

## CASE REPORT

### PARTIAL HYDATIDIFORM MOLE WITH A LIVE FETUS: A RARE ENTITY

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**ABSTRACT: BACKGROUND:** Gestational trophoblastic neoplasia (GTN) represents a spectrum of premalignant and malignant diseases that occur after abnormal fertilization.<sup>[1]</sup> GTN includes complete hydatidiform mole (CHM), partial hydatidiform mole (PHM), invasive mole, choriocarcinoma, and placental-site trophoblastic tumor (PSTT). CHM and PHM together account for 80% of all cases of GTN.

**KEYWORDS:** Molar pregnancy, BETA-hcg, partial mole, gestational trophoblastic, Hydatidiform, villous hydroses.

#### CASE REPORT:

- In our case, a 27 yrs old G3P2L2 presented with vague abdominal pain.
- Vomiting -2 episodes.
- Amenorrhea since 3 months.
- On ultrasound the fetus corresponded to 15weeks 0 days with fetal heart rate of 142 bpm with no external congenital abnormalities.



**Fig. 1**

- In fig-a, the placenta was fundoposterior in position which was partly normal and partly interspersed with multiple variable sized cystic spaces (molar placenta).



**Fig. 2**

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- The cystic spaces are avascular on colour Doppler as shown in fig-b, and also noted with active fetal cardiac pulsations (FHR)-142 beats per minute.



Fig. 3

### OTHER INVESTIGATIONS:

#### Pre evacuation HCG values:

**S.V.S. MEDICAL COLLEGE & HOSPITAL**  
 SETTING NEW STANDARDS  
 Yerrugonda, MAHABUBNAGAR - 507796 (30 lines)

Name	Shyamala	Sex	F
IP/OP	414/40 (also 389)	Age	30 yrs.
Ref Doc	Prad	Date	30/7/2014

**DEPARTMENT OF BIOCHEMISTRY**

$\beta$ HCG: 80,000 mIU/ml

Normal ranges

Non pregnant: < 5

Pregnancy weeks:

3-4 wks: 9-130

4-5 wks: 75-2,500

5-6 wks: 850-20,800

6-7 wks: 4,000-1,00,200

7-12 wks: 11,500-2,89,000

13-16 wks: 18,300-1,37,000

16-29 wks: 1,400-53,000

29-41 wks: 940-60,000

METHOD: Two-site immunoenzymometric assay

Prof. Dr. S. S. S. S.

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## Post evacuation HCG values:

**S.V.S. MEDICAL COLLEGE & HOSPITAL**  
 SETTING NEW STANDARDS  
 Yerragonda MAHABUBNAGAR - P: 227790 (32 lines)

Name	Shanala	Sex	Female
IPOP	4111111 (08542-18227)	Age	30 Years
Ref Doc	Free	Date	4/2/14

**DEPARTMENT OF BIOCHEMISTRY**

BHCG: 1890 mIU/ml

**Normal ranges**  
 Non pregnant: < 5  
 Pregnancy weeks:  
 3-4 wks: 9-130  
 4-5 wks: 75-2,600  
 5-6 wks: 850-28,800  
 6-7 wks: 4,000-1,00,200  
 7-12 wks: 11,500-2,89,000  
 12-16 wks: 18,300-1,37,000  
 16-29 wks: 1,400-55,000  
 29-41 wks: 940-60,000

*frederick*

## Histopathological Correlation:

**SVS Medical College & Hospital**  
 MAHABUBNAGAR P: 08542-227907  
 Department of Pathology

Name: Shanala      Age: 37Y      Date: 01/08/14  
 Ref by DR: SVS      Sex: F      REP DATE: 4/2/14

**HISTOPATHOLOGY REPORT**

#NO: 2272/13      IP/OP NO: 414140

**NATURE OF SPECIMEN** : Evacuated contents from uterus.

**CLINICAL HISTORY** : Amenorrhoea since 3 months  
 Vomiting since 2 days.

**GROSS EXAMINATION** : Received multiple grape like vesicles along with grey brown bits of blood clots altogether measuring 6x6x1 cms.

