

Gemellar Pregnancy Combining a Hydatiformed Mole and a Normal Singleton Pregnancy

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Abstract:- Twin pregnancy associating a complete mole and a normal pregnancy with its own healthy trophoblast is a rare entity. The majority of studies show that the prognosis of such an association includes a risk of progression to a gestational trophoblastic tumor. We report a case of a patient who consulted for second trimester metrorrhagia and whose ultrasound revealed a bi-chorionic twin pregnancy: two gestational sacs, one with a living fetus of 21WA, another containing an amniotic cavity with a trophoblast in honeycomb appearance measuring 14cm. Medical termination of pregnancy was indicated: Induction of labor with misoprostol followed by endo-uterine aspiration. The expulsion product was in the form of a living fetus of 20 weeks with its own trophoblast associated with a vesicular mass of 14 cm and which on histological examination corresponded to a complete hydatidiform mole.

Keywords:- Twin Pregnancy; Hydatidiform Mole; Obstetrical Ultrasound.

I. INTRODUCTION

Twin pregnancy combining a complete mole and a normal pregnancy with its own healthy trophoblast is a rare entity occurring in 1 in 22,000 to 1 in 100,000 pregnancies [1]. The majority of studies show that the prognosis of such an association includes a risk of progression to a gestational trophoblastic tumor. The continuation of pregnancy is controversial given the risks of immediate and distant maternal complications. We report through a case report the management of this particular situation.

II. CASE REPORT

A 43 year old patient, VG IIIIP (3 live infants by the vaginal route and a miscarriage), admitted for second trimester metrorrhagia after 20 weeks of amenorrhea.

Clinical examination found a conscious patient, hemodynamically and respiratorily stable, with a closed cervix with endo-uterine bleeding, uterine height above gestational age.

Obstetrical ultrasonography objectified a bi-chorionic twin pregnancy: two gestational sacs, one with a live fetus

of 21SA, another containing an amniotic cavity with a honeycomb-like trophoblast measuring 14cm (Figure 1).

A parallel biological assessment was performed, which objectivized a chorionic gonadotropin hormone (beta-hCG) level of 1788900mUI/L, without anemia (Hb at 11.5), hyperthyroidism (TSH at 1.18) or diabetes (GAJ at 0.72).

Medical termination of pregnancy was indicated: induction of labor with misoprostol followed by endo-uterine aspiration. This indication is based on the poor prognosis of this combination, particularly the risk of progression to a gestational trophoblastic tumor. The expulsion product was in the form of a live fetus of 20 SA with its own trophoblast associated with a vesicular mass of 14 cm (Figure 2) and which on histological examination corresponded to a complete hydatiform mole. A void ultrasound was performed.

Monitoring of the plasma beta HCG curve showed a regression of the beta-hCG level after expulsion with no myometrial invasion on the control ultrasound.

III. DISCUSSION

Twin mole with coexistence of an egg with a live fetus and a molar pregnancy is a relatively rare entity. The management of these pregnancies is difficult, given the complications such as fetal death, bleeding, preeclampsia, hyperthyroidism, and the risk of progression to a gestational trophoblastic tumor [2,3].

This risk of gestational trophoblastic tumor is the most feared and its incidence seems to be higher in the case of association of a complete hydatidiform mole with a normal pregnancy according to the majority of published studies [2,4,5] with rates varying between 50 and 57%.

On the other hand, sebire et al [6] found a similar rate of tumor risk between simple hydatiform moles (16%) and hydatiform moles associated with twin pregnancies (19%). Repeated ultrasound scans can monitor the evolution of the placenta molar and suggest myometrial invasion with color Doppler [7]. Recommendations for the management of GGAMH are not yet codified, but some authors suggest that pregnancy can be carried to term if the diagnosis is made late and in the absence of complications [8] and that the probability of live birth varies between 16 and 56% [9]. In

cases where the diagnosis of GGAMH was made at an early age, termination of pregnancy is often indicated [10]. In the case of our patient, we opted for termination of the pregnancy because of the very young age of the pregnancy and the risk of complications that could have occurred if we had agreed to maintain the pregnancy. The evolution was marked by a regression of bhCG levels without the appearance of a gestational trophoblastic tumor.

IV. CONCLUSION

The risk of complications and in particular of myometrial invasion is increased in the case of twin pregnancies associating a hydatiform mole with an evolving pregnancy compared to an isolated complete hydatiform mole. There are currently insufficient arguments to recommend termination of these pregnancies or to accept monitoring despite the maternal risks. For our patient, we have adopted the first attitude which seems more reassuring.

LEGENDS OF THE FIGURES



Figure 1: Ultrasound showing two gestational sacs, one with a live fetus with 21SA, the other containing an amniotic cavity with a honeycomb trophoblast.



Figure 2: Live fetus of 20 SA with its own trophoblast and vesicular mass (right).

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