CASE REPORT

Rare Case of Twin Pregnancy with Complete Hydatidiform Mole and Coexisting Fetus (CHMF) following Infertility Treatment

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Introduction

Twin pregnancy consisting of complete molar pregnancy and a coexisting fetus occurs with an estimated incidence of 1 per 22,000–100,000 pregnancies, and may be increasing due to the greater use of assisted reproductive techniques [1]. These pregnancies are associated with significant maternal and fetal complications including preeclampsia, thromboembolic disease, hyperemesis, hemorrhage, intrauterine demise, and an increased risk of persistent trophoblastic disease. In this study, we report the case of twin pregnancy with a complete hydatidiform mole (CHM) that was managed conservatively according to the patient's request and circumstances.

Case History

A 25-year-old obese patient with features of polycystic ovarian disease presented to the Institute of Reproductive Medicine with 2-year history of primary subfertility. After a detailed evaluation she underwent one cycle of

intrauterine insemination (Husband) after controlled ovarian stimulation with clomiphene citrate, recombinant FSH (150 U), and Inj menotrophin (150 U), she finally conceived. Ultrasound at 8 weeks opined of single intrauterine gestation with good cardiac activity. Patient presented with symptoms of occasional spotting during her 18 weeks of gestation. She developed severe anemia (7 g from an initial level of 14 g) for which she received IV iron sucrose infusion. Ultrasound at 20 weeks of gestation (Fig. 1a, b) showed single live gestation with findings suggestive of coexistent molar pregnancy. Doppler study was normal, and her beta hCG levels were 5,45,460 MIU at the time of diagnosis. The couple was counseled regarding possible outcome and complications; however they wished to continue the pregnancy with prompt follow-up. At 23rd week, she presented with history of profuse bleeding per vaginum and expelled normal female fetus (330 g) with molar tissue. She underwent suction evacuation under anesthesia. Post procedure, she received packed cell transfusion. Her liver function, renal function, and thyroid function tests were found to be normal. Fetal karyotype was normal. Histopathology (Fig. 2) was consistent with molar changes. She was discharged in a stable condition. Her weekly follow-up beta hCG showed a decreasing trend. Her beta HCG levels decreased to 72.33 MIU by the end of 5th week, which reduced further down to 5 MIU by 18 weeks post expulsion and, subsequently, monthly follow-up showed consistent negative levels at less than 2.39 MIU at our unit. No evidence of post molar trophoblastic neoplasia was noticed on follow-up.

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Fig. 1 a, b Ultrasound picture of complete hydatidiform mole with coexisting fetus and normal placenta

Discussion

Twin gestations consisting of complete molar changes and a coexisting normal fetus (CHMF) are rare, with an estimated incidence of 1 in 22,000–100,000 pregnancy. These pregnancies are often associated with severe maternal complications such as persistent vaginal bleeding, severe preeclampsia, fetal loss due to late miscarriage and persistent gestational trophoblastic neoplasia (GTN) [2, 3], and intrauterine death.

Recent advances in ultrasound and molecular genetics have increased our understanding and hence enhanced the perinatal management of complete and partial hydatidiform mole. By contrast, the management of a twin pregnancy with a normal fetus and a CHM remains complex and controversial. Pregnancies complicated by CHMF may result in a viable live born infant in approximately 40 % of the time [4].

Fig. 2 Hydropic degeneration of chorionic villi with trophoblastic degeneration with central cyst formation

Conclusion

Continuing pregnancy and achieving a successful live birth may be an option for patients who clearly understand the increased risks. Management is complicated and women should be counseled about the maternal and fetal complications, and the pregnancy must be monitored carefully by a perinatal team with experience in high-risk obstetrics and access to neonatal care.

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