



Case Report

# Twin pregnancy with one normal fetus and one complete mole

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## Abstract

Twin pregnancy with a complete mole and a coexisting healthy fetus is a rare condition. There is increased risk of developing severe complications and development of persistent trophoblastic disease. A 28 years old 2<sup>nd</sup> gravida, with 1<sup>st</sup> vaginal delivery reported to the hospital at 20 weeks gestation as a case of dichorionic twin pregnancy. On routine USG, it showed a complete mole with a coexisting live fetus. The patient had features of anemia and severe preeclampsia. After explaining the risk to the patient and bystanders, they requested to terminate the pregnancy. She was induced for the same and delivered a normally appearing fetus. This was accompanied by evacuation of the mole. Diagnosis of complete mole was confirmed by histopathology. Twin pregnancy with a complete mole and a coexisting healthy fetus is a rare condition. The decision regarding management of this condition is difficult due to the various complications associated especially development of choriocarcinoma.

## Key words

Twin pregnancy, Complete mole with coexisting fetus, Persistent trophoblastic disease.

## Introduction

Twin pregnancy consisting of a complete mole and a co-existing healthy fetus is rare; the incidence of such an occurrence is 1 in 22000 to 1 in 100000) [1]. Management of these pregnancies is difficult because of the associated complications such as fetal death, vaginal bleeding, pre-eclampsia, preterm delivery and

increased risk of persistent trophoblastic disease. This presents the physician and patient with significant clinical dilemma between immediate intervention and expectant management, particularly in the case of highly desired pregnancy. The decision will be guided by the problems that are already present and those that may arise. The patient's parity status will also influence the decisions. Consequently

early termination of pregnancy has been advised, though not all women will consider this option particularly in the case of highly desired pregnancy.

### Case report

A 28 years old G<sub>2</sub>P<sub>1</sub>L<sub>1</sub>, with previous one full term vaginal delivery, was referred to our hospital at 20 weeks of gestation as a case of dichorionic twin pregnancy with a complete mole and a coexisting healthy fetus detected on routine ultrasound. On examination, she was found to be anemic and showed features of pre-eclampsia. Uterus corresponded to 28 weeks size. Maternal serum  $\beta$  HCG was more than 1 lakh mIU/ml.

Repeat ultrasound showed 2 sacs. One sac was with single live intrauterine pregnancy of 20 weeks as breech. Placenta was fundal and anterior. Liquor was adequate. No gross anomalies were seen. Second sac showed a complete mole (with snow storm appearance) separate from the placenta in the posterior wall, completely covering the internal os. Bilateral large theca-lutein cysts were present.

Diagnosis of complete mole with coexisting fetus (CMCF) was made. After counselling, she opted for termination of pregnancy. She was induced with PGE<sub>1</sub> and developed excessive bleeding per vaginum 4 hours later. Vaginal examination revealed cervix fully effaced, 3 cm dilated and molar tissue was felt through the os. Under general anesthesia, suction evacuation of molar tissue was done. She was given oxytocin for controlling the bleeding. Second amniotic sac was ruptured and baby was delivered as breech. It showed no external structural abnormalities and placenta appeared grossly normal. Histopathology was consistent with complete mole. **(Photo – 1)**

**Photo – 1:** Baby, umbilical cord, Placenta and mole.



It was a case of complete mole with coexisting healthy fetus as there were two separate gestational sacs, one with a complete mole and the other one with a normal fetus showing growth consistent with that for expected gestational age with no gross anomalies. However, no karyotyping of the conceptus was done.

Post natal period was uneventful and patient was discharged on 7<sup>th</sup> post natal day. She was followed up for persistent trophoblastic disease (PTD) with  $\beta$  HCG monitoring. She did not require chemotherapy for the treatment of gestational trophoblastic disease (GTD) as her serum beta-HCG level was normalized after 6 weeks and remained normal at 1 year of follow up.

### Discussion

Complete hydatidiform mole (CHM) consists of diffuse swelling of villous tissue, diffuse trophoblastic hyperplasia and no embryonic fetal tissue. Complete moles typically have a complete diploid karyotype, and 85 percent of these are 46, XX. Partial moles have a triploid karyotype (69, XXX, 69, XXY, or less commonly, 69, XYY) that is composed of one maternal and



two paternal haploid sets of chromosomes [2]. In partial hydatidiform mole (PHM) there is focal trophoblastic proliferation and focal swelling of villous tissue with presence of fetal tissue. Accurate differentiation between PHM and CMCF is essential as there are chances of survival of a normal fetus in CMCF.

CMCF progressing to a viable healthy infant is an extreme rarity as most of such pregnancies will be terminated prematurely either because of persisting hemorrhage or severe preeclampsia.

Sebire (2002b) described the outcome of 77 twin pregnancies, each composed of a complete mole and a healthy cotwin. Of this group, 24 women chose to have an elective termination, and 53 continued their pregnancies. Twenty-three gestations aborted spontaneously at less than 24 weeks, 2 were terminated because of severe preeclampsia, and 28 pregnancies lasted at least 24 weeks resulting in 20 live births. The authors demonstrated that coexisting complete moles and healthy co-twin pregnancies have a high risk of spontaneous abortion, but approximately 40 percent result in live births. In this study, the risk of progression to GTN was 16 percent in first-trimester terminations and not significantly higher (21 percent) in women who continued their pregnancies [3]. Risk of developing persistent trophoblastic disease (PTD) should be kept in mind. Fetal karyotyping to confirm a normal chromosomal pattern is also recommended [4, 5].

Pregnancies with complete mole and coexisting healthy fetus that continue up to a viable stage suggest a benign trophoblastic nature and are not at an increased risk of developing PTD. Features that are considered as absolute indications for terminating pregnancy are severe preeclampsia, severe vaginal bleeding,

intractable hyperemesis gravidarum, hyperthyroidism, and evidence of trophoblastic embolisation.

## Conclusion

Twin pregnancy with a complete mole and a coexisting healthy fetus is a rare condition. Management of such a condition is difficult because of the serious maternal and fetal complications associated with it like severe preeclampsia, vaginal bleeding and persistent trophoblastic disease. Management is a dilemma of the obstetrician. The decision will be guided by the problems that are already present and those that may arise. The patient's parity status will also influence the decision.

## References

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