

Partial Molar Pregnancy: Diagnostic Challenges and Management Insights in Early Pregnancy

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Introduction

- Partial molar pregnancy is a rare form of gestational trophoblastic disease.
- It often presents similarly to early pregnancy complications, such as miscarriage or hyperemesis gravidarum.
- Accurate diagnosis can be delayed due to nonspecific clinical and imaging findings.
- Timely recognition is essential to prevent complications and ensure appropriate follow-up.

Objectives

- Highlight key diagnostic challenges in distinguishing partial molar pregnancy from other early pregnancy complications.
- Emphasise the importance of histopathological confirmation in diagnosis.
- Outline appropriate management, including surgical intervention, beta-hCG surveillance, and referral to a trophoblastic centre.

Conclusion

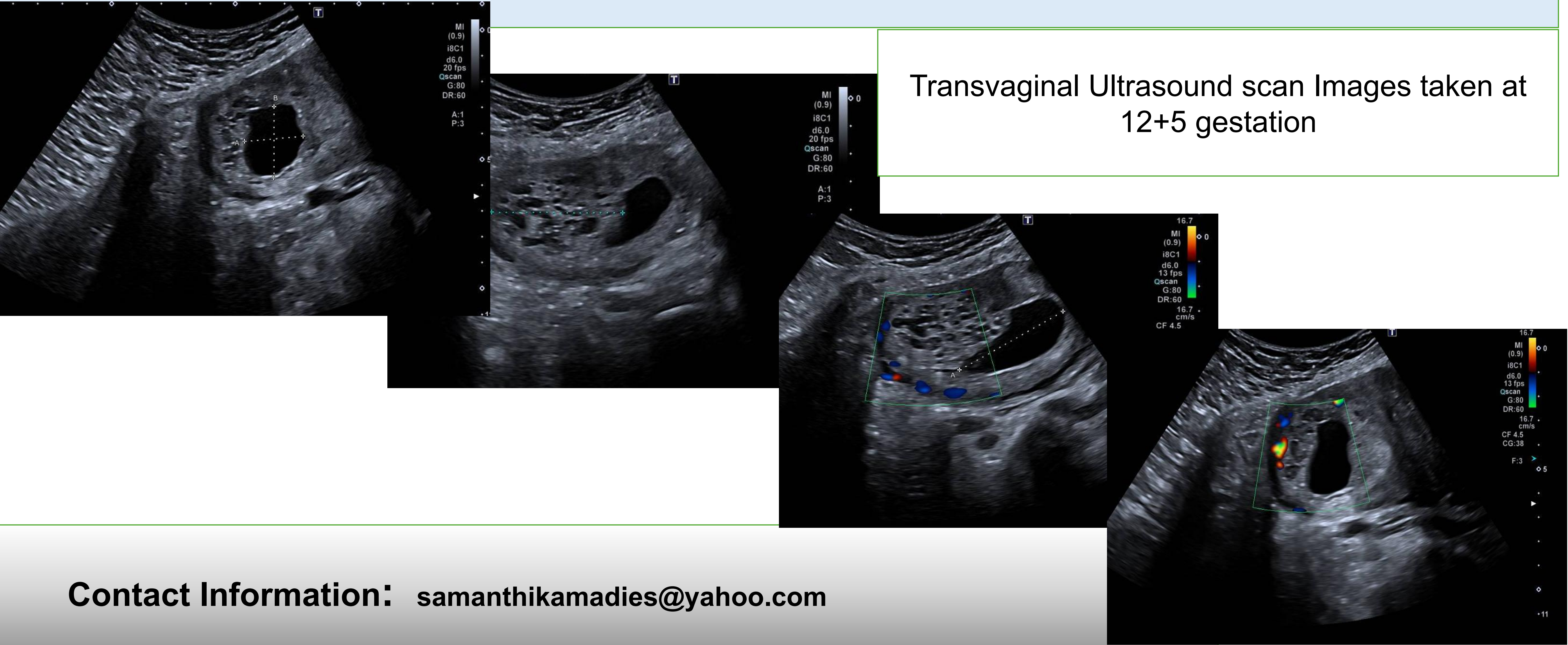
Partial molar pregnancy can mimic common early pregnancy complications, delaying diagnosis. Persistent symptoms and disproportionate beta-hCG rise should raise suspicion. Ultrasound features may be subtle; histological confirmation remains definitive. Early diagnosis, surgical management, and referral to specialised centres ensure optimal outcomes and reduce the risk of persistent trophoblastic disease.

References

- Royal College of Obstetricians and Gynaecologists (RCOG). Gestational Trophoblastic Disease: Green-top Guideline No. 38. London: RCOG Press; 2020.
- European Organisation for Treatment of Trophoblastic Diseases (EOTTD). Practical guidelines for the pathological and genetic diagnosis of hydatidiform moles. University College Cork; 2024.
- Seckl MJ, Sebire NJ, Berkowitz RS. Gestational trophoblastic disease. Lancet. 2023;401(10390):2081–94.

Case Report

- Patient: 35-year-old woman, 6 weeks gestation, presenting with vaginal bleeding.
- Initial assessment: Beta-hCG 10,000 IU/L; clinically diagnosed as threatened miscarriage.
- EPAU follow-up: Intrauterine pregnancy confirmed; repeat scan scheduled.
- Recurrent presentations: Ongoing mild bleeding and rising beta-hCG levels (up to 98,000 IU/L).
- Symptoms: Persistent nausea and vomiting resistant to treatment.
- 12+5 weeks scan: Transvaginal ultrasound showed non-viable gestational sac with vesicular appearance.
- Management: Surgical evacuation performed; intraoperative blood loss >1000 mL, requiring transfusion.
- Histology: Confirmed partial molar pregnancy.
- Follow-up: Referred to regional trophoblastic disease centre for monitoring and care.



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