



Hydatidiform Molar Pregnancy with Co-existent Normal Fetus

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Case Presentation

A 28yo G4P3 at 13w0d with history of asthma and no PNC presented with hyperemesis gravidarum. TVUS on initial presentation (1/24) revealed a 7x3x9 cm area consistent with subchorionic hemorrhage, laboratory **workup showed elevated AST/ALT and HCG >225,000**. Further US imaging was concerning for twin gestation of a normal fetus with a coexistent molar pregnancy necessitating a quantitative HCG that returned **243,214 (equivocal)** with patient opting to do CVS as an outpatient.

At 13w5d the patient presented with PPRM after CVS and was scheduled for D&E. Subsequent multidisciplinary discussion ensued with the decision to proceed with general anesthesia with preparation for hemorrhage. Management intra-operatively included 2 large bore IV access sites, 2U pRBCs in the operating room, pre-operative buccal misoprostol, intra-op paracervical block with lidocaine with 1:200k epi, methergine and oxytocin infusion with the possibility of paracervical vasopressin and TXA administration. She had a general anesthetic with 1,200ml blood loss and was discharged POD 1 with close OB follow-up for pathological specimen and HCG measurements.

The plan was to follow HCG levels weekly to 0 then monthly for 6 months. Patient advised on contraception and agreed with the plan to start once HCG levels were 0. **POD 16 pathology resulted as complete molar pregnancy with co-existent fetus**. The CXR was negative, without evidence of metastasis. Unfortunately, the patient was lost to follow up after POD 24 with only 2 HCG levels drawn, most recent value of 295.

