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Neonatal Death Associated with Fetomaternal Transfusion Syndrome in a Case of Complete Hydatidiform Mole Coexisting with a Fetus

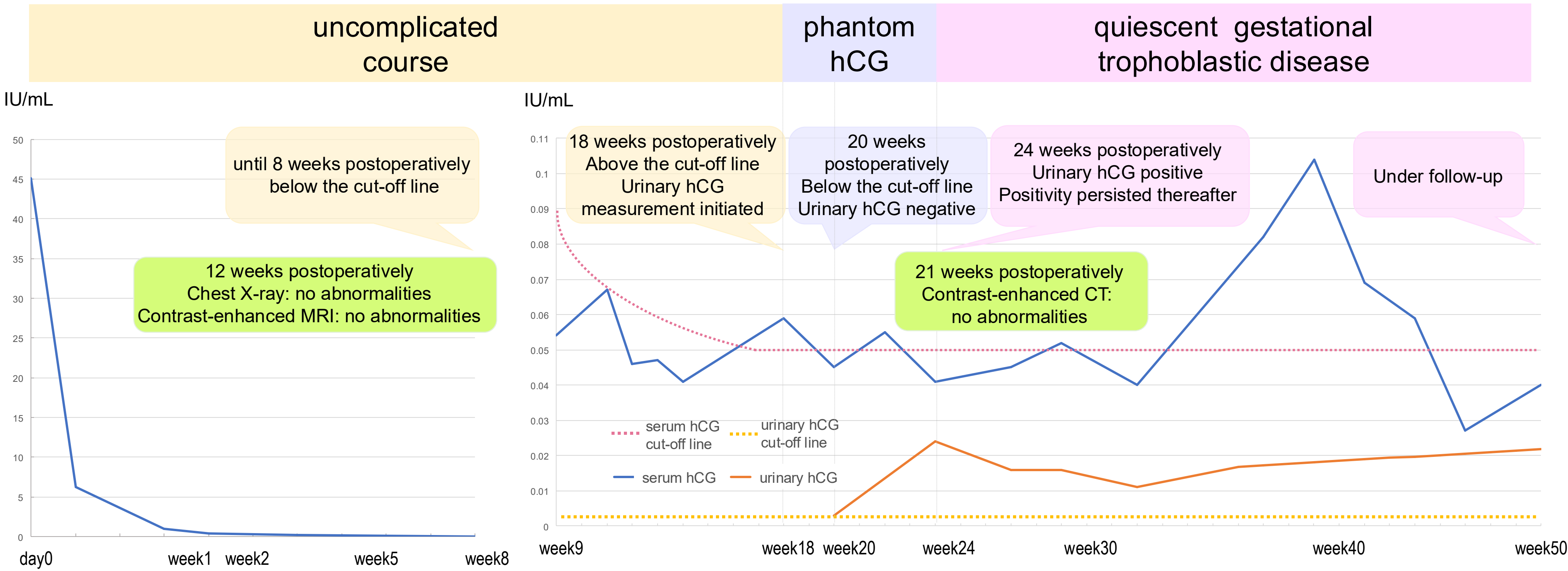
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Introduction

Complete hydatidiform mole coexisting with a fetus (CHMCF) occurs in approximately 1 in 20,000 to 100,000 pregnancies. The intrauterine fetal demise rate is approximately 40%; however, its association with fetomaternal transfusion syndrome (FMT) remains unclear. We report a case of fetal distress at 23 weeks of gestation requiring emergency cesarean section, diagnosed as both FMT and CHMCF.

Case Report

A 29-year-old nulliparous woman was referred at 20 weeks and 2 days of gestation due to cervical shortening. A cystic appearance around the placenta was observed in early pregnancy but was not documented at the time of referral.



