

Embryonic Molar Pregnancy: A Case Report

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Keywords

Gestational trophoblastic diseases, Partial hydatidiform mole, Foetus vivant.

Introduction

Partial hydatidiform mole (PHM) is one of the gestational trophoblastic diseases also known as embryonal mole. This is a pregnancy containing a pathological human egg with villi undergoing vesicular transformation, but retaining a recognisable placental shape and an amniotic cavity with a foetus. We report a case of partial mole discovered incidentally in a 31-year-old parturient in the maternity ward of the CHU ibn Rochd at risk of premature delivery at 24 weeks of amenorrhoea.

Results

The case concerned Mrs R.F, aged 31, I.G.I./IIP (1 live child by vaginal delivery and a spontaneous miscarriage), who had consulted the obstetric emergency department for uterine contractions in a pregnancy presumed to be 6 months old, poorly monitored, in whom the clinical examination revealed normal blood pressure, a negative urine test with a uterine height of 22cm.

The vaginal examination revealed a closed posterior cervix, no bleeding, and the rest of the clinical examination was without any detectable abnormalities. Obstetric ultrasound showed a progressive mono-fetal pregnancy with positive cardiac activity, cephalic presentation, with a fundial anterior placenta containing multiple microvesicles, with a cervical length of 2 cm. Une bhcg quantitatif réalisée objectivant une valeur à 667641 UI/L.

A pelvic MRI revealed a voluminous anterior fundic placenta, with an unremarkable foetus with multiple microvesicular transformation of the placenta.

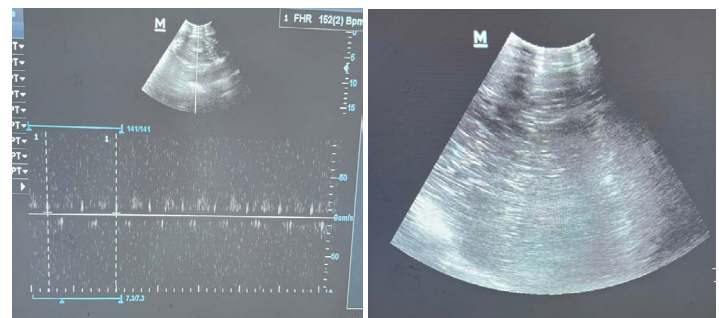


Figure 1: Image A: positive cardiac activity, image; B: Fundial anterior placenta with multiple microvesicles.

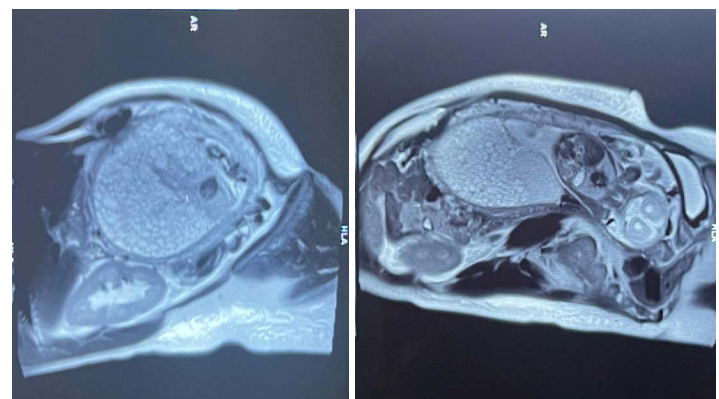


Figure 2: MRI image of a placenta undergoing vesicular transformation of the molar type.

The decision was to terminate the pregnancy, but the patient refused.

Discussion

Embryonal mole is one of the gestational trophoblastic diseases. It is a mixture of mole vesicles and normal placental villi with recognisable embryonic tissue [1].

Partial mole is almost always triploid; it accounts for 10% to 20% of spontaneous abortions and is characterised by :

- A cessation of development at various stages of pregnancy, from the first weeks to 24 or more weeks after birth;
- The existence of an embryo or foetus is often accompanied by intrauterine growth retardation and congenital malformations;
- Macroscopic and especially histological examination of the expelled, aspirated or curetted material helps to confirm the diagnosis.

PHM occurs more frequently in young women (peak frequency at 27 years), who often have a history of spontaneous abortion [2,3], more frequent than complete hydatidiform mole, with an incidence of 3 per 1000 pregnancies [2]. The most common diagnostic circumstance is spontaneous abortion in the first trimester, although pregnancy rarely persists beyond the first trimester [4].

The association of a live foetus with a normal karyotype is a very rare situation, occurring in 0.005 to 0.01% of all pregnancies, and diagnosis in this case is often difficult, especially in the absence of revealing clinical signs [5,6]. Despite their rarity, gestational trophoblastic diseases remain formidable because of the haemorrhagic, infectious, invasive, neoplastic and metastatic complications they cause [1]. Histological diagnosis of these different entities is not easy, which is why surveillance is so important [4,7].

These anomalies generally result from dispersed fertilisation of a normal haploid oocyte, producing a triploid set of chromosomes [8]. In the presence of triploidy, the foetus cannot survive after birth due to multiple malformations and severe intrauterine growth retardation secondary to the affected placental circulation.

Early diagnosis of a PHM leads in the majority of cases to termination of the pregnancy due to the frequency of triploidy and the maternal risk and progression to persistent trophoblastic disease [9,10]. Strict monitoring of the mother and foetus can help to achieve a favourable outcome, and the pregnancy is only evacuated in cases of foetal anomalies or deterioration in the mother's condition [8]. Several factors can affect the outcome of the foetus in a partial molar pregnancy. These include the foetal

karyotype, the size of the abnormal placenta, the speed of molar degeneration and the development of foetal anaemia or other obstetric complications such as prematurity [5].

Conclusion

PHM is a relatively rare genetic disorder. They have histopathological and cytogenetic characteristics and a relatively distinct course from MHC. Great vigilance is required in order to suspect them at an early stage and make a reliable diagnosis to ensure optimal management.

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