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Sad Fetus Syndrome

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1. Introduction

Hydatidiformmole are classified into incomplete and complete. They are usually caused by abnormal conception and are characterized by edematous villi with a proliferation of trophoblasts.[1]

Hydatidiform mole subtypes are usually diagnosed using routine ultrasound assessment early in first trimester[2].

A rare subclass of gestational trophoblastic disease is a partial mole with a co-existing live fetus a condition sometimes called "sad fetus syndrome[2].

2. Case Report

A 20 year old G2A1with 7 weeks 3 days POG according to her last menstrual period, came with c/o bleeding pv since 1 day, pain abdomen since 1 day.

The pregnancy was a planned conception occurring after 11 months married life.

The pregnancy was confirmed with positive urine pregnancy test questioning about menstrual history revealed cycles of four to five days every 28 to 30 days.

Past medical, surgical or family history was unremarkable.

O/E
pallor+, BP120/80mmHg, PR82bpm. P/A-soft, non-tender. p/s-bleeding from OS Noted, p/v-OS was closed Ultra sound examination revealed a single live fetus of weeks and 3days in duration with 0.67CRL with bicornuate uterus with left horn showing heterogeneous echogenic contents with a echoing central area-partial mole. We ordered additional investigations through our hospital's designated laboratory. B-HCG was210, 310mIU/ml.

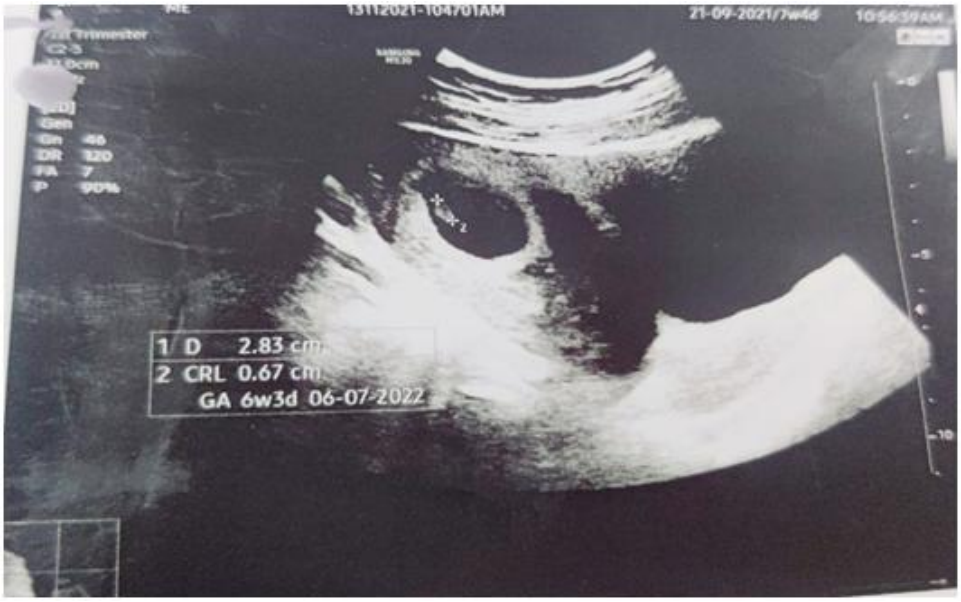
At 9 weeks and two days she reported concerns a passage of clots followed by spontaneous abortion. The molar tissue was expelled intermittently.

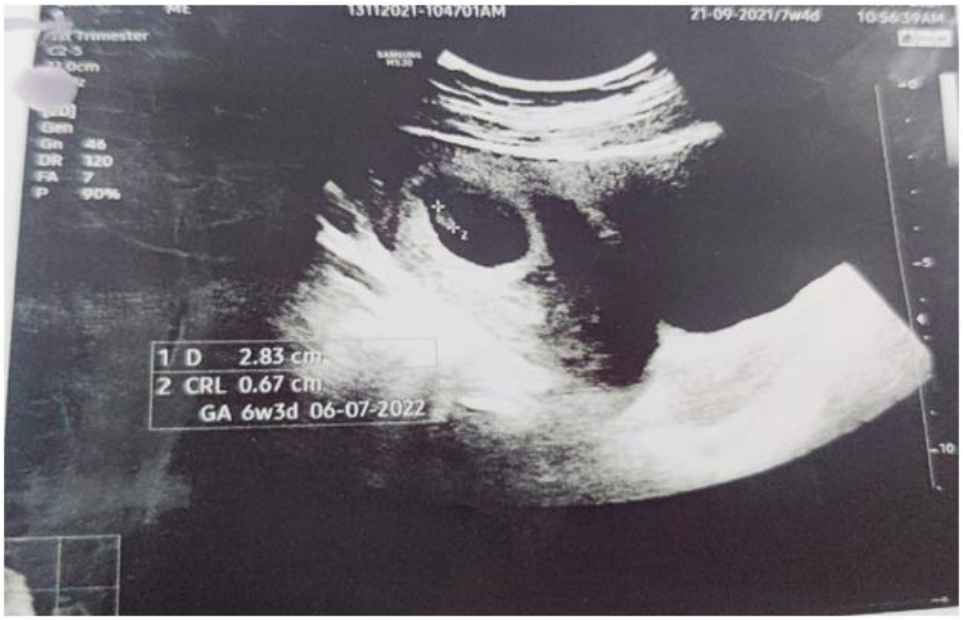
After the expulsion of molar tissue, short-term general anaesthesia was administered to the patient followed by suction curettage.

