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# TWIN PREGNANCY WITH COEXISTENT PARTIAL HYDATIFORM MOLE AND VIABLE FOETUS: A RARE CASE REPORT

**Dr Vasavi Anantharaman, Dr Durga devi and Dr Mohanapriya**

Department of Obstetrics, Government Theni Medical College , Theni

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**ABSTRACT**

A twin pregnancy with a partial mole and a concurrent viable foetus is a rare obstetrical condition. We present a case of a 24-year-old $G_2P_1L_1$ diagnosed with a dichorionic pregnancy, with one sac containing alive foetus and the other showing features of a partial molar pregnancy. The patient underwent emergency hysterotomy due to complications. Histopathology confirmed partial hydatidi form mole. This case highlights the diagnostic, therapeutic and prognostic challenges in managing such rare entities.

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## INTRODUCTION

Twin pregnancy with a coexistent hydatidiform mole and a live foetus is extremely rare, occurring in only0.005–0.01% of all pregnancies (1)It is associated with significant maternal and foetal morbidity due to complications such as severe bleeding, preeclampsia, hyperthyroidism, and risk of gestational trophoblastic neoplasia. (2) Diagnosis is usually established via ultrasonography,supported by biochemical markers such as serum β-hCG. Management remains controversial, often requiring individualised decision-making.

We presentar are case of dichorionic twing estation with oneviable foetus and one sac showing features of a partial mole, managed by hysterotomy.

## CASE PRESENTATION

A case of a 24-year-oldwoman, gravida 2 para1live1presented at15weeks 5days gestation to the casualty with complaints of per-vaginal spotting for 3 days. Her previous pregnancy was uneventful. She had LSCS in view of breech presentation and the last child's birth was 1.5 years back. She has conceived spontaneously and had regular antenatal checkups. Clinical examination revealed pallor and per abdominal examination showed a uterus of 24 weeks' size, not tense and non-tender. On per vaginal examination, cervix was uneffaced, os closed with blood stains on examining finger. Vitals were stable. Ultrasound abdomen had revealed a dichorionic twin pregnancy with a single live foetus in one sac and a second sac containing multiple cystic areas in the lower part of the placenta,suspicious for molar changes. The viable foetus showed normal growth parameters with an estimated gestational age of 16 weeks. (Figure 1)

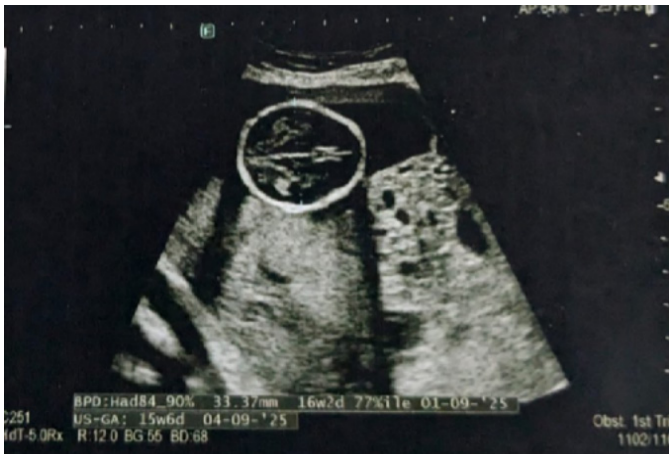


**Figure1.** Ultra sound image depicting a foetus with a partial mole.

Haematological investigations showed low haemoglobin 8.7 g/dl. Her liver and renal function reports were normal.BleedingTime-3min30sec,Clottingtime5min18secPT-14.8SecINR

1.11. Peripheral smear showed microcytic hypochromic anaemia and other cell lines were normal. Thyroid function test showed TSH of 0.3μIU/ml. Herβ-hCG level was5,000mIU/ml. Urinalysis showed no proteinuria. Chest X-ray was normal.

*Corresponding author: **Dr Vasavi Anantharaman**

Department of Obstetrics, Government Theni Medical College , Theni

She was transfused with 2 units of packed red blood cells andcounselled regarding the risks of gestational trophoblastic disease. Due to worsening of per vaginal bleeding, she underwent emergency hysterotomy under general anaesthesia. Intraoperative findings included: Retro placental clots of ~350 gm Blood loss ~600 ml

Molar tissue was evacuated and a dead born male fetus(~100gm)delivered.

