HYDATIDIFORM DEGENERATION ON THE PLACENTA WITH A NORMAL FOETUS

(A Case Report)

by

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The incidence of hydatidiform mole with a foetus present is 1 in 20,000 pregnancies. Of 85 cases of mole with coexistent foetus reported in the literature, 55 were associated with a single placenta and 30 were cases of dizygotic twins in which the molar tissue was separate from the normal placenta associated with the foetus. There were eleven abnormal foetuses among those associated with a single placenta.

The incidence of chromosome anomalies among spontaneous abortions reported in literature varies from 8 to 40 per cent with a mean of 21 per cent. Carr, in 1969 found triploidy present in five per cent of all spontaneous first trimester abortions and almost half of these cases had hydatidiform degeneration of the placenta. Only five cases of triploidy and hydatidiform degeneration of the placenta have been described where the pregnancy continued beyond the third month.

The most common phenotypic feature of triploid abortuses is found not in the embryo, but in the placenta. Almost 70 per cent of specimens with hydatidiform degeneration are triploid while this anomaly is found only in about 13 per cent of abortuses diagnosed as hydatidiform mole. Another interesting feature is the occurrence of sex chromatin in a large number of cases, sex ratio studies have shown a female preponderance. Anything which leads to fertilization of an "aged" ovum, either intrafollicular or extrafollicular aging of ova may predispose to chromosomal disorders. Conceptions occuring within six months of discontinuing oral contraceptives have a higher incidence of polypoidy.

Atkin and Klinger (1962) mention developmental abnormalities in their case of foetus with a single molar placenta, where they found triploid chromosome constitution in the mole and double sex chromatin masses in some of the nuclei of the foetal tissues.

Case Report

A twenty-five years old female patient was admitted on 24-9-1971 with a history of five months' amenorrhoea followed by vaginal bleeding since eight days.

Obstetric History: One full term normal delivery two years ago. Patient was still lactating.

Menstrual History: Normal regular cycles.

Past History: Nothing relevant. There was no history of having ever taken oral contraceptive pills.

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On examination, patient was a well built woman, slightly anaemic, pulse rate 78 per minute, blood pressure 100/70. There was no oedema of the feet. All systems were normal.

The uterus was about twenty-six weeks' size and felt doughy. There was a suggestion of external ballottment. The presentation was probably breech, there was no fluid thrill.

On vaginal examination the external os was closed and there was slight bleeding.

The patient was treated as a case of threatened miscarriage and kept under observation. She felt better and stated that she felt foetal movements but foetal parts could not be felt distinctly and the size and consistency of the uterus remained the same.

The following investigations were done:

Red blood count 3,800,000 per c.mm. Haemoglobin—11 gms. per cent. Kahn test—negative. Blood Group—Group B, Rh D positive.

Urine—There was no albuminuria. X-Ray film of the chest showed clear lung fields. X-Ray film of the abdomen showed a small foetal shadow high up in the right lumbar region. The pregnancy appeared to be intrauterine. A soft tissue shadow was filling the rest of the uterine cavity.

On 30th September patient had labour pains and vaginal bleeding. Vaginal examination revealed that the cervix was taken up, dilated upto two fingers, soft placental tissue was felt on the right side. Bleeding was present.

Intravenous glucose 5 per cent with 10 units of pitocin was given. The pulse rate was 100 per minute. Blood pressure 120/80 mm. of Hg. Labour pains increased and the patient first passed a large placenta which had undergone vesicular degeneration. This was followed by a foetus as breech delivery at 11-30 a.m.

The whole placenta had undergone vesicular degeneration except for a few patches of normal looking placental tissue scattered here and there. It was forming one discoid structure 37 cms. in diameter weighing one kg. and two hundred grammes. The vesicles were of varying size from a few millimetres to one centimetre in diameter.

A part of the placenta was covered with membranes and the umbilical cord was attached to this part in a battledore mode of insertion. The length of the umbilical cord was 25 cms.

The foetus was a female, well developed weighing 450 grammes. It was a fresh stillbirth. There was no evidence of any congenital malformation.

Patient's general condition was good The puerperium was uneventful. She was discharged on 8-10-1971. A month later patient came for a follow up. Her general condition was good. The uterus was well involuted. Urine Aschheim Zondek test was negative.

Discussion

In this case we were not able to study the excretion of chorionic gonadotrophin or do cytogenic investigations.

The foetus had no developmental abnormality.

In cases with abnormal foetuses the chromosome constitution of foetus and placenta was 69XXX. The foetal abnormalities that have been noted are syndactyly, polycystic kidney and in the male abnormality of the external genitalia and Leydig cell hyperplasia. Beischer *et al* (1967) reported a case where the foetus had effusion in the serous cavities, a lumbar meningomyelocele 2 cms. in diameter underneath which the vertebral column showed posterior spina bifida involving lower four lumbar vertebrae. The brain showed absence of corpus callosum and septum pellucidum and hyperplasia of the cerebellum.

In this case there was no severe anaemia or toxaemia though Bain *et al* had to deal with prolonged pre-eclampsia in their patients.

Acknowledgement

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