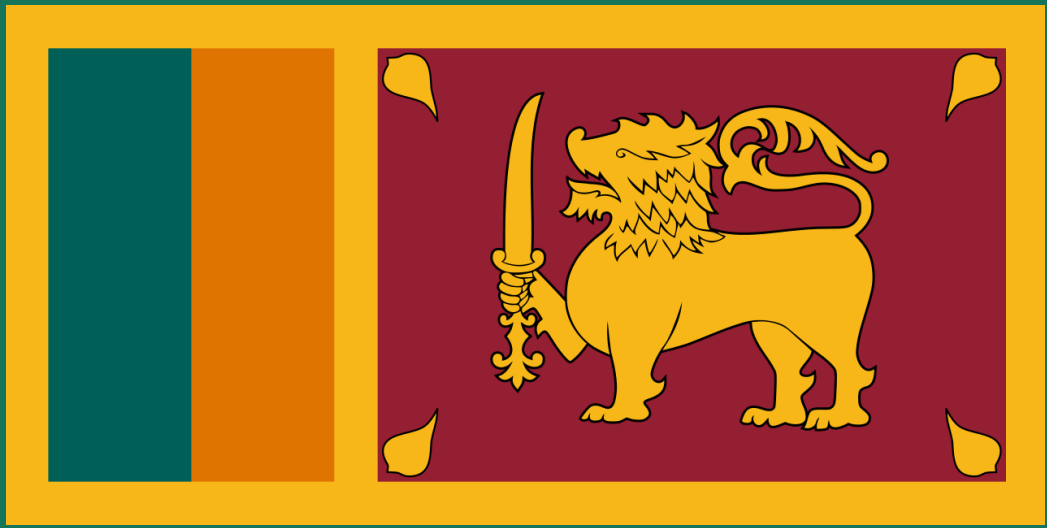




A case report on complete hydatidiform mole coexisting with a diploid twin fetus

leading to gestational trophoblastic neoplasm

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INTRODUCTION

- Complete mole coexisting with a twin fetus (CMCF) is an exceedingly rare condition that poses diagnostic & therapeutic challenges.
- Ultrasound is vital in making an early diagnosis, and the continuation of pregnancy is a multidisciplinary decision based on many factors, as there's an increased risk of fetomaternal morbidity & mortality.