An ultra sound after the procedure confirmed an empty uterine cavity.

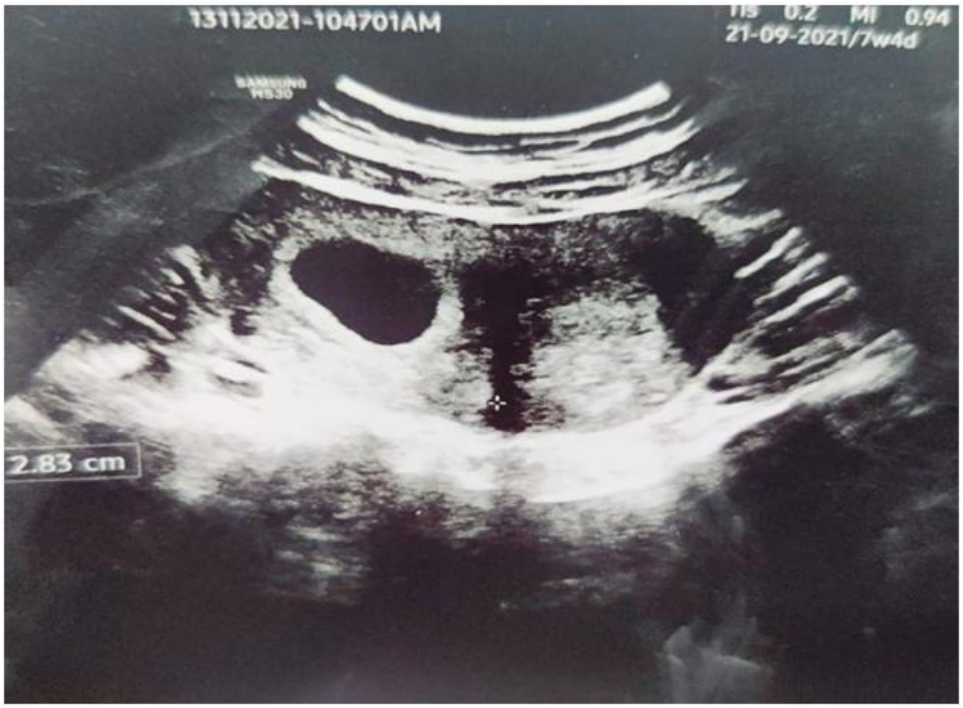
B-hCG levels were monitored post-termination.

Approximately in one day the patient was discharged home, we noted a β-hCG level of 143534 mIU/mL. Upon discharge we instructed the patient to follow up with repeat serial measurements of her β-hCG levels. 4 weeks following the abortion her βhCG levels were 320mIU/mL, six weeks following the abortion hCG was undetectable.





3. Discussion



Sad fetus syndrome, also known as molar pregnancy with concomitant live fetus, is a rare phenomenon.[4]

Its incidence is reported at 0.005% to 0.01% of all pregnancies.

Molar pregnancies with a coexistent live fetus occur in three variations[6]. The most common variant includes a twin pregnancy with one fetus being healthy and the other being a complete mole.[1]

Less common is a twin pregnancy harboring a healthy fetus/placenta with a partial mole, and the rarest variant is a healthy single fetus with a partial molar placenta, as was the case with our patient.

The management of a partial mole with coexistent fetus remains a challenge due to the wide array of complications associated with the condition.

Amniocentesis remains the diagnostic test of choice, and termination of the pregnancy may be required in the due course

4. Summary

Molar pregnancy with a coexistent live fetus is a rare and challenging condition.

Common clinical presentations that should alert the clinician to this rare condition include bleeding p/v, anemia,

hyperemesisgravidarum, hypertension, thyrotoxicosis and uterine size disproportionate to uterine age.

The management of a partial mole pregnancy with a coexistent fetus is especially challenging due to the wide array of complications, the most common of which are severe haemorrhage, sepsis, thyrotoxicosis and coexistent mole/choriocarcinoma.

Ultrasound examination and β-hCG level measurements have proved to be efficient in tracking the clinical progression of the condition.

Amniocentesisis the diagnostics of choice and terminating the pregnancy may be required.

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