Complete invasive molar pregnancy coexisting with normal fetus – Treated with intrathecal and systemic polychemotherapy

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Objective
Complete molar pregnancy coexisting with normal fetus is very rare. The reported incidence is 1 in 10,000 to 100,000 gestations. The management of molar pregnancy with coexistent fetus is controversial. In most of the cases pregnancy is terminated due to complications such as miscarriage, vaginal bleeding, hyperemesis and preeclampsia. Other reported complications are persistent gestational trophoblastic disease, preterm labour and fetal death. Antenatal detection of mole co existing with a viable fetus should warrant genetic analysis and search for gross malformation of the fetus.

Methods
We report a case exhibiting a molar pregnancy and a coexisting normal fetus. We believe this is the first reported case. A 36 year old woman, in her third pregnancy, para 1+1 presented to EPAU with hyperemesis and bleeding per vagina at 9 weeks of gestation. She had one previous CS and TOP at 14 weeks. She was non-smoker and did not drink alcohol. She was taking pregacare and cyclizine for nausea. An early pregnancy scan done suggested a viable fetus with multiple cystic areas in the placenta with a large area of haemorrhage noted superior to the gestation sac. Beta hCG was 640,000 IU. The right ovary was noted to have a corpus luteal cyst. She was scanned at 10 weeks when the appearance of a large bulk of placenta with molar like changes raised the possibility of partial mole in the presence of a normal looking live fetus. As her nausea was very severe, she was started on ondansetron and metoclopramide with little effect. Pregnancy progressed to 12 weeks +3 days when NT scan was carried out, which suggested structurally normal looking fetus with NT of 1.3mm. The placenta was big disproportionately, covering the internal os completely and was abnormal looking with the fetus pushed to one side. Complications such as intermittent bleeding, placenta praevia, preeclampsia, prematurity, hyperemesis, miscarriage and IUD was discussed. The option of interruption of pregnancy was discussed. She decided to have a termination as symptoms of severe nausea continued and the placental mass was growing and uterus was up to her umbilicus at 13 weeks of gestation. She had surgical termination after counseling.

Results
Her Beta-hCG continued to be raised persistently to 40,000 IU therefore she had a course of Methotrexate but did not respond. There were distant metastases noted in the lungs. She was given intra-theacal chemo and poly chemotherapy including Actinomycin. Her Beta-hCG decreased to 5 IU/l after 4 months and is now currently discharged from the active surveillance.

Conclusion
The majority of pregnancies in which there is coexisting fetus with molar change in placenta have been reported in association with twin pregnancies. In such cases, fertilization results in a complete hydatidiform mole (CM) and normal co-twin. Usually there is a clear distinction, both sonographically and pathologically. The other differential diagnosis includes confined placental mosaicism, triploid partial mole, placental mesenchymal dysplasia, and missed abortion with its degenerated gestational sac. In this case the uterus was growing very fast in accordance with the placenta giving the suspicion of invasive molar pregnancy. Surprisingly the fetus was completely normal looking and growing normally. Abnormal placenta warrants thorough examination to exclude fetal anomaly. Histological examination of placenta is strongly recommended. Genetic analysis of the fetus should be performed if there is suspicion during antenatal period.