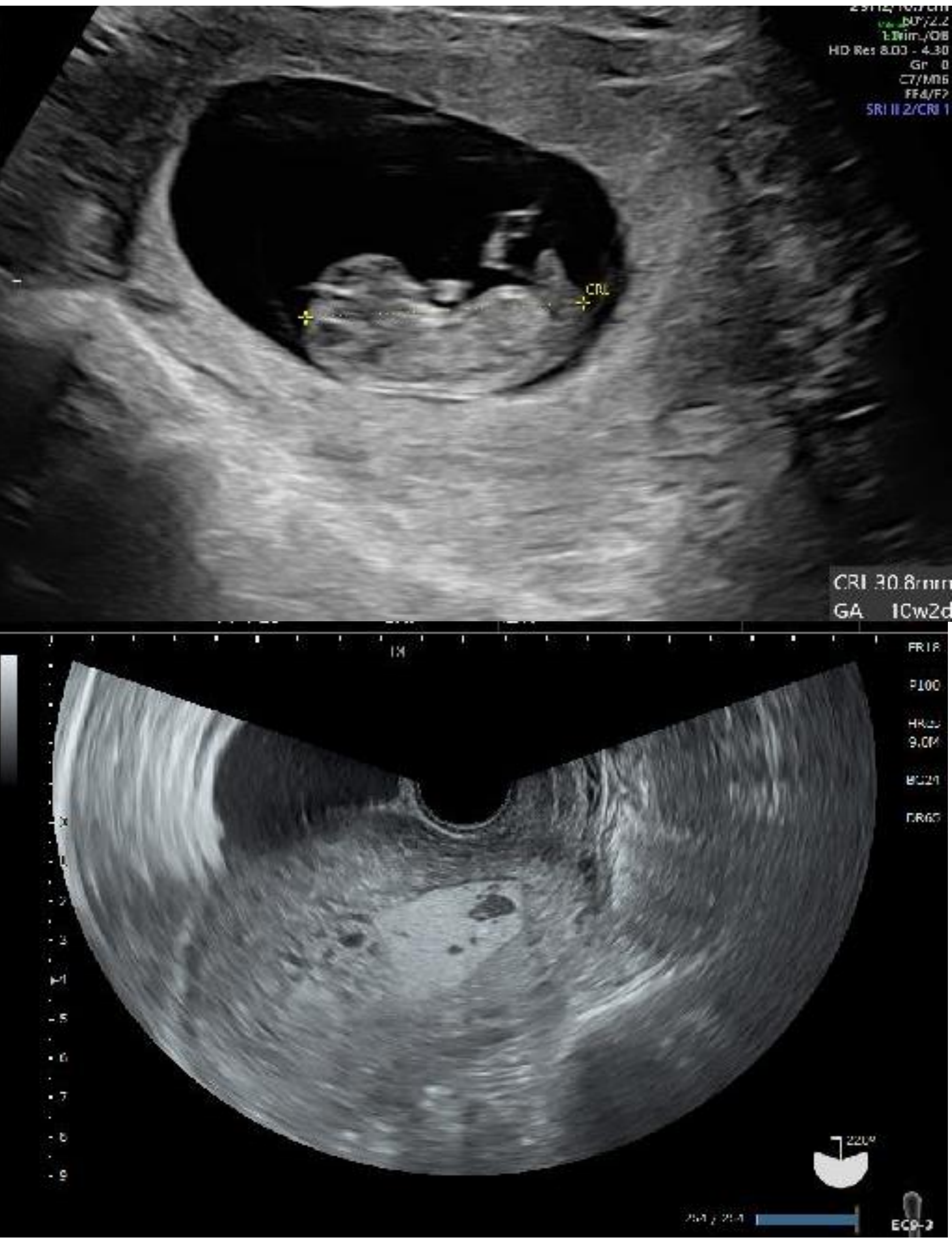
At 21 weeks and 0 days, she was admitted for threatened preterm labor with vaginal bleeding and bulging membranes. A cervical cerclage (McDonald method) was performed at 21 weeks and 2 days, stabilizing her condition. At 23 weeks and 3 days, she reported decreased fetal movement, and fetal bradycardia was detected on ultrasound. An emergency cesarean section was performed for fetal distress. The placenta contained multiple hydropic villi, some of which were connected to the normal placenta. Neonatal findings

- Male infant, 661 g, Apgar score 1/1/5
- Severe anemia (Hb 1.0 g/dL, Ht 4.1%)
- Metabolic acidosis (UA pH 6.96).

The infant died 2 hours after birth. The maternal blood test revealed HbF 2.7%, AFP 35,850 ng/mL, and hCG 45,026 IU/mL, which led to the diagnosis of FMT. Pathological examination confirmed CHMCF.

Conclusion

The pathophysiology of CHMCF may contribute to placental barrier disruption, potentially leading to the development of FMT.



(Figure 1) Ultrasound examination at 11 weeks of gestation



(Figure 2) Multiple vesicular structures were clustered and attached to the placental parenchymal margin.