

RECURRENT MOLAR PREGNANCY

NIRMAL KUMAR SEN,* M.B.B.S., D.G.O., M.R.C.O.G.

Hydatidiform mole is known from a time, as back as the medical history can be traced, but the etiology and pathogenesis still remain obscure. Minor degrees of hydatidiform degeneration of the choriomic villi, have been detected in the aborted ova, but opinions vary as to the significance of this change being a simple degenerative process (Novok 1952), to a subclinical phase of hydatidiform mole.

Cases are on record where molar degeneration has occurred in one of the placentae in a twin pregnancy co-existing with a normal foetus with placenta (Rao *et al* 1975). Recurrences of molar pregnancy is another mystery reported infrequently. Two cases of recurrent molar pregnancy are being reported.

Case 1

Mrs. M.N. 30 years, Muslim, Para 0 + 5 was admitted in Eden Hospital on 1-4-70 with the following complaints:

(i) Amenorrhoea—20 weeks. (ii) Occasional vaginal bleeding for one month and (iii) Vague pain with occasional cramps in the lower abdomen for one month.

Menstrual History: Menarche—12 years, 30 + 2 days, 3-4 days flow—average—Last menstrual period 5th November, 1969.

Obstetric History

1. January 1964—20 weeks spontaneous abortion at home? Molar changes. 2. October 1964—20 weeks molar pregnancy—Vaginal evacuation done in Eden Hospital. 3. 1965—16 weeks molar pregnancy—Vaginal evacuation none in

*Ex-Registrar, Eden Hospital, Medical College Hospital, Calcutta. Surgeon, Deptt. of Obst. & Gynae., I.P.G.M.E. & R. and S.S.K.M. Hospital, Calcutta.

Eden Hospital. 4. 1966—16 weeks molar pregnancy—Vaginal evacuation done at Eden Hospital 600 cc—Blood transfused. 5. 1967—16 weeks molar pregnancy—Vaginal evacuation done at Eden Hospital by Prof. K. N. Mitra (Courtesy reference) 600 cc Blood transfused.

Husband has a second wife—Para 2 + 0, term normal delivery—Past History of Illness—Patient had enteric fever in 1960.

Examination on admission—General condition—fair, pulse—86 pm, respiration—18 pm, B.P.—110/70 mm of Hg.

Systemic Examination—Nothing abnormal detected.

Per abdomen—Height of Uterine fundus—24 weeks size of pregnancy. No external ballotment, No foetal parts felt, no foetal heart sounds recorded.

On Vaginal Examination—Cervix—tubular Os-closed—trace vaginal bleeding during examination.

Special Laboratory Examination—Blood—Hb 10 gm%, Group AB Rh + ve. WBC—7000/cmm, poly—66%, lympho—30%, memo—2%, eosino 2%.

Routine Examination of Urine—Nothing abnormal detected. **Pregnancy Test of Urine—**Positive.

4-4-70—Titre of Chorionic Gonadotrophin Positive 1/200 dilution: 1/400 negative.

8-4-70—Titre—1/200 negative: 1/400 negative: Albumin—trace.

X-Ray—Lower abdomen—No foetal shadow seen. Chest—clear.

16-4-70—The uterus was 26 weeks pregnancy size. Laparotomy was done under gas and oxygen anaesthesia. Anterior hysterotomy was done by a lower segment incision on the uterus. The mole was evacuated. Biopsy was taken from the uterine myometrium. The ovaries were healthy studded with small cysts.

Postoperative recovery was uneventful.

Histopathology Report—Hydatidiform mole without involvement of the myometrium.

Follow up—18-5-70—Uterus clinically just bulky. Diagnostic curettage done—No evidence of mole.

Pregnancy test of urine—Negative, X-ray chest—clear.

Case 2

Mrs. U.H.—22 yrs. Para 1 + 2 was admitted in Eden Hospital on 25-6-70 with the presenting complaints of:

(i) Amenorrhoea—14 weeks. (ii) Persistent brownish discharge per vaginam for one month. (iii) Pain lower abdomen with occasional cramps for last 15 days. (iv) Patient had excessive vomiting and anorexia during the first eight weeks of amenorrhoea.

Menstrual History: Menarche—14 yrs., 30 + 5 days, 3-5 days, flow—average. Last menstrual period—4th March 1970.

Obstetric History

1. 1965—Term normal delivery at home—girl living well uneventful puerperium. 2. 1966—Induced abortion done at 8 weeks of pregnancy. 3. 1969—Molar Pregnancy—12 weeks, vaginal evacuation done at Eden Hospital, Blood transfused. Follow up was—uneventful.

Examination on admission—General condition—fair, pulse—98 pm, respiration—20 pm, B.P.—120/76 mm of Hg.

Systemic Examination—Nothing abnormal detected.

Per abdomen—Height of the uterine fundus corresponded to 22 weeks of gestation. No ballotment felt, no foetal movements or foetal heart sound appreciated.

On Vaginal Examination—Cervix—tubular, Os—closed. Dark brown discharge on examining fingers.

Special Investigations—Blood—Hb 8.5 gm%—Group B Rh + ve.

Urine—Routine examination—Nothing abnormal detected. Pregnancy test—positive in 1:200 dilution.

Patient had a frank haemorrhage on 28-6-70. Vaginal evacuation of the mole was done following rapid dilatation of the Cervix. 600 cc of Blood Group B Rh + ve was transfused.

The vesicles of the mole were small. Histopathology report—no evidence of malignancy.

The postoperative recovery was uneventful.

Follow up—9-7-70 Patient was doing well. Pregnancy test of urine—negative, A follow up endometrial curettage was done—no moles detected.

10-8-70—Uterus—normal size. Pregnancy test for Urine—Negative.

Discussion

Hydatidiform mole is a curiosity ever since medical history can be traced but the etiology is still a controversy. The disparity of incidence according to the geographic distribution and racial preponderance is unsolved yet (Ratnam *et al* 1975). The possibility of an infective origin (? viral) has been assumed. Tominoga *et al* (1966) have observed that 80-90% of hydatidiform mole had a female chromatin pattern, suggesting that XX constitution favours the continued growth of trophoblast, forming benign trophoblastic tumours.

Normal foetus born to a second wife by same husband in the first case evokes the possibility of genetic disparity. In the first case a deliberate abdominal hysterotomy was performed to avail myometrial Biopsy. Prophylactic Chemotherapy has been advocated, to check recurrence and possible malignancy. Acosta-Sison (1964), Tow (1966) have claimed a definite decline of incidence of Chorio-Carcinoma following hydatidiform mole. Normal pregnancy is on record following prophylaxis by chemotherapy with no evident congenital abnormality (Radha *et al* 1974). The possibilities of teratogenic effect resulting from chromosomal damage and recessive mutagenic damages is in view and the rational compromise drawn at is a rigid close post-operative follow-up and administration of chemotherapy in individual cases. In neither of the cases reported chemotherapy was given and both the patients were well till 2 years.

Summary

With all the unestablished curiosities regards the etiology, pathogenesis and

consequences, 2 unusual cases of recurrent molar pregnancy are reported with follow up.

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