Atypical presentation of molar pregnancy at third trimester: a case report from eastern Nepal

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ABSTRACT

A 20 years old primi-gravida lady at 35 weeks of gestation presented to a remote mountainous district hospital with the complaint of per vaginal bleeding on and off with the passage of clots for 10 days. On further examination with an ultrasound scan, she was found to have heterogeneous cystic lesions inside the uterine cavity suggestive of molar pregnancy. She underwent dilatation and evacuation using Bier's forceps after initial resuscitation. Histopathology confirmed the diagnosis of partial molar pregnancy. The postoperative period was uneventful and the patient was discharged on the third day with the advice of close monitoring and to follow up with beta-HCG and Chest X-ray.

Keywords: beta-HCG, dilatation and evacuation, molar pregnancy, third trimester

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INTRODUCTION

Molar pregnancy is classified as a gestational trophoblastic disease that results from abnormal trophoblastic proliferation, pathogenically found as complete mole and partial mole.[1] The prevalence of molar pregnancy is 1 in 500-1000 pregnancies.[2] Complete hydatidiform mole usually occurs as a result of duplication of a single sperm with fertilization of an empty oocyte with no evidence of fetal tissues. But, the partial mole has trophoblastic tissues with two sets of paternal haploid genes and one set of maternal haploid genes with evidence of some fetal tissues.[3]

Molar pregnancy usually presents with lower abdominal pain, vaginal bleeding, and morning sickness along with increased symphysis-fundal height for gestational age and with rare signs of hyperthyroidism, early-onset pre-eclampsia, and acute respiratory failure.[4] Molar pregnancy can be strongly suggested by ultrasound examination however definitive diagnosis requires histopathological examination of the product of conception.[5]

Molar pregnancy is generally treated by suction and evacuation and should be followed up weekly for Beta-human chorionic gonadotrophins (Beta-HCG) estimation until it reaches undetectable.[3] Here we present a case that was managed at a resource-limited setting by General Practitioners (GPs) and underwent a unique procedure called dilatation and evacuation using Bier's forceps instead of simple suction evacuation at third trimester.

CASE REPORT

A 20 years primigravida lady at 35 weeks of gestation presented to the remote mountainous district hospital of eastern Nepal (Charikot Hospital) with the complaint of per vaginal bleeding on and off with the passage of clots for 10 days. She had no ANC visit to the hospital till the third trimester as she thought she would be fine herself. Her medical history was unremarkable. On examination, she was pale with a blood pressure of 100/60mmHg and pulse of 100/min with afebrile status, per abdomen finding was consistent with 30 weeks of symphysio-fundal height with no clear palpable fetal parts and absent fetal heart sound. Per vaginal examination was done (after initial ultrasound scanning) and found to have closed external Os.

Initial resuscitation was started with intravenous crystalloids and baseline investigations were sent for complete blood count and platelets, blood group, renal function test, liver function test, Beta-HCG titer. Her blood reports have a low Hemoglobin level of 6gm/dl (corrected with 4 pints of fresh blood). Her thyroid function test (TFT) was normal (TSH 3mIU/L), with no proteinuria. Ultrasound scan of abdomen/pelvis revealed heterogeneous cystic lesions (Pic 1) inside the

Figure 1. Ultrasound findings suggesting molar pregnancy

uterine cavity suggestive of molar pregnancy. Patient and attenders were counseled about the diagnosis, procedure, potential risks, need for close follow up and family planning.