**MICROSCOPIC EXAMINATION** :

Sections examined show chorionic villi with extensive hydropic degeneration and foci of trophoblastic tissue.

**DIAG** : FEATURES ARE SUGGESTIVE OF HYDATIFORM MOLE

Regular follow up of the case is advised.

REPORTED BY  
 PATHOLOGIST  
 DR. K.P.A. CHANERASEKHAR

*Dr. G. Srinivas*  
 LIC SIGNATURE

SUGGESTED CLINICAL CORRELATION  
 KINDLY DISCUSS, IF NECESSARY

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### Post-operative Clinical Macro-specimen showing a Fetus along with Molar Pregnancy:



Fig. 4

- A live fetus of 150gms was delivered.
- The diagnosis of partial mole was followed up by beta Hcg pre (80,000) and post evacuation (1890) and confirmed by histopathological examination.
- Partial hydatidiform mole (PHM) with a live fetus is a rare condition.

PHM is a histopathological entity characterized by focal trophoblastic hyperplasia with villous hydrops and identifiable fetal tissue.

#### DISCUSSION:

- Ultrasonography is the imaging investigation of choice to confirm the diagnosis of hydatidiform mole. A transabdominal and transvaginal imaging with transducers of highest frequency possible should be performed.<sup>[2,3,4,5,6]</sup> Clinical examination and beta-human chorionic gonadotropin (beta-hCG) determinations are the recommended initial tests for hydatidiform mole. It is characterised by its focal distribution, slower transformation, the presence of an embryo or fetus, and a triploid karyotype (70% are 69, XXY; 27% are 69, XXX; 3% are 69 XYY). The extra set of chromosomes is often of paternal origin.
- Hydatidiform moles should be regarded as premalignant lesions because 15-20% of complete hydatidiform moles (CHMs) and 1% of partial hydatidiform moles (PHMs) undergo malignant transformation into invasive moles, choriocarcinomas, or, in rare cases, placental-site trophoblastic tumors (PSTTs).<sup>[7,8]</sup>
- Performed by an interventional radiologist, selective embolization of the uterine artery is reported as a well-tolerated and effective treatment option for managing severe bleeding from residual uterine vascular malformations in patients with gestational trophoblastic tumors that have been treated.<sup>[9,10]</sup>

**INVESTIGATION:** Ultrasonography is the imaging investigation of choice for hydatidiform mole. The established roles for sonography include the following:<sup>[11,12,13,14,15,16]</sup>

1. Initial diagnosis.
2. Assessment of treatment responses.
3. Determination of invasion in malignant forms of gestational trophoblastic neoplasia.(GTN)
4. Determination of recurrent disease in malignant forms of GTN.

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**COMPUTER TOMOGRAPHY, MRI:** CT and/or MRI evaluation are not usually performed initially but may be used to determine if there is extension of molar tissue outside the uterus.<sup>(17)</sup> CT may show an enlarged uterus with areas of low attenuation, or hypoattenuating foci surrounded by highly enhanced areas in the myometrium.

MRI is indicated in patients with malignant forms of gestational trophoblastic neoplasia (GTN) for an assessment of tumor vascularity and of myometrial and parametrial extension.

**MRI findings may include the following:**<sup>[18,19,20,21,22]</sup>

1. Heterogeneous endometrial enlargement with several hyperintense foci that represent hydropic villi on T2-weighted imaging.
2. Focal tumor masses in the endometrium and/or myometrium.
3. Loss of uterine zonal anatomy (indistinctness of the endometrial-myometrial border).
4. Pathologic myometrial, endometrial, and parametrial vasculature characterized by dilated and tortuous vessels.

### DIFFERENTIAL DIAGNOSIS:

1. Fetal demise with placental hydropic change: beta HCG levels are invariably low in this case.
2. Twin pregnancy with one normal twin and one complete hydatidiform mole: the normal twin usually has its own normal placenta.
3. Placental mesenchymal dysplasia.

Sonograms of partial hydatidiform mole (PHM) may show cystic changes similar to those of CHM but in a more focal distribution. The major distinguishing feature of PHM is embryonic tissue. These patients are prone to preterm labour and premature rupture of membranes (PPROM).

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### **FINANCIAL OR OTHER**

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