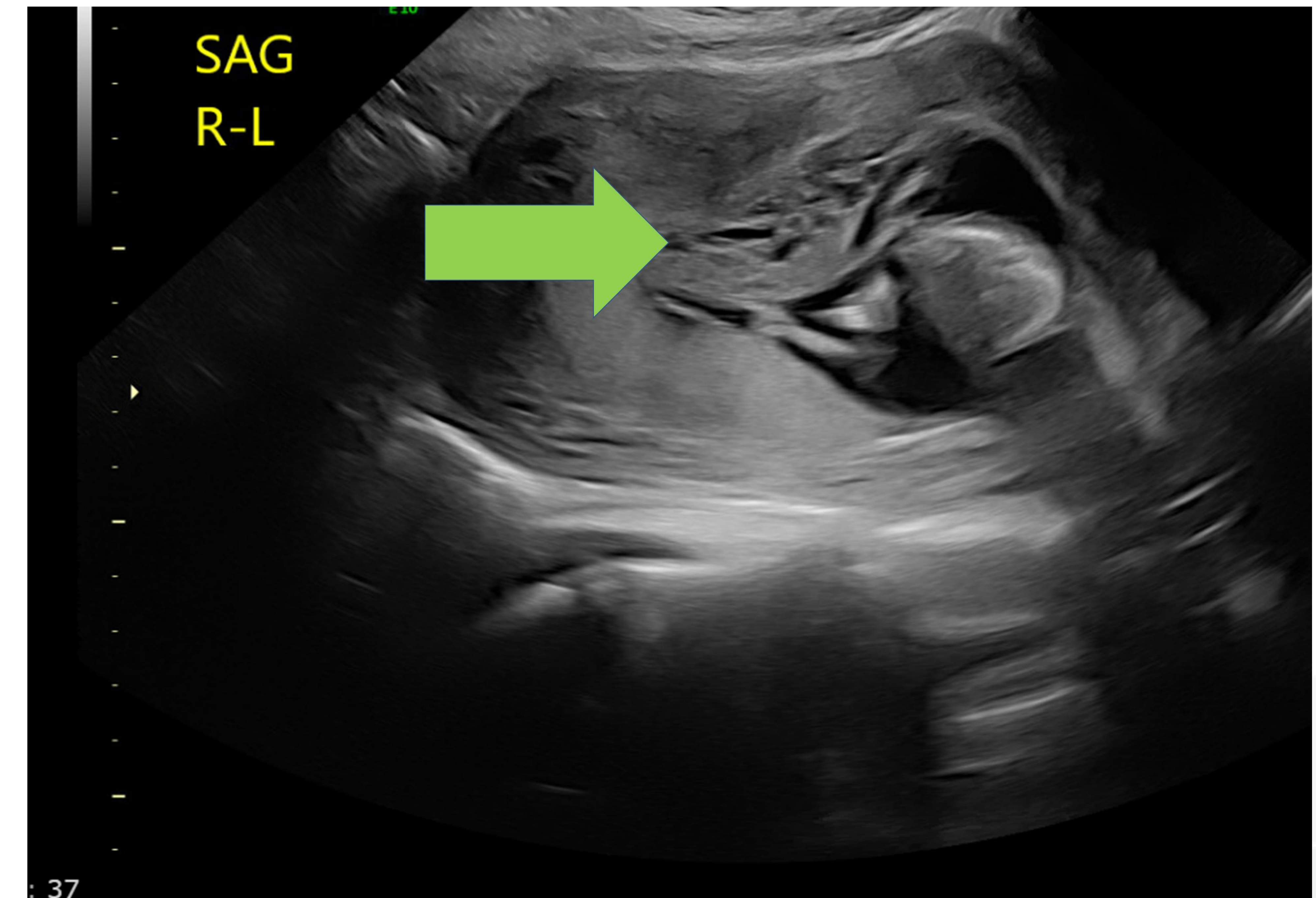


Figure 1: Trophoblastic Tissue and Coexistent Normal Placental Tissue on US

Discussion

- Gestational trophoblastic disease (GTD) consists of pathologies that can result in malignant complications with 0.5% average development in complete molar pregnancies and 0.1% development in partial.¹
- Presentation can include irregular vaginal bleeding, hyperemesis, early failed pregnancy, excessive uterine enlargement with rarer signs of hyperthyroidism, early onset pre-eclampsia or respiratory failure.²
- Patients must be carefully managed intra-operatively to lower risk of embolization, followed closely and placed on contraception when cured, as the risk of subsequent molar pregnancy is 1% after one mole.³
- Molar evacuation may be accompanied by excessive bleeding and the risks of tumor embolization must be weighed against hemorrhage; prostaglandins and oxytocin may be used.²
- Optimal follow-up following a molar pregnancy is continued for six months after normalization of HCG levels.
- Close follow-up confirms successful treatment and identifies patients who may require chemotherapy or additional surgery.

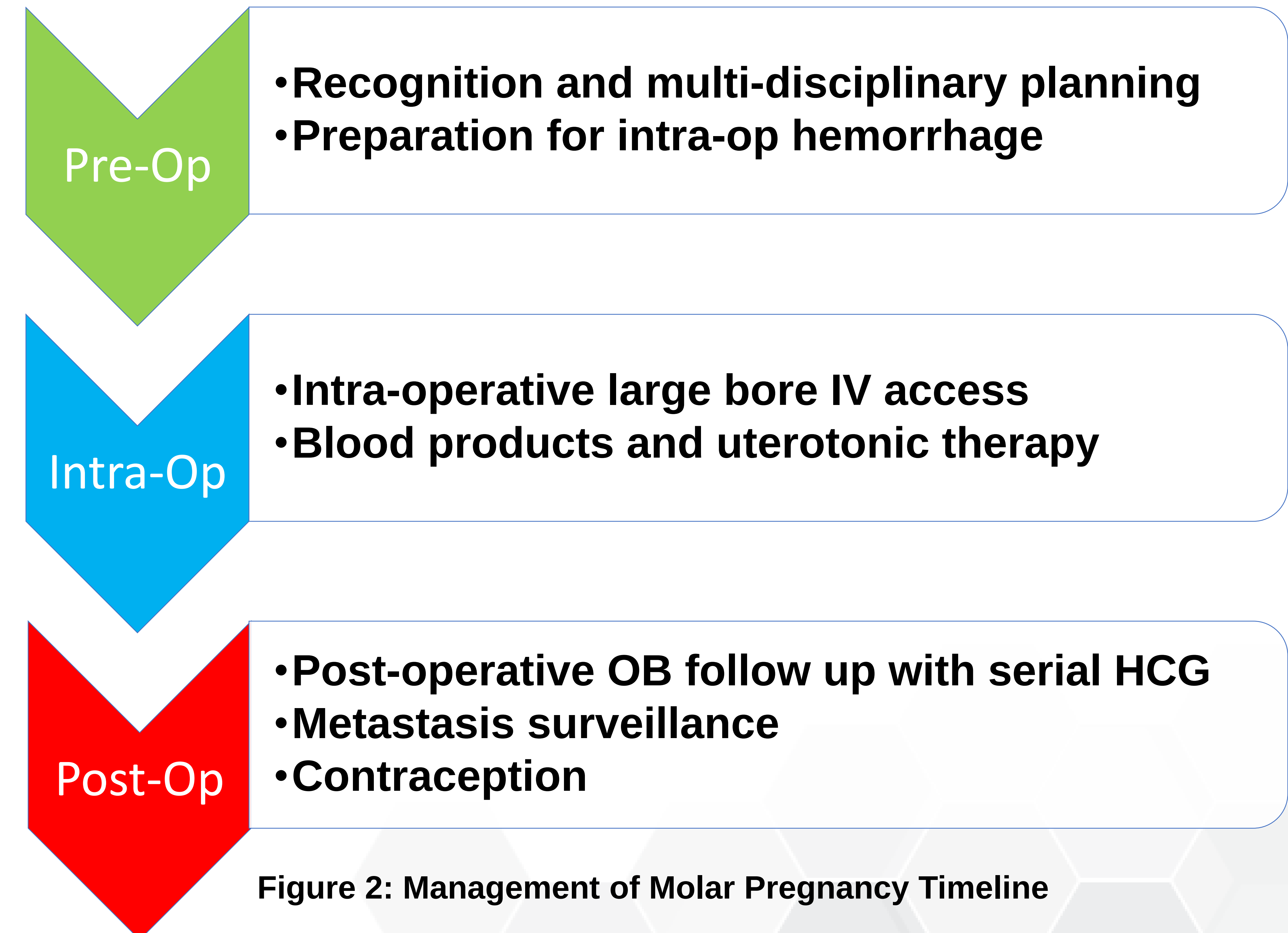


Figure 2: Management of Molar Pregnancy Timeline

References:

- 1) Cavaliere A et al. (2009)
- 2) Management of Gestational Trophoblastic Disease: Green-top Guideline No.38 -June 2020.
- 3) Berkowitz RS, Goldstein DP. 2009