Placenta and molar products were delivered and uterine curettage was done. (Figure 2 and 3)

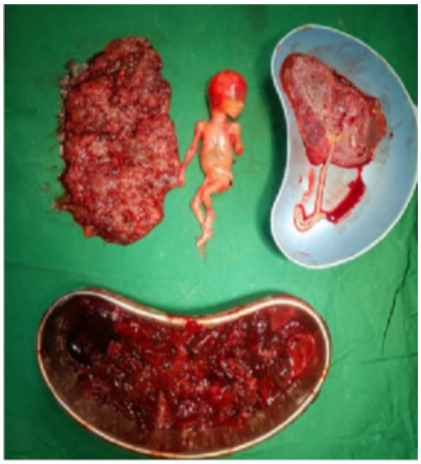

**Figure 2.** Postoperative picture showing foetus, normal placenta, retro placental clots and partial mole.

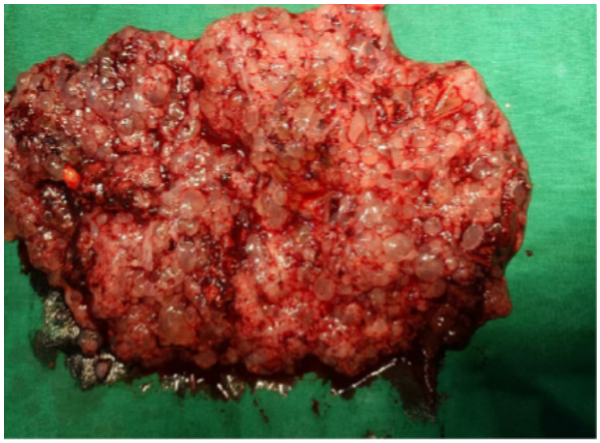

**Figure 3.** Zoomed image of a Partial mole.

In view of uterine atonicity, medical management was proceeded with a Foley tamponade and bilateral uterine artery ligation. Three units of packed cells were transfused postoperatively. The patient's postoperative period was uneventful, and the patient was treated with higher antibiotics. On day 3, β-hCG was 2350 mIU/ml and on day 7, it was reduced to 250 mIU/ml. She was discharged on day 8 and was under regular follow-up with serial β-hCG monitoring.

Histopathology revealed enlarged, irregular villi with scalloped borders, cistern formation and focal non-circumferential trophoblastic proliferation, consistent with partial hydatidiform mole.

## DISCUSSION

Coexistence of a partial or complete mole with a live foetus is a rare entity posing a clinical dilemma. Risk factors are previous molar pregnancy,extreme maternal ages(>35yearsand<20 years) and geographic and ethnic factors (3). The mainstay of diagnosis is by ultrasound abdomen. MRI can be used to differentiate between partial and complete mole, myometrial invasion of placenta if suspected. Possibility of survival of normal foetus with complete hydatidiform mole varies between 30-50% (4). While some pregnancies can be continued with close monitoring, risks include severe maternal haemorrhage before or at the time of delivery, preterm labour, preeclampsia, hyperthyroidism, thyrotoxicosis, intrauterine foetal demise and progression to gestational trophoblastic neoplasia (2).Amniocentesis can be done at16 weeks to determine foetal karyotype (5). Target scan at mid-trimester and serial scans every 2 weeks for foetal growth to monitor high risk foetus. Termination of pregnancy is often advised when maternal complications arise which could have been amplified by the presence of molartissue.

In our case, owing to severe vaginal bleeding, emergency hysterotomy was per formed. Al though there is no suggested mode of delivery of molar pregnancy coexisting with normal foetus, American institute of cancer research recommends curettage at the time of caesarean to help continued decline of β-hCG levels and also reduces the risk of metastasis of trophoblastic cells by uterine contraction in vaginal delivery (4). The patient is being monitored with serial β-hCG levels, which are crucial for detecting persistent disease. Incidence of gestational trophoblastic neoplasia following partial hyda tidiform mole coexisting with live foetus is 4% (3). There is no Difference in incidence of gestational trophoblastic neoplasiapertaining to the mode of delivery(4).

This case emphasizes the importance of early diagnosis and multidisciplinary management in such rare pregnancies.

## CONCLUSION

Twin pregnancy with a coexistent partial mole and a viable foetus is a rare and high-risk condition. Early diagnosis with ultrasound and β-hCG estimation, close maternal monitoring, and individualized management strategies are essential for optimizing outcomes.

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