World Journal of Pharmaceutical and Life Sciences
WJPLS
www.wjpls.org
SJIF Impact Factor: 6.129

PARTIAL MOLAR PREGNANCY CARRIED TO TERM: A CASE REPORT

Dr. Rim Laaboudi*, Dr. Rania Nejjar, Dr. Maria Hijji and Pr. Elyoussefi Mounia

Department of Obstetrics, Gynecology, Oncology and High Risk Pregnancy Souissi Maternity Hospital Rabat.

***Corresponding Author: Dr. Rim Laaboudi**
Department of Obstetrics, Gynecology, Oncology and High Risk Pregnancy Souissi Maternity Hospital Rabat.

Article Received on 24/02/2023 **Article Revised on 16/03/2023** **Article Accepted on 06/04/2023**

ABSTRACT

Partial hydatidiform mole MHP is also called embryonal mole, is part of the gestational trophoblastic diseases. It is characterized by the vesicular transformation of a pathological human egg.[1] Their origin is biparental with a supernumerary chromosomal batch of paternal origin in 85% of cases.[2] It is diagnosed in most cases during a spontaneous abortion, exceptionally it persists beyond the first trimester.[3] We report a rare case of a partial molar pregnancy carried to term in a 40 year old woman diagnosed in the emergency room with a retro placental hematoma at 37 weeks of amenorrhea.

KEYWORDS: Partial molar gestation, Pregnancy carried to term, live fetus.

INTRODUCTION

Partial hydatidiform mole is the most frequent entity of gestational trophoblastic diseases. It is characterized by a cystic transformation of the chorionic villi in early pregnancy, resulting in a gestational sac enclosing a fetus and excessive secretion of choriogonadotropin (HCG) hormone.[4] These abnormal villi are unable to meet the needs of the fetus and in 97% of cases the fetus dies within the first few weeks of pregnancy. The association of a fetus at term and of normal morphology during a molar pregnancy remains exceptional reaching 0.01% of all pregnancies.[5] We report a rare case of molar pregnancy diagnosed at term resulting in a fetus of normal morphology.

Clinical Observation

This is a 40-year-old G4P3 parturient, with 2 live children delivered by cesarean section and a history of a curetted abortion at 15 weeks of amenorrhea, presented to the emergency department for acute pelvic pain associated with metrorrhagia at 37 weeks of amenorrhea (SA).

The pregnancy was unattended, no prenatal consultation was done.

The clinical examination showed a blood pressure of 160/100 mmHg, proteinuria was positive at 3 crosses. The uterine height was 27 cm, with uterine contracture.

Obstetrical ultrasound found a progressive pregnancy in breech presentation with biometry of 34-35 SA and a heterogeneous fundal placenta with a retroplacental hematoma.

A vaginal touch was performed showing a mid-long cervix open at 1 finger with minimal blackish bleeding. The workup showed a hemoglobin of 5g/L, βHCG of 100,000 IU/L.

The patient underwent emergency cesarean section, intraoperatively, gravid uterus increased in size but normal in appearance, transplacental extraction of the fetus in apparent death state of normal morphology, male sex with a birth weight of 1900g (Figure1). The placenta was vesicular in appearance weighing 450g (figure 2).

Pathological examination of the placenta confirmed the diagnosis of MHP. The chromosomal study of the placenta showed a triploid karyotype of 69XXY, but the karyotype of the newborn was normal (46 XY).

The newborn died at H2 of life due to respiratory distress.

The parturient had no postpartum complications and the βHCG level dropped rapidly.

Figure 1

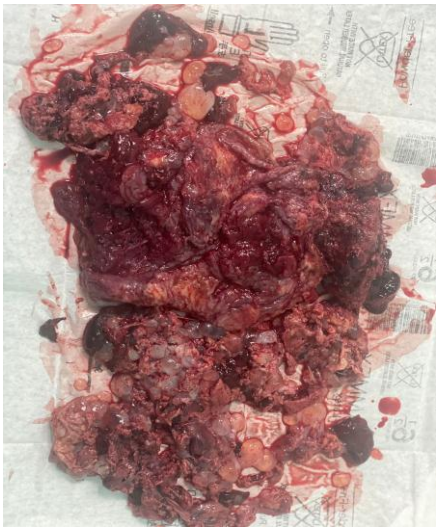

Figure 2

DISCUSSION

Molar pregnancy is considered a nonviable conception anomaly, which results from abnormal fertilization with a triploid chromosomal batch, leading to excessive placental growth and abnormal fetal development.[6] In the presence of triploidy, the fetus can no longer survive due to complications such as severe intrauterine growth retardation and multiple fetal malformations.[7]

The coexistence of a molar pregnancy with a diploid fetus arriving at term remains an exception, whose diagnosis is increasingly difficult.

In this situation the main differential diagnosis is a twin pregnancy with a diploid fetus and a normal placenta, and a second placenta in complete mole.[8] Placental mesenchymal dysplasia is also a rare differential diagnosis.[9]

Early diagnosis of MHP with termination of pregnancy reduces the risk of maternal complications such as peclampsia, eclampsia, anemia, and progression to persistent trophoblastic disease, hence the value of close monitoring of the mother by βHCG testing.[10] However, the risk of persistent trophoblastic disease after partial mole is reduced, the incidence is 3% when there is trophoblastic hyperplasia on histological examination. There is no relationship with ploidy.[11]

CONCLUSION

Despite the perfect knowledge of the physiopathological mechanisms of chromosomal anomalies in molar pregnancies, the partial form with diploid fetus carried to term remains a pathology that is confusing because of the often lack of clinical arguments in favor of the diagnosis. Great vigilance is necessary in order to suspect them at an early stage to make a reliable diagnosis allowing optimal management.

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