

# Partial Mole Coexistence with a Normal Live Fetus in Twin Pregnancy

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## Abstract:

We present a case of dizygotic diamiontic twin pregnancy in which one fetus was normal with normal placenta, the 2nd fetus was normal appearing with partial molar placenta.

The patient was a 31-year-old presented to Central Private Hospital; her gestational age was 22 weeks +5 days following IVF (after 10 years of primary infertility) of diazygotic diamiontic twin pregnancy as a case of vaginal bleeding from 8 weeks of gestation with uterine contractions.

All required investigation and clinical assessments were carried out and revealing partial molar pregnancy in one fetus and normal placenta of the other one. Maternal BhCG was high for gestational age.

The patient had gestational DM & hyperthyroidism. Appropriate treatment regarding her conditions was implemented

All appropriate management was implemented. The patient continued to bleed. Within few days of admission she had premature uncomplicated labor with normal vaginal delivery (gestational age was 23 Wks +3 days), both babies appeared normal, one placenta morphologically & histologically typical of H.mole. The other one completely was normal.

Monitoring of serum BhCG and follow up transvaginal US was done until BhCG level returned to normal after 3 months of delivery without chemotherapy.

Close monitoring of pregnancy from early stages and discussing the possible complications to mother and baby (such as baby may be chromosomally abnormal & may not survive) with parents is important to manage such complications.

It is also necessary to have post-natal close follow up for maternal BhCG levels to assess any possibility of invasive mole or choriocarcinoma.

## Introduction:

Partial mole is a sub-type of H.mole which in turn falls under the spectrum of gestational trophoblastic disease [1]. The partial hydatidiform mole is usually triploid (one maternal and two paternal haploid sets), either from dispermic fertilization or from fertilization with an unreduced diploid sperm. There is usually a fetus and a large placenta. The fetus usually dies within a few weeks of conception. Very rarely, a partial molar pregnancy is digynic (two maternal and one paternal haploid set). In these cases, the placenta is small, the villi show minimal hydropic changes, and the fetus is growth-restricted. Some of these pregnancies resulted in live births, with subsequent early neonatal death [2]. We present a case of dizygotic, diamiontic twin pregnancy in which one fetus was normal with normal placenta, and the other fetus normal

appearing with partial molar placenta. Incidence of normal fetus & partial molar placenta is 0.005-0.01% of all pregnancies [3], [4]. The percentage of twins with one molar pregnancy is expected to increase with proper treatment for infertility and early diagnosis with ultrasound [5].

## Case Report:

The Patient was 31 years old when she presented to Central Private Hospital, her gestational age was 22 weeks +5 days with IVF (after 10 years of primary infertility) of diazygotic diamiontic twin pregnancy as a case of vaginal bleeding from 8-week gestation with uterine contractions.

Ultrasound revealed first fetus with no fetal structural abnormalities (no evidence of growth retardation or gross congenital anomalies) & normal fetal biometry with partially (one half) cystic placenta & other half was normal placenta.

Another fetus was completely normal with normal placenta.

Maternal BhCG was 109467 MIU/ml.

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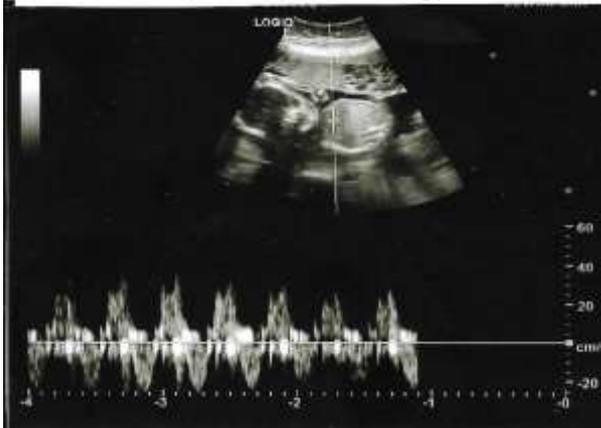
The patient had gestational DM & thyroid dysfunction.

Investigations included thyroid function test, thyroid antibodies, oral glucose tolerance test and thyroid gland ultrasound.

