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TWIN PREGNANCY COMPRISING OF HYDATIDIFORM MOLE AND A FOETUS: DIAGNOSIS AND TREATMENT

Prof. O.C. IKPEZE MRCOG, FMCOG, FWACS FICS.
DR A.O. IGWEGBE, FWACS, FICS.

Department of Obstetrics and Gynaecology,
Nnamdi Azikiwe University Teaching Hospital,
P.M.B 5025,
Nnewi, Nigeria.

Correspondence:
Prof. O.C. Ikpeze,
Department of Obstetrics & Gynaecology,
Nnamdi Azikiwe University Teaching Hospital,
P.M.B 5025,
Nnewi, Nigeria.

INTRODUCTION

The occurrence of twin pregnancy in which a fetus coexists with hydatidi from mole is very rare with an estimated incidence of 1in 10,000 to 1 in 100,000 pregnancies[1]. Important diagnostic tools include ultrasound, B hCG estimation, DNA typing and histopathology[2]. Attempts to prolong pregnancy with a view of obtaining a live birth usually fail[3] and by allowing the development of a larger mass of molar tissue, puts the woman at a higher risk of persistent trophoblastic disease[4]. The present case was diagnosed sonographically at 11 weeks of gestation, followed by suction evacuation of the uterus. A very interesting feature is that the fetus and hydatidiform mole had different amniotic sacs with clearly demonstrable intervening amniotic membranes.

CASE REPORT.

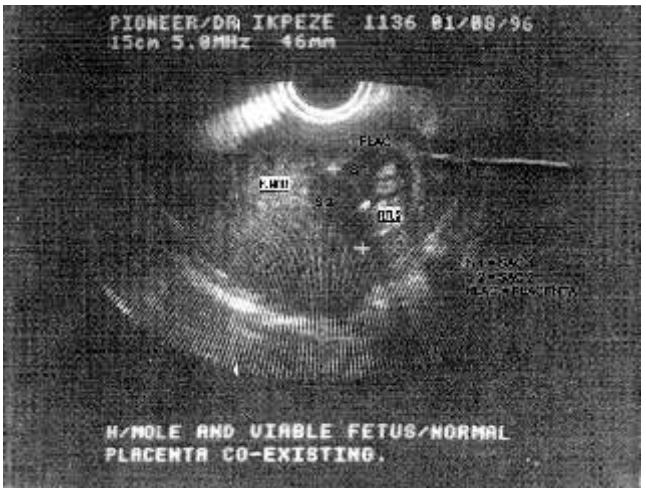
A 25 year old Nigerian woman presented after 11 weeks of amenorrhoea with intermittent vaginal bleeding of two weeks duration. She had had 3 previous normal term pregnancies and no history of an abortion. Her last confinement was one year previously. She was generally fit and normotensive. However the uterine size was equivalent to 24 weeks of gestation. Pelvic examination showed that the cervix was uneffaced and closed. Her Blood group was O. Rh(D) postive, and urinalysis was normal without proteinuria.

Sonographic examination was performed using the 3.5 MHz BCF Xtrascan abdominal sector scanner (BCF, Livingston, Scotland). The findings (See Figure 1) showed a diamniotic twin gestation comprising[1]of a live fetus at 11 weeks 4days gestational age, determined by crown-rump length with its own normal placenta and a complex echogenic and echolucent mass representing the molar vesicular mass in the other sac. A diagnosis of hydatidiform mole co-existing with a normal pregnancy was made. After counseling, suction evacuation of the uterus was performed. The fetus and a large quantity of vesicular tissue were obtained. Her post-operative period was uneventful, chest X-rays were normal. Histological examination confirmed a benign hydatidiform mole. She was followed up for one year during which period she had barrier contraception and HCG levels became undetectable.

Discussion

The co-existence of a normal pregnancy and a hydatidiform mole is very rare with an estimated incidence of between 1 in 10,000 to 1 in 100,000 pregnancies[1]. Ozumba and Ofodile have reported such a case from the same region of Nigeria in a 56-year-old apparently menopausal woman3. Hsu et al have also reported a case in which DNA typing showed that the fetus and placenta were derived from the mother and the father while the hydatidiform mole was entirely of paternal origin[2]. The incidence of the co-existence of a fetus and a hydatidiform mole will expectedly be higher in areas where the incidences of twinning and of hydatidiform molar pregnancy are relatively high. The incidence of twin pregnancy in Eastern Nigeria is 27 in 1000 pregnancies[5], while hydatidiform mole has an incidence of 1 in 12000 pregnancies[6]. This co-existence therefore presents an important, though infrequent, diagnostic problem in this region. Histological and genetic studies of molar tissues are also very important for successful management. Basically there are two types of benign hydatidiform moles. A complete mole usually has a 46XX karyotype with both sets of chromosomes being of paternal origin[7], while a partial mole has a triploid karyotype, with the extra set of chromosomes being of paternal origin[8]. In partial mole, there is also a variable amount of embryonic tissue development together with the molar tissue[8]. The importance of this distinction is that a complete mole has a greater potential for malignancy[9].

The treatment of this condition is evacuation of the uterus, and vacuum aspiration is considered the method of choice, as opposed to medical induction using oxytocic drugs which is thought to carry an increased risk of persistent trophoblastic disease[10]. Because of the possibility of progression to malignant trophoblastic disease, careful and prolonged follow-up of such women is required.



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