

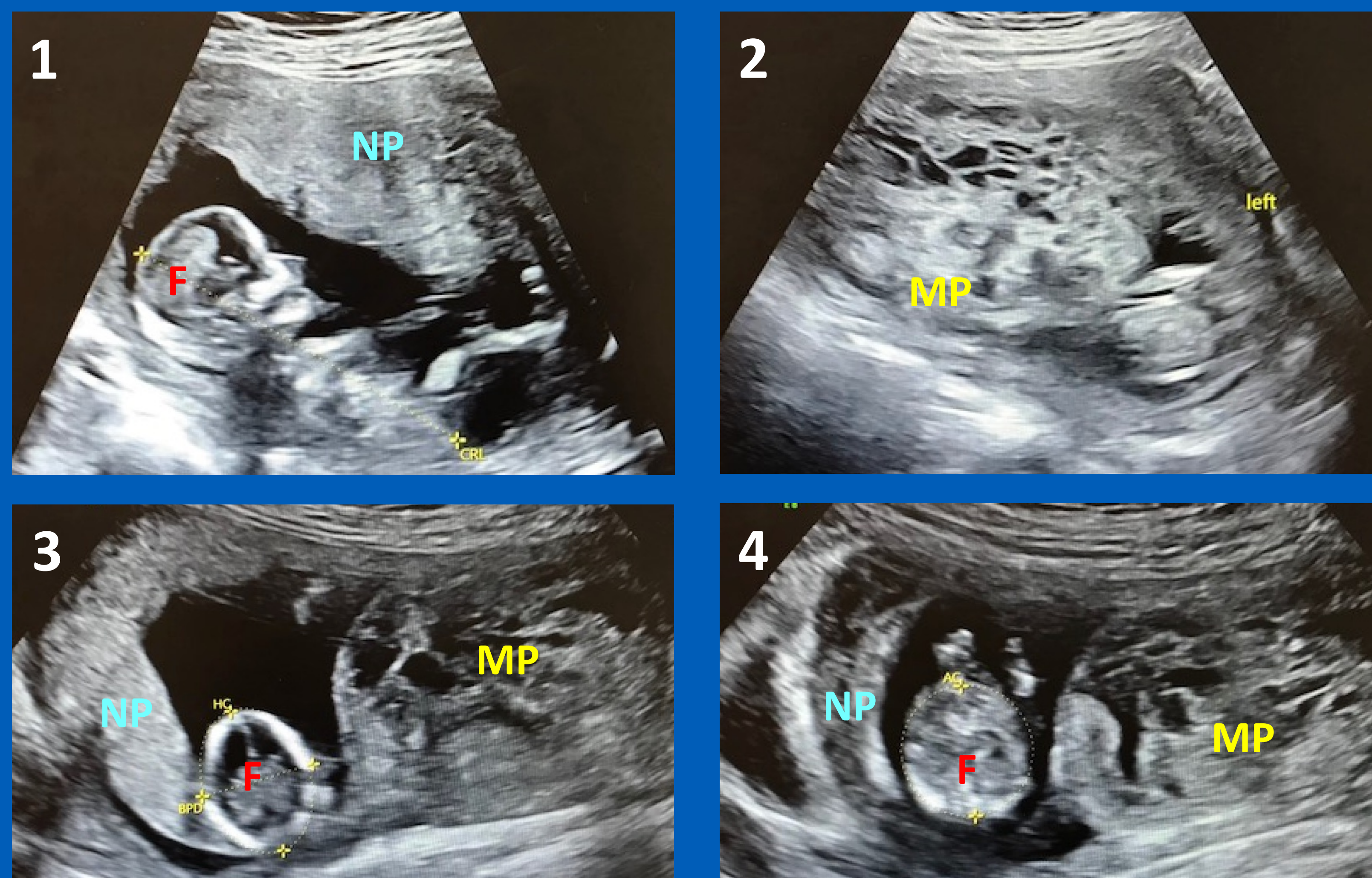
Complete hydatidiform molar pregnancy with a co-existing fetus: A case report

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OBJECTIVE

Complete hydatidiform molar pregnancy with a coexisting fetus (CHMCF) is a rare condition affecting 1 in 20,000-100,000 pregnancies¹. It is fraught with potential complications such as spontaneous abortion, hyperemesis, hyperthyroidism, preterm delivery, intrauterine death, preeclampsia and haemorrhage^{1,2,3}. Due to the increasing availability of ultrasound, CHMCF is often diagnosed in early pregnancy and surgically evacuated prior to the onset of these complications^{1,2}. We present the clinical course of a CHMCF diagnosed at a district hospital in the UK.



Figures 1, 2, 3 and 4: Demonstrate ultrasound images taken at 13 weeks gestation. Fetus (F) with normal placenta (NP) can be clearly seen alongside molar pregnancy (MP) with hydatiform appearance.

CASE REPORT

A nulliparous woman, pregnant spontaneously from a consanguineous relationship presented to hospital for routine first trimester scan. Imaging at 13 weeks demonstrated a normally grown baby with an anterior high placenta but hydatiform appearing placental tissue in the fundal area. PAPP-A 1.59 MoM and bHCG 31.2 MoM. She was referred to a tertiary fetal medicine unit for a second opinion. Chorionic villus sampling was performed from the normal placental tissue and demonstrated normal qPCR analysis with no evidence of triploidy – suggesting the diagnosis of CHMCF. This patient developed severe hyperemesis with multiple admissions to hospital for management and hyperthyroidism requiring treatment with propranolol to manage persistent tachycardia.

Sadly, at planned follow up at 15 weeks a late miscarriage was diagnosed. The woman underwent surgical dilatation and evacuation under ultrasound guidance at 15+5 weeks gestation. Intraoperative findings included a bulky 22-week sized uterus, singleton fetus of 15-week size and large amount of placental tissue trophoblastic in appearance with large cystic areas. Blunt instrumentation was used to remove the fetus under ultrasound guidance and uterotonics were avoided to minimise the risk of dissemination. Histology results confirmed CHMCF. This patient is awaiting follow up at the national centre for gestational trophoblastic neoplasia (GTN) but fortunately, her bHCG levels have decreased appropriately.

DISCUSSION

This case has several implications on practice. Firstly, whilst CHMCF is rare, due to the increasing use of artificial reproduction technology, the incidence of twin pregnancies and therefore this complex phenomenon is likely to increase². Secondly, due to the risk of GTN, it is important that CHMCF patients are followed up. The risk of GTN is higher in complete molar pregnancies compared to partial molar, with the risk in CHMCF estimated to be higher still². Finally, due to the risk of severe perinatal complications, these patients should be counselled accordingly, including the option of termination. Very few centres within the UK have the skillset to manage complex second trimester surgical terminations so it is important that this skill is maintained and disseminated.

CONCLUSION

CHMCF is a rare and complex obstetric phenomenon associated with severe perinatal complications.

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