HYDATIDIFORM MOLE WITH A COEXISTENT FOETUS

(A Case Report)

by

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Unusual manifestations of molar pregnancies such as eclampsia (Mueller and Lapp, 1949, Teoh *et al* 1967), ascites (Hooper *et al* 1966) and intra-peritoneal haemorrhage (Acosta—Sison, 1962) have been reported from time to time. The following case of a molar pregnancy with a foetus is reported for its unusual presentation.

Case Report

Mrs. S., a seventh gravida, aged 35 years, entered the hospital on 13th September 1967 at 6 p.m., complaining of respiratory embarrassment and moderate vaginal bleeding since 22 days. She noticed sudden enlargement of the abdomen 12 days prior to admission. Amenorrhoea was of three months duration. No quickening was noted. There were no complaints of headache, nausea, vomiting or visual disturbances. Micturition was normal. Her previous pregnancies were uneventful. The last childbirth was five years ago. She had an abortion of five months two years ago. The menstrual periods had been regular since then.

She was thinly built and anaemic. Respirations which were thoracic in type were at the rate of 40 per minute. The sternomastoids were also in action. No oedema of the lower extremities was noted. Her blood pressure was 90/60 mm of Hg. The pulse rate was 112 per minute. The cardiovascular and respiratory systems did not reveal any abnormality. The liver and spleen were not palpable.

The uterus was enlarged to a height corresponding to the size of a 30 weeks gestation; it was not tender and was inactive. No veins were seen on the abdominal wall. As the uterus was tense it was difficult to palpate any foetal parts, but ballotment was suspected. A fluid thrill was elicited, though shifting dullness could not be demonstrated. No foetal heart sounds could be heard.

The external genitalia were normal. Speculum examination showed a healthy cervix and the bleeding to originate from the uterine cavity. No vesicles were seen.

A diagnosis of acute hydramnios in a uniovular twin pregnancy with mild accidental haemorrhage was made. The presence of ballottment excluded the possibility of a vesicular mole.

The results of laboratory investigations were as follows: Hb. 8.0 [illegible]s; WBC—6,100; polymorphs 66; lymphocyte 32; eosinophils 2. X-ray chest was unremarkable.

X-ray abdomen; No foetal parts were seen. Pregnancy test (immunologcial): positive in undiluted urine; negative in dilution.

On 15th September 1967, two days after admission, amniocentesis was performed to relieve her respiratory embarrassment. A few c.c. of straw-coloured fluid was aspirated. Punctures from other sites failed to aspirate liquor. The next day she complained of abdominal discomfort and that night at 12.30 a.m. she had a bout of vaginal bleeding of about 200 c.c. Fifteen minutes later she lost another 200 c.c. of blood. 5 units of pitocin were given I.M. and 40 units added to the intravenous drip. Vaginal examination showed the cervix to be 6 cms. dilated and molar tissue extruding out.

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The molar tissue was digitally separated and the expulsion of molar tissue was aided by fundal pressure. A piece of well formed placenta weighing 100 grams was found. Methergin 0.5 mgm was given I.V. and the uterine cavity curetted. At the conclusion of the operation a pelvic examination was made. No adnexal masses were palpable but foetus was removed from the vagina. It had probably been held up by the speculum retracting the posterior vaginal wall.

She was relieved of her dyspnoea by the next day and had an uneventful recovery. The pregnancy test became negative on the ninth day. She was advised a hysterectomy but refused the procedure. She was discharged on 26th September 1967.

Pathology report

The molar tissue was composed of vesicles varying in size from 3 to 5 mm. in length. It was intimately mixed with blood and straw-coloured fluid. The placenta weighed 100 grams and measured 3 inches by 4 inches. The female foetus weighed 65 grams and was 4 inches in length. No obvious malformations of the foetus were seen.

Microscopic: The large villi with trophoblastic proliferation were odematus and avascular. Unfortunately, the placenta was not saved and no histo-pathological study could be done.

Comments

The incidence of an embryonic mole, as quoted by Beischer (1966), is I in 200,000 pregnancies. As it is of uncommon occurrence, this condition is often undiagnosed antenatally. In late pregnancy where foetal parts are palpable, the molar degeneration is not suspected. Similarly, in early pregnancy a molar change may be diagnosed but the presence of the foetus missed. Symptoms such as hyperemesis, vaginal bleeding, excessive enlargement of the uterus and severe pre-eclamptic toxaemia should make one suspect placental dysfunction of the degenerative type at any period of gestation.

An accurate diagnosis during pregnancy has been reported by Harper and Macvicar (1963) using ultrasonic visualisation. Molar pregnany is detected by various labarotory investigations such as urinary chorionic gonadotrophin titre (Teoh *et al* 1966). There is an increase in urinary 17-ketosteroids (Goddard, (1960), serum S.G.O.T. (Tobin, 1963), and ACTH activity (Strobel, 1961). The ratio of serum alpha and beta lipo proteins is lowered. (Ma *et al* 1965). The total urinary oestrogens approximate that found in the non-pregnant woman. An abnormal Estrone/Estradiol ratio was detected as early as the 12th week (Bonnano *et al* 1963), Barlow *et al* (1967) reported a reduced Estriol as compared to normal early pregnancy. Use of the above tests in all cases of molar pregnancy may be helpful to detect the presence of a foetus.

The prognosis to the foetus depends on its viability. Of the 92 cases analysed by Beischer (1966) only 19 cases survived the neonatal period, of whom 3 were congenitally malformed. The foetus can survive if there is sufficient normal placental tissue for its growth. However, the large bulk of the molar tissue leads to mechanical distension of the uterus causing an early onset of labour.

It is often difficult to differentiate between a complete degeneration of one placenta of uniovular twins and degeneration of part of a single placenta as in this case.

Hertig (1940) is of the opinion that this may be an exaggeration of early hydatidiform changes at the junction of the definitive placenta and chorion laevae, when the chorion laevae is

undergoing atrophy at 8 to 12 weeks with loss of foetal circulation, but continued activity of the trophoblast. Shettles (1960) put forward the theory that this may be due to a simultaneous fertilisation of a normal ovum and of a polar body. This view has been supported by Baggish *et al* (1968) in their studies of chromosomal aberrations of the embryo. Faulty endometrium due to oestrogen or vitamin deficiencies may also interfere with proper nidation.

Summary

A case of molar pregnancy with an associated foetus is described. The diagnosis and possible aetiology are reviewed.

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