Triplet pregnancy with complete hydatiform mole following ovulation induction

Oztas E, Erkenekli K, Celen S, Caglar AT, Dansman N
Zekai Tahir Burak Women's Health Education and Research Hospital, Ankara, Turkey

Objective
Multiple pregnancies consisting of a complete hydatiform mole and coexisting fetuses are rare but may increase due to the widespread use of ovulation induction. The risk of persistant trophoblastic neoplasia is high and the management of such cases may change due to the secondary complications. Generally termination of the pregnancy is necessary, although favourable outcomes were reported with healthy term deliveries.

Methods
We report on a triplet pregnancy conceived following clomiphen citrate therapy with two normal fetuses and a complete hydatiform mole.

Results
A 27 year old primigravid woman presented at 12 weeks with vaginal bleeding. Ultrasonography revealed two viable fetuses appropriate for gestational age, two separate normal placentas and a third multicystic molar appearing placenta of 130×83mm in diameter located at the posterior wall of the uterus, both of the ovaries were enlarged in size with multiple theca lutein cysts. Elevated serum β-hCG level was determined as >500, 000 mUI/ml. Thyrotropin was 0. 009 IU/ml with elevated free T3 andT4 levels (6. 29 pg/ml and 2. 16 ng/dl, respectively). Chest X-ray was normal and +1 proteinuria was detected in spot urine examination. During follow-up tachycardia (134 beats/min) and hypertension with a blood pressure of 155/100 mmHg developed, so dilatation and evacuation (D&E) was performed. However severe dyspnoea developed 2 hours later and the arterial blood gases at room air showed hypoxaemia with a PaO2 of 67 mmHg. Chest X-ray showed bilateral interstitial infiltration. The patient was transported to intensive care unit and chest computed tomography (CT) revealed pulmonary edema. Intravenous furosemide together with antibiotics was started and after 3 days she was discharged. Serum βhCG level decreased to 71. 523 mIU/mL at the day 11 but increased to 86. 00 mIU/mL again at the second week and transvaginal ultrasonography revealed recurrent molar tissue of 33×30mm in the endometrial cavity extending towards the myometrium. Chest and cranial CT were normal. After the patient was diagnosed to have a persistent trophoblastic disease, vacuum aspiration was performed and 50 mg methotrexate weekly was given. Serum levels of βhCG decreased to the level less than 5 IU/mL and now she is free from the disease for 3 months. According to the results of karyotyping, the pregnancy consisted of a hydatidiform mole with a 46 XX karyotype and both of the fetuses had the 46 XX karyotype as well.

Conclusion
The optimal management of such pregnancies can be either immediate termination of pregnancy to avoid the potential maternal complications or conservative approach may be an alternative. The definitive treatment needs to be further investigated, however now, according to the results of recent reports, it seems more feasible to continue pregnancy but only when the patient is stable, fetal karyotyping is normal and close follow-up of the patient with serial βhCG measurements and ultrasonography is possible. The true incidence of this rare entity is difficult to establish, and some suggest that increased incidence of iatrogenic multiple gestations will cause a higher incidence.