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# Twin Gestation with a Complete Mole and Coexisting Normal Fetus

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**Abstract:** ***Twin pregnancy with a complete hydatidiform mole and co existing live fetus is a rare encounter. A case of a 28 year old woman, who conceived spontaneously to have a twin pregnancy with a live fetus and coexisting complete mole has been presented. The pregnancy was terminated at 19 weeks as the patient had continues bleed per vagina and developed severe anemia. Level of serum beta HCG concentrations returned to baseline and remained within the normal range at 12 weeks post termination.***

**Keywords:** Twin Gestation; BETA HCG; Molar Pregnancy

## 1. Introduction

Gestational trophoblastic disease along with a normal intrauterine pregnancy has been reported in2.5 – 5 % of all molar pregnancies[1,2]and 1 in 20,000 – 1,00,000 pregnancies[3]. This clinical entity is named as sad fetus syndrome. Ultra sound helps in diagnosing these cases but the management of these cases is still a dilemma. Termination of the pregnancy is recommended to avoid complications like preeclampsia, thyrotoxicosis and increased risk of persistent trophoblastic disease[4]. There are reports of pregnancy continuation and delivery of a normal live baby. Complete mole is usually found to be associated with advancing maternal age and assisted reproductive techniques[5].

## 2. Case Report

Mrs A aged 28 years had presented withhistory of 5 months of amenorrhoea and heavy bleeding per vagina of oneday duration. Patient had been having irregular bleeding fromthe 2nd month of pregnancy which and was treated conservatively. Scan done at 7 and 9 weeks showed a progressively increasing sub chorionicbleed, and at 13 weeks scan done due to increased bleeding showed a single live gestation of 13+2weeks and a well-defined cystic complex mass along the posterior walls of the sac merging with the placenta,which was suspected to be a complet mole. Patient conituned to have the bleeding , which was on and off and treated conservatively. Patient was referred to us for further managementat 19+2weeks.

On examination the patient was found to have moderate to severe anemia, with stable vitals; fundal height was corresponding to 26 weeks of gestation( POG – 19+2 weeks) , Speculum examination showed minimal bleed p/vand grapelike vesicles .On per vaginal examination cervix was found to be pulled up and a mass was felt in the pouch of Douglas. Scan showed bilateral theca lutein cysts,and a twin gestation,with one live morphologically normal fetus and anothercomplete mole.Blood investigation revealed Hb of 7 mg/dl, beta HCG of >2, 00,000mIU/dl , and low serum TSH of 0.024mIU/L. Due to persistent bleeding and passage of grape like cluster termination of the pregnancy was decided and informed consent was obtained for the same.

Induced with Foley's catheter.Moles weighing about 500gms was expelled following which there was spontaneous rupture of membrane and a fresh still born foetus of 450 gms with no gross anomalies was expelled along with a placenta of a normal morphology . Patient continued to bleed in spite of uterotonics and needed check curettage to stop the persistent bleeding.Patient needed 2 units of packed cell transfusion. Patient was discharged after 1 day, in a stable condition.

On day7 patient had minimal bleed p/v and her serum beta HCG was 75,000mIU/dl and scan showed persistens of the bilateral theca lutein cysts .

4 weeks following abortion the beta HCG was 371mIU/dl and thetheca lutein cysts had resolved completely and by 6 weeks post evacuation beta HCG was undetectable. The check pelvicscan showed normal uterine and ovarian morphology.

## 3. Discussion

Until now,over 200 casesof twin pregnancy with CHMF are documented in the literature, while only 56 cases resulted in a live birth [6]. In the late 1970s, Vassilakos et al. was the first to describe 2 different pathologic entities, partial and complete hydatidiform mole (CHM), having different mechanisms of origin,diagnosed based on cytogenetic analysis [7].

[10] The exact incidence of this extremelyrare entity is difficult to establish, and many suggest that the recent increased incidence of iatrogenic multiple gestations is the cause of a higher incidence of CHMF [6].

Ultrasonography has made it easy to diagnosis a hydatidiform mole and co-existentfetus in the first trimester [11]The management of these pregnancies can be either immediate termination to avoid the potential maternal complications [8,9]. 75% of such cases do not progress beyond 20 week period of gestation.

Risk of developing persistent gestational trophoblastic tumor (pGTT) should always be remembered in all these pregnancies. The key factor seems to be the molar component,weatheris partial or complete. Complete mole has a relatively higherchance of (20%) developing pGTTcompared to 4% risk in partial molar pregnancy.[12] It is not clear whether this increased risk is due to a delay in diagnosis with prolongation of pregnancy or an intrinsic propensity toward pGTT. Higher incidence of pGTT was observed in women with complete mole interrupted at a previable stage than in those who were allowed to progress to a gestational age of fetal viability (68 versus 28%)[10]. It is hypothesised that the pregnancies with complete hydatidiform mole and coexistent surviving fetus which continue upto viablity stage are not to be at any greater risk of developing pGTT.

Indications for terminating pregnancy in these cases are severe preeclampsia, intractable vaginal bleeding, hyperemesis gravidarum, hyperthyroidism, and evidence of trophoblastic embolisation. In a clinically stable patient an additional relative indication for therapeutic intervention is uterine enlargement markedly greater than the gestational age.

It will be difficult to outline the optimal management in gestational trophoblastic disease coexisting with live twin as most of the suggestions are based on either anecdotal case reports or retrospective compilation and analysis of such reports. Whatever be the antenatal management for these patients, careful surveillance for the pGTT is warranted. Clinicians should continue to report their experience with such unusual cases, as a large series of patients will be necessary to formulate a clinical policy.

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