Partial Hydatidiform Mole - An Unusual Presentation

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MJAFI 2006; 62 : 295-296

Key Words: Partial mole; Hydatiform mole

Introduction

Gestational trophoblastic disease is among the rare tumours that can be cured even in the presence of wide spread dissemination [1,2]. Gestational trophoblastic disease includes a spectrum of inter-related tumours, including complete and partial hydatidiform mole, which have varying properties for local invasion and metastasis. The incidence varies from 1:2000(USA), 1:160 (India), 1:80 (Indonesia). The exact aetiology is still unknown, but maternal age >35yrs, dietary deficiency has been attributed.

Human chorionic gonadotrophin, a serum tumour marker with high sensitivity has improved the accuracy in screening, monitoring, management and follow up of these patients [2-5].

Case report

20 years old primigravida, a resident of Himachal Pradesh who was asymptomatic on routine antenatal checkup, was sent for a ultrasound scan at 19 weeks period of gestation. The scan revealed a live foetus corresponding to the period of gestation with scalp oedema, dilated ventricles of the brain, skin oedema and ascites. The placenta was covering the internal os completely. There was 15cm mass with cystic

Fig. 1 : Photograph showing mass with cystic spaces inside the uterus, next to the placenta

spaces inside the uterus, next to the placenta (Fig. 1). It also revealed bilateral adenexal masses of 7.5x9cm each. On examination she was normotensive, pulse rate was normal, with no pallor or pedal oedema. Uterine height was corresponding to 26 weeks period of gestation. Investigations revealed haemoglobin of 10gm%. All the biochemical parameters were normal and serum beta human chorionic gonadotropin levels were 200, 410 mIU/ml. The abortion was induced using 200 microgram of tablet misoprostol vaginally and oxytocin drip. She aborted completely and the approximate blood loss was 1200 ml.

Histopathological examination, confirmed the diagnosis of partial hydatidiform mole. She was followed as per the standard protocol and beta human chorionic gonadotrophin became undetectable after about 8 weeks of the abortion.

Discussion

The term hydatidiform mole has been derived from the Greek word 'Hydatis' meaning a drop of water and the Latin word 'molar' meaning a mass. Hydatidiform mole can be partial or complete. Partial mole constitutes 15-25% of the molar pregnancies. It has a triploid karyotype either after a dispermic fertilisation or diandrogenetic fertilisation. A foetus if present with the partial mole exhibits stigmata of triploidy, and shows features of symmetric intrauterine growth retardation. A partial mole must be differentiated from the complete mole with normal foetus as the chances of the persistent disease after the partial mole are less than 4% but increase to 20% with the complete mole. The definite diagnosis of partial mole is confirmed by pathological and cytogenetic studies [6-8].

The patients with a partial mole usually present with signs and symptoms of an incomplete/missed abortion and the diagnosis is made only after the histopathology examination report [1,5,6]. The patient usually presents in the 1st trimester and vaginal bleeding is the commonest presentation in 75% of the cases. Hyperemesis, preeclampsia, hyperthyroidism and theca luteal cysts are

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present in less than 2% of cases. Uterine size is less than the period of gestation and the pre evacuation human chorionic gonadotrophin levels are less than 100,000miu/ml [1,2,5,6].

In this case, the patient was asymptomatic till late 2nd trimester and disease was detected on ultrasonography. The height of the uterus was more than period of gestation, pre-evacuation human chorionic gonadotropin levels were much higher than 100,000miu/ml and bilateral theca luteal cysts were of the considerable size. The foetus in this case, was corresponding to the period of gestation, which is not seen in cases of partial mole.

Follow up of the patient in the post evacuation period and counselling for the contraception forms an essential part of the management [2,5].

Conflicts of Interest

None identified

References

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Events Calendar

29th July 2006

CME on Recent Advances in Management of Haemorrhagic Disorders

Venue: Armed Forces Medical College, Pune-40
Contact Person: Lt Col PK Gupta
Dept of Transfusion Medicine, AFMC, Pune-40.
Tele No. : 020-26306267; email :depttmfmc@rediff.com

14th –15th October 2006

Surgery Conference 2006

(Emergencies in Surgery)
Venue: Armed Forces Medical College, Pune-40
Contact Person: Col V Baskaran
Organising Secretary
Dept of Surgery, AFMC, Pune
Tele: Office: 020-26306016, 020-26306017

10-12th November 2006

Annual Conference of Research Society of Anaesthesiology

Venue: Armed Forces Medical College, Pune-40
Contact Person: Col KK Upadhyay, vsm
Dept of Anaesthesiology & Critical Care, AFMC, Pune-40
Tele No : 020-26306036, 26306274 (O)
email : rsacp2006@rediffmail.com

7-10th December 2006

ICAAICON 2006

40th National Conference on Allergy, Asthma & applied Immunology

Venue: Desh Bhagat Yaadgar Hall, Jalandhar
Contact Person: Dr. HJ Singh
Ranjit Hospital, Patel Chowk, Jalandhar
Tele No : 0181-2620600;
Fax : 2620700;
Cell: 09814217738
email : drhj@sify.com;
Website : www.ICAAICON2006.com

23-24th December 2006

CME on Stem Cell

Venue: Armed Forces Medical College, Pune-40
Contact Person: Lt Col PK Gupta
Dept of Transfusion Medicine
AFMC, Pune-40
Tele No : 020-26306267
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