The patient had gestational DM controlled by diet & Metformin tablet (1000mg twice) monitored by glucose chart, she also had hyperthyroidism which controlled well with physician by Carbimazole tablet (5mg 3 times) with Propranolol tablet (10mg twice) All required management was given to patient appropriately including management for uterine contractions (Progesterone suppositories/twice daily & Progesterone tablet /10mg twice daily)

All appropriate management was implemented, although, patient still had bleeding. A few days after admission she had premature labor with normal uncomplicated vaginal delivery at gestational age 23Wks +3 days, both babies appeared normal (first one weighs 375gm & second one weighs 400gm), one placenta morphologically and histologically typical of H. mole, other one completely normal.

Serum titer of BhCG of mother decreased to 203 within one month of delivery without chemotherapy. 10 days after delivery, follow up transvaginal US revealed irregular vascular thickening of endometrium (this may indicate persistence trophoblastic disease of pregnancy/choriocarcinoma) Serum BhCG returned to normal level after 3 months of delivery without chemotherapy.



### Discussion:

There are three types of Hydatidiform mole with coexistent normal fetus. First type is a twin pregnancy with one normal fetus (normal placenta) and another complete mole; the second is a twin pregnancy with one normal fetus (normal placenta) and another partial mole as in our case; and the third is a singleton normal fetus with partial molar placenta [6].

Presence of medical complication with very high S  $\beta$  hCG ( $> 106$  IU/L) portend a poor outcome and suggestive of aggressive trophoblastic growth, it serves as an indication for the termination of pregnancy in such cases [7].

Many authors reported cases of partial molar pregnancy with live fetus; Lavaya RAI et al reported a case of live fetus in twin pregnancy with Hydatidiform mole [8].

Management of molar changes associated with normal appearing fetus still remains challenging. The serum B hCG level can be used as a marker, if serum B hCG level is greater than 106 mIU/mL, termination of pregnancy is recommended [9].

In our case all required investigations and clinical assessments were done during the pregnancy & after labour.

Our patient had gestational DM controlled by diet & Metformin tablet followed by glucose chart, she also had hyperthyroidism which controlled well with physician by Carbamazole tablet with Propranolol tablet

All required management were given to patient appropriately including management for uterine contractions (Progesterone suppositories & Progesterone tablet)

Serial measurements of BhCG & follow up with transvaginal US after labour were done until BhCG returned to normal value after 3 months of labour, this indicates patient had no persistent gestational trophoblastic disease & didn't need chemotherapy

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## الحمل العنقودي الجزئي مع جنين غير مشوه في حالة التوأم

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### الخلاصة:

نقدم حالة من الحمل التوأم ثنائي الكيس ثنائي الجنين حيث يكون احد الاجنة طبيعيًا مع المشيمة الطبيعية ، ويكون الجنين الآخر طبيعيًا مع المشيمة العنقودية الجزئية. كانت المريضة تبلغ من العمر 31 عامًا عندما قدمت إلى المستشفى المركزي الخاص ، وكان عمر الحمل 22 أسبوعًا و 5 أيام مع إجراء التلقيح الاصطناعي (بعد 10 سنوات من العقم) كانت المريضة تعاني من تقلصات الرحم و نزف مهبلي منذ 8 أسابيع من الحمل. تم إجراء جميع التحاليل المطلوبة والتقييم السريري للمريض والكشف عن الحمل المولي الجزئي في جنين واحد والمشيمة الطبيعية للجنين الثاني ، كان هرمون الحمل مرتفع بالنسبة لعمر الحمل. كانت المريضة تعاني من السكري واختلال في وظيفة الغدة الدرقية، وأعطيت العلاجات المناسبة لها. بعد السيطرة على نسبة السكر في الدم استمر نزيف المهبل و بعد أيام قليلة كان لديها ولادة طبيعية مبكرة طبيعية ، مشيمة الطفل الاول كانت عنقودية جزئية ، وأخرى طبيعية تمامًا. تمت متابعة مستوى هرمون الحمل مع التصوير بالموجات فوق الصوتية المهبلية حتى عودة الهرمون الحمل الى المستوى الطبيعي بعد 3 أشهر بدون علاج كيميائي. لذا فإن المراقبة الدقيقة للحمل من المراحل المبكرة ومناقشة المضاعفات المحتملة للأم والطفل مع الوالدين أمر مهم لمنع مثل هذه المضاعفات. من الضروري أيضًا إجراء متابعة هرمون الحمل في الدم بعد الولادة لتقييم أي احتمال حدوث مضاعفات خطيرة.