliver a healthy female child. Management of the pregnancy in such rare conditions should be determined on one-to-one basis and the possibility of increased complications should be discussed with the family and prognosis explained. Unfortunately, the karyotype of the newborn in our case was not determined because of financial issue.

Though some authors questioned the follow up of patient with partial hydatidiform mole by serum hCG, such patients should be followed up at regular interval maximum for one year<sup>7,8</sup>.

## CONCLUSION

To conclude pregnancies with normal live fetus coexistent and partial molar placenta is extremely rare because of numerous maternal and fetal complications. Even if karyotype was not determined in our case, Since the fetus was normal at birth and the child continues to be growing normally, the abnormal cell population might appear to be confined to the placenta. Complete evaluation of the placental tissue is important even in cases with normal fetal outcome as focal molar changes which might be unsuspected during antenatal period, may affect the future obstetrical outcome.

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## CONFLICT OF INTEREST: None

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