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Embryonic Molar Pregnancy: A Rare Case Report

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Abstract

Partial hydatiform mole (MHP) represents a spectrum of trophoblastic-related disorders occurring during pregnancy. Also known as embryonal mole, it is characterized by a recognizable ovum abnormality with vesicular transformation of villi but with recognizable placental appearance and amniotic cavity containing the fetus. First-trimester spontaneous abortion most commonly suggests the diagnosis. Partial moles rarely persist beyond the first trimester and are then a cause of maternal and fetal complications and diagnostic confusion. MHP of genetic origin is triploi d with extra chromosome of paternal origin. The coexistence of normal fetal karyotype and MHP is exceptional. We report a rare case of partial molar pregnancy with liveborn diploid fetus in a 30-year-old woman diagnosed with threat of premature labour associated with placenta previa at 11 weeks of amenorrhea (WA).

Keywords: Partial mole, diploid karyotype, liveborn fetus

Introduction

Partial hydatidiform mole (PHM) is a gestational trophoblastic disease. It is more frequent than complete hydatidiform mole with an incidence of 3 per 1000 pregnancies [1]. The only risk factor that has been clearly identified is maternal age [2, 3]. It is characterized by a focal hydropic degeneration of the placenta with a recognizable gestational sac and a fetus with excessive secretion of choriogonadotropin (HCG) hormone. The genetic origin of MHP corresponds to a triploid conception with an additional chromosomal batch of paternal origin [4]. The association of a live fetus with a normal karyotype is a very rare situation occurring in 0.005 to 0.01% of all pregnancies and the diagnosis in this case is often difficult, especially in the absence of revealing clinical signs [4, 5]. We report a rare case of a partial molar pregnancy diagnosed late at 11 weeks of amenorrhea with delivery of a fetus with a normal karyotype.

Patient and observation

Patient age 30 years, grouping O+, without notable pathological history, irregular cycle, G1: current pregnancy to be estimated at 11 weeks according to the precise DDR without previous ultrasound done, with 2 PNC and normal prenatal check-up. In front of the evolution marked by the exaggeration of the sympathetic signs of the pregnancy, the patient consulted or a BHCG was asked to 924540 mui/ml, in the ultrasound we find an intra cavitary image in honeycomb with Doppler taking, posterior wall to 9mm, we also objective an evolving intra-uterine pregnancy with LCC=10 weeks 2 days (figure1) The

patient was admitted to the gynecologist department at the hospital of maternity and reproductive health the orange ones. An ultrasound-guided aspiration was performed, the anatomopathological examination confirmed the diagnosis of embryonic mole. The patient received complementary monochimiotherapue treatments with negativation of the bhcg figures during the monitoring.

Discussion

Molar pregnancies are classified as nonviable conceptions [6]. This is a conception anomaly, which manifests itself as an overgrowth of the placenta and the absence of normal fetal development. These abnormalities usually result from the dispersed fertilization of a normal haploid oocyte and produce a triploid set of chromosomes [7]. In the presence of triploidy, the fetus cannot survive after birth due to multiple malformations and severe intrauterine growth retardation secondary to the affected placental circulation.

The coexistence of a diploid fetus with MHP is an extremely rare situation in which the fetus can survive to term [5, 8]. In this association, the main differential diagnosis is a twin pregnancy with a diploid fetus and a normal placenta and a second placenta in complete mole where the first evaluation is interested in finding a normal separate placenta [9]. Placental mesenchymal dysplasia is a placental vascular lesion that is also a rare differential diagnosis with MHP that should not be overlooked [10].

Early diagnosis of MHP leads in most cases to termination of the pregnancy due to the frequency of triploidy and the maternal risk and the possibility of progression to persistent trophoblastic disease later [11, 12]. Close monitoring of the mother and fetus can help to achieve a favorable outcome, and evacuation of the pregnancy is only required in cases of fetal anomalies or deterioration of the maternal condition [13]. Several factors can affect fetal outcome in partial molar pregnancy. These include the fetal karyotype, the size of the abnormal placenta, the rate of molar degeneration, and the development of fetal anemia or other obstetric complications such as prematurity [14].

