

# A CASE REPORT ON COMPLETE MOLAR PREGNANCY

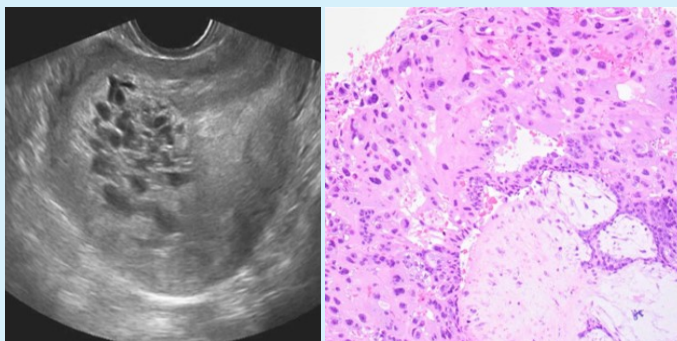
Author - Dr. TRUPTI AGRAWAL

## INTRODUCTION

Molar pregnancy comprises two distinct entities, partial and complete mole, which can be distinguished by means of gross morphologic, histopathological examination and according to chromosomal pattern. Complete moles have no identifiable embryonic or fetal tissues. Classically, the chorionic villi have diffuse trophoblastic hyperplasia and generalized swelling, and trophoblast at the implantation site has diffuse, marked atypia. Complete moles usually have a 46, XX karyotype, and are derived completely from father.

## OBJECTIVES

This case report on Molar pregnancy emphasize on clinical presentation along with diagnosis using beta hCG and sonography findings. Report also highlights on the treatment modality and outcome of the pregnancy.



## CASE REPORT

31 year old G2P1L1 (LSCS) presents at 10 weeks of pregnancy with vaginal bleeding. , along with abdominal cramp and nausea. Patients past medical and family history are unremarkable. The patient was alert, oriented and had tachycardia rest of the vitals were within normal limits .On physical exam fundal height was 2 cm below umbilicus. Abdomen was soft and mildly tender on lower quadrants. Pelvic examination reported discharge of blood clots and brown-colored grapelike material. The cervical OS was dilated to approximately 2cm.

Lab results as follows: hb 8.6 g/dL, TLC 13,000, platelets at 153,000, inr of 1.5 and TSH of 0.011, lft and rft were normal. Beta HCG was 461,636 mIU/mL. Pelvic- sonogram reviled a cloud like image, with absence for heartbeat.

Hence was planned for Suction and Evacuation along with blood transfusion and intra operatively the sample obtained was grape like structures and was sent for pathology examination which confirmed a complete hydatidiform mole.

Patient's recovery was unremarkable; patient was discharged home after 48 hours.



The patient was instructed on importance of using reliable method of birth control and monitoring of levels of HCG (first 48 hours post evacuation, weekly until hcg <5 miu/ml, then monthly X 6-12 months).

## DISCUSSION

Hydatidiform mole is principally a disease of chorion. It is best regarded as a benign neoplasia with malignant potential. Complete moles secrete high levels of beta-hCG, much higher than normal pregnancy, . This proves to have an important role as a tool when trying to diagnose a complete mole. The rapid rise in the beta-hCG level is responsible for potential complications such as hyperthyroid features, theca lutein cysts, or preeclampsia with or without severe features. Thus, Patients diagnosed with molar pregnancy should be evaluated for potential medical complications such as anemia, toxemia, or hyperthyroidism. There is also a 6-32% chance of progression to malignant choriocarcinoma and about a 12-15% chance of progression to persistent GTD.

The ACOG recommends that for patients with H-mole, beta hCG levels should be measured 48 hours after evacuation and every 1 to 2 weeks until levels are undetectable. After attaining undetectable levels, follow-up measurements are made at monthly intervals for an additional 6 months.

## CONCLUSION

The patient described presented with signs and symptoms of first-trimester missed abortion. She had the classic features of molar pregnancy (e.g. uterus that is larger than appropriate for gestational age, a marked elevation of the hCG level, and a characteristic appearance of a mole on ultrasonographic ) and also confirmed by HPE. Suction curettage is recommended for evacuation, after which serial hCG levels should be done. Patients should be instructed to use reliable contraception during the entire interval of hCG monitoring.

Early booking of pregnant women to antenatal care clinics and routine first trimester ultrasounds has made diagnosis easier and earlier before any complications arise. Histological review for all miscarriages is mandatory for the detection and diagnosis of H-mole.

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