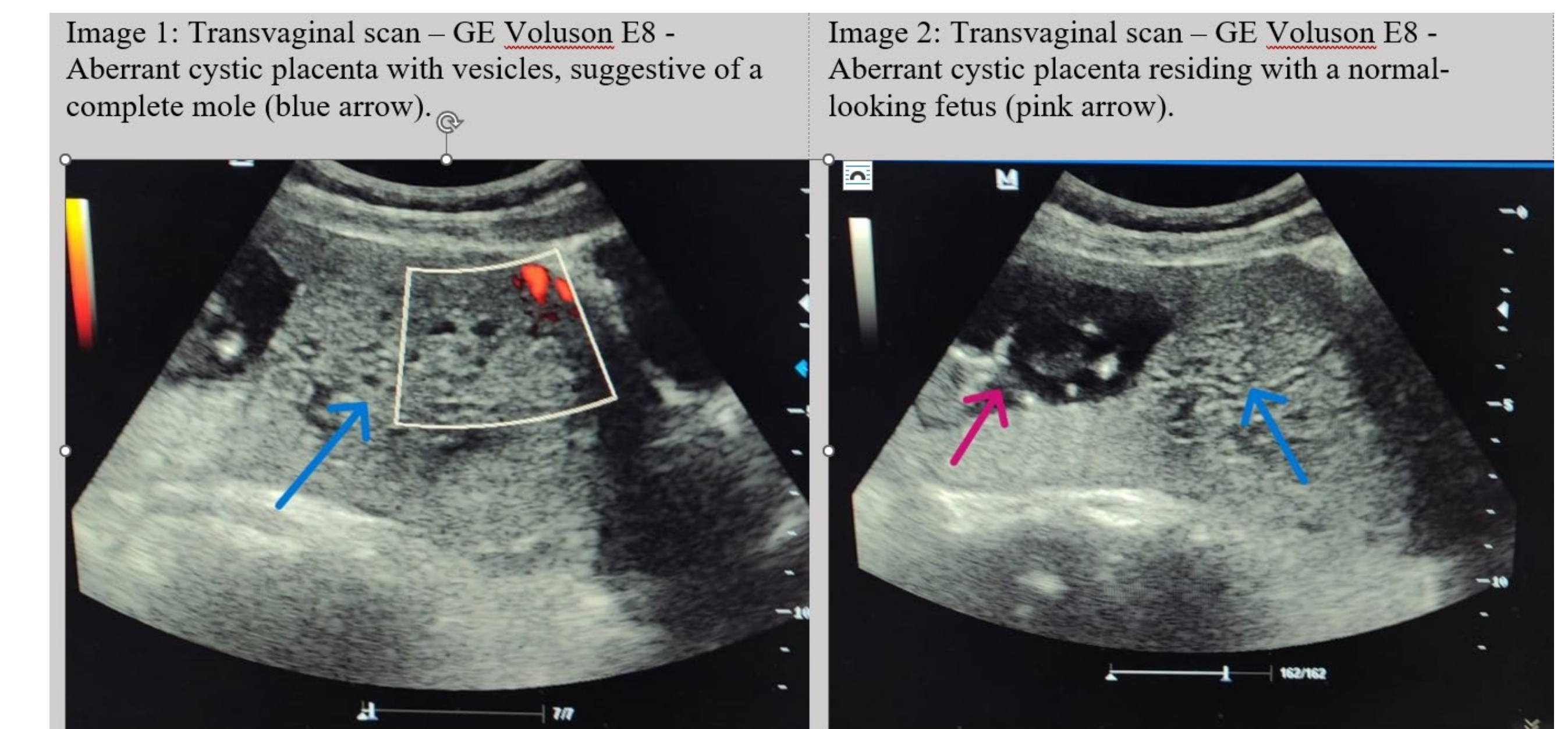
CASE PRESENTATION

- A 41 year old primigravida was incidentally diagnosed with CMCF at 8 weeks of gestation during early pregnancy scan.
- She was explained the findings, however she insisted on continuing pregnancy.
- She later presented with severe vaginal bleeding at 14 weeks, which led to suction-evacuation of the uterus, as a life saving measure.
- Routine postnatal monitoring revealed a drop followed by a rise of serum β -hCG at eight weeks which led to the diagnosis of GTN with pulmonary metastases.
- MDT decision was based on FIGO scoring system – Stage III, score 6, for which she was treated with single-agent chemotherapy with a satisfactory response.

DISCUSSION

- Two mechanisms of dizygotic twins with molar pregnancy are possible. A normal diploid fetus can coexist with either a complete mole (all paternal in origin) or a partial mole (PM) (triploid, maternal or paternal in origin). Our patient had the former, a CMCF. This occurs when an empty egg is fertilized by a sperm, which leads to isolated duplication of paternal genetic material.
- Diagnosis is primarily based on ultrasound. A normal-looking fetus of appropriate dimensions for gestation, together with an aberrant cystic mass, is likely to be CMCF.
- Unusual elevation of β -hCG and suggestive clinical features, including vaginal bleeding, the passage of vesicles, rapid abdominal enlargement, elevated blood pressure, preeclampsia, hyperemesis, and hyperthyroidism, are known presentations.
- Discrete guidelines are not yet established due to rarity & management remains controversial. Continuation of pregnancy should be decided after counselling the couple on all possible maternal & fetal complications.
- Surgery (suction evacuation) remains the mainstay of treatment. There's controversy surrounding the extent of the surgery and fertility preservation in young women.

- Maternal complications occur in about 50%, including elevated BP with preeclampsia, hyperthyroidism, hyperemesis, and vaginal bleeding, which may end up in a hysterectomy & the probability of gestational trophoblastic neoplasm (GTN).
- Fetal complications include fetal growth restriction, miscarriages, intrauterine fetal demise, preterm labour & associated complications.
- There's approximately a 25–50% chance of live birth if pregnancy is permitted to continue until a reasonable level of maturity is reached.



CONCLUSION

Early prenatal diagnosis, appropriate counseling, meticulous antepartum surveillance, and adequate postnatal follow-up can achieve satisfactory fetal and maternal outcomes in CMCF.

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