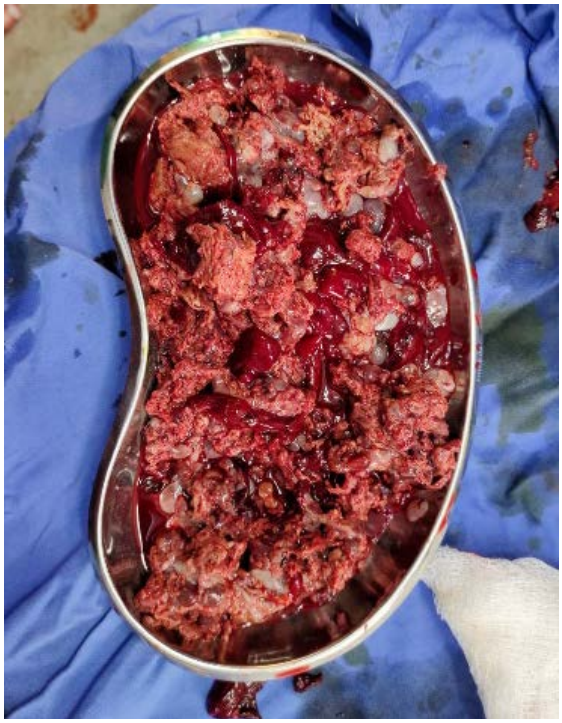

Figure 2. Molar tissues after evacuation

Initially, suction and evacuation were attempted after sublingual tablet misoprostol 400 mcg, but the procedure was unsuccessful due to matured molar tissues (Pic 2), so, finally, the evacuation was carried out successfully using Bier's forceps

(forceps generally used for second-trimester abortion) with the infusion of Oxytocin. Histopathology confirmed the diagnosis of partial molar pregnancy. The postoperative period was uneventful and the patient was discharged on the third day with the advice of birth control pills, monitoring levels of Beta-HCG, Chest X-ray, and clinical symptom follow-up on 1st week, 2nd week, 4th week, 3 months, and 6 months.

DISCUSSION

Molar pregnancy is a form of benign gestational trophoblastic disease.[6] Most forms of molar pregnancy present with hyperemesis, per vaginal bleeding, hyperemesis, abdominal pain, and sometimes hypovolemic shock. Mostly, diagnosis of molar pregnancy can be achieved with ultrasonography and measurement of serum Beta-HCG, usually in the first trimester.[7]

Our patient presented in the third trimester (as she did not visit any health facility for an anti-natal checkup (ANC) with on and off per vaginal bleeding with a positive pregnancy test. Third-trimester presentations are rare these days due to better and accessible antenatal care. A review of the literature revealed very few cases of molar pregnancy presenting in the third trimester. A case report of, 21-years G2P1L0 un-booked patient at 39 weeks with a singleton pregnancy with a coexisting molar pregnancy, managed with cesarean section has been reported. [8]

Another case report of Italy, 37-year old white woman, G1, at 30 weeks of gestation presenting with partial molar pregnancy with a normal-appearing male fetus with diploid karyotype delivered at 31 weeks of gestation has been reported.[9] But, our case is quite different from theirs as it did not have any fetal parts.

Every case of molar pregnancy should be evaluated for possible complications like pre-eclampsia, hyperthyroidism, anemia, and ovarian cysts. Vacuum curettage is the preferred treatment for molar pregnancy who wish to maintain fertility.[10] But, in our case we attempted suction evacuation initially after crystalloids resuscitation and blood transfusion, but molar tissues could not be evacuated and we used Bier's forceps which are generally used in the second trimester dilatation and evacuation (D&E) procedure, and almost 1500gm of matured tissues evacuated. To decrease the risk of postpartum hemorrhage (PPH), oxytocin infusion started along with blood transfusion. This is probably the first report managed by GPs at resource-limited setting and the use of Bier's forceps to evacuate matured molar tissues.

Management modality depends on women's fertility status. A hysterectomy is an option for those who do not wish to maintain fertility. Prophylactic chemotherapy after the evacuation of molar pregnancy is associated with a reduction in the incidence of persistent mole from 20% to 3% in high-risk patients (age>40 years, Beta HCG>1, 00,000 mIU/ml, uterine enlargement, theca leutin cysts >6cm, medical complications).[11]

After the evacuation of molar pregnancy, strict follow up for serum Beta-HCG measurement is recommended at 1-2 weeks, until 3 consecutive tests to establish normal Beta-HCG levels as there is the risk of invasive mole or choriocarcinoma in approximately 15-20% of patients with complete mole and that of 1-5% in the partial mole. Use of oral contraceptives for about initial 6 months are preferably recommended as they suppress endogenous luteinizing hormone (LH). [10]

CONCLUSION

Partial molar pregnancy in third trimester is a very rare condition that possess a management challenge. Early diagnosis and proper management of molar pregnancy are paramount to reducing maternal morbidity and mortality. After evacuation, every case of molar pregnancy should be counseled for family planning and strict follow-up and close monitoring.

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Conflict of interest

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