

A Case of Twin Pregnancy with Hydatidiform Mole and Coexistent Live Foetus

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ABSTRACT

Introduction: Twin pregnancy with live foetus and coexistent hydatidiform mole, a rare phenomenon of past, is showing an upward trend due to the rise in the induction of ovulation. The reported incidence is 1 in 22,000- 1 lac pregnancies with the most common being complete mole and coexisting live foetus. Current guidelines for management of a twin pregnancy with coexistent mole recommend close clinical monitoring if the mother and fetus are stable and urgent delivery in the setting of complications.

Case report: Here we present a case of 25 years old primigravida referred to our institute with complaint of pain abdomen and bleeding per vaginum and on transabdominal ultrasound this case report reviews a rare entity of twin pregnancy with Hydatidiform mole (H. mole) and coexistent live foetus. Current guidelines for management of a twin pregnancy with coexistent H. mole recommend close clinical monitoring if the mother and foetus are stable and urgent delivery in the setting of complications.

Conclusion: The increased risk of maternal complications and placental trophoblastic disease was explained to the patient, particularly the potential for developing choriocarcinoma. Considering patient's decision termination of pregnancy was done and patient expelled grape like vesicles and dead foetus.

Keywords: Twin Pregnancy, Hydatidiform Mole, Coexistent Live Foetus

risk of maternal complications and placental trophoblastic disease was explained to the patient, particularly the potential for developing choriocarcinoma. Considering patient's decision, termination of pregnancy was done and patient expelled grape like vesicles and dead foetus. Four weeks post-partum, her β -HCG dropped to 15,000 IU/ml and continued to decline at 6 weeks to 2,230 IU/ml.

DISCUSSION

Twin pregnancy with Hydatidiform mole and coexistent live foetus is an exceptionally rare condition that is frequently accompanied by complications including vaginal bleeding, hyperemesis gravidarum, hyperthyroidism, thromboembolic disease, intrauterine foetal death, and pre-eclampsia. Due to the severity of complications expectant management of continuing pregnancy is not without substantial risks. Patient's counselling on the risks of complications and malignancy should be emphasized in a multidisciplinary setting with Gynaecologic Oncologists and Maternal-Fetal Medicine specialists. If expectant management is chosen, patients may be reassured that several studies show similar risk of GTN with the continuation of such pregnancy compared to a first trimester termination.² However due to the high-risk nature of expectant management, extremely close surveillance is strongly recommended — this may include hospitalization in some circumstances, particularly in those with vaginal bleeding. Postpartum management for HCG monitoring for GTN risk assessment is also essential. Stellar et al. noted a higher risk of developing PTD in cases with twin molar pregnancies with a co existent foetus, when compared to singleton molar pregnancies.³ Suksai et al. demonstrated that antenatal complications (especially pre-eclampsia, hyperthyroidism, and hyperemesis gravidarum) were associated with adverse perinatal events for those with Twin pregnancy with Hydatidiform mole and coexistent live

INTRODUCTION

Twin pregnancy with Hydatidiform mole and coexistent live foetus, a rare phenomenon of the past is showing an upward trend due to the rise in induction of ovulation. The reported incidence is 1 in 22000-1 lac pregnancies and the most common being complete mole and coexistent live foetus. The reported prevalence for partial mole with coexisting foetus is 0.005%-0.01% of pregnancies.¹

CASE PRESENTATION

We present a case of a 25 year old primigravida at 20 weeks period of gestation who conceived after the infertility treatment with clomiphene citrate and got referred to our hospital with complaint of lower abdominal pain and bleeding per vaginum. On examination patient had tachycardia (110/min) with normal blood pressure. Patient was anaemic which was corrected by transfusing two units of PRBCs. Her LFTs, RFTs and thyroid profile was within normal limits. Uterine size was approximately 28 weeks and trans abdominal ultrasound showed Hydatidiform mole with coexistent live foetus. Her serum beta HCG was 2,70,000mIU/ml and chest x ray was normal. The increased

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Figure-1: Molar Tissue



Figure-2: Product of Conception Expelled



Figure-3: USG at 20 Weeks

foetus.⁴ Low initial HCG level less than 400,000 mIU/mL was the best predictor of live births in these patients in a logistic regression prediction model. Therefore, they suggest that patients with an initial HCG level less than 400,000 mIU/mL with no antepartum complications are appropriate candidates for pregnancy continuation. In our case patient did not want to continue her pregnancy so termination was done.

CONCLUSION

We present a case report of twin pregnancy with hydatidiform mole and a coexistent live foetus that presented with complaint of bleeding per vaginum and pain abdomen.

Patients autonomy, informed consent and confidentiality was given higher priority to provide the best standard of care.

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