Conclusion

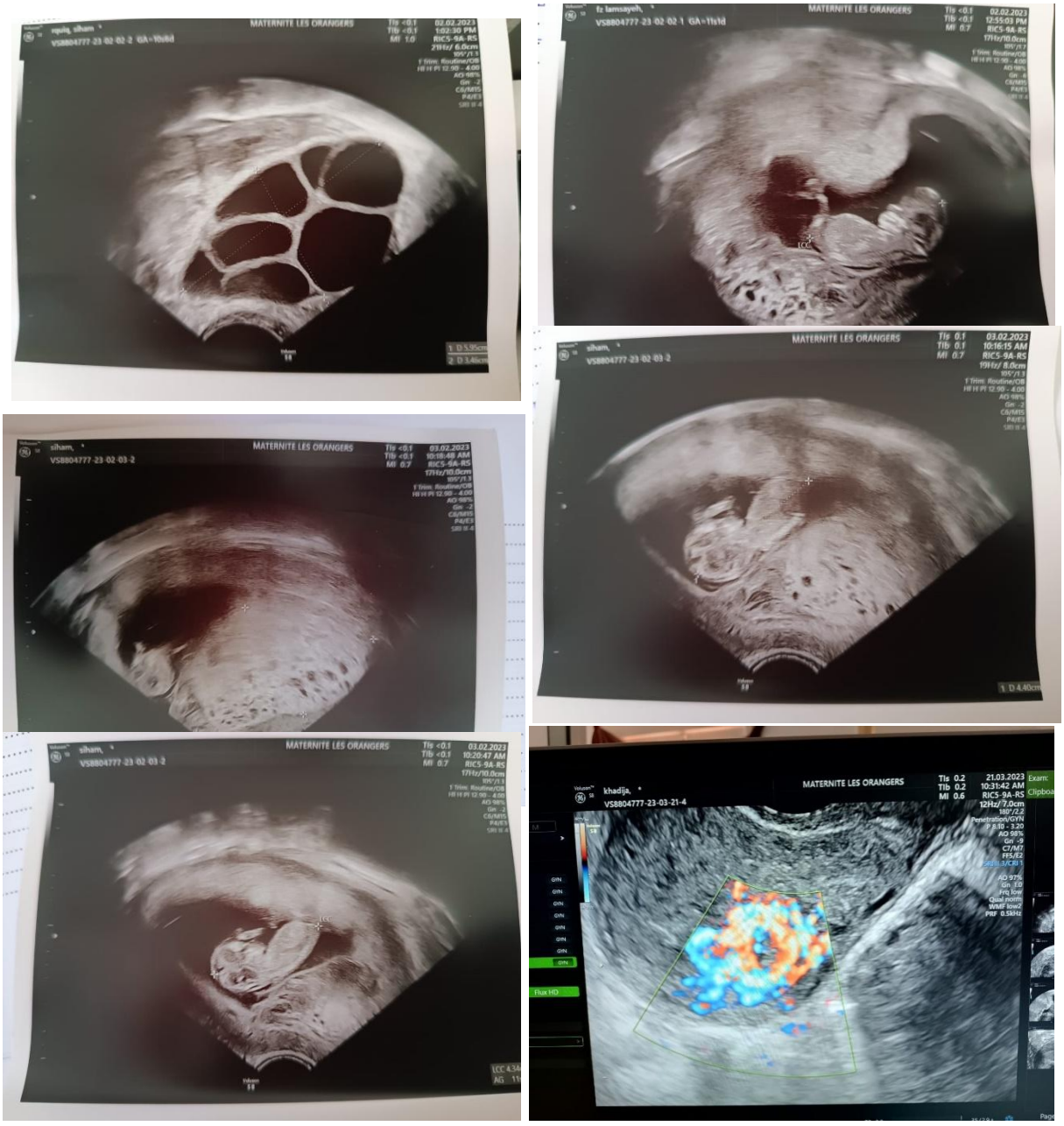
Despite the perfect knowledge of the pathophysiological mechanisms of chromosomal abnormalities in molar pregnancies, the partial form with diploid fetus remains a confusing pathology because of the frequent absence of clinical arguments in favor of the diagnosis. Great vigilance is necessary in order to suspect them at an early stage and make a reliable diagnosis for optimal management.

Author Contributions:

- All authors have approved the final version of the manuscript

Figures

Figure 1:ultrasound aspects of embryonic soft tissue before aspiration



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