

Recurrent Partial Hydatidiform Mole

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Abstract

Hydatidiform moles are abnormal conceptions characterised by atypical hyperplastic trophoblasts and hydropic villi. Their incidence is approximately 1 in 1000 pregnancies. The recurrence risk of hydatidiform mole is approximately 1 in 60 in a subsequent pregnancy and 1 in 6.5 in the third pregnancy. In cases with recurrence, the majority of moles are of the same type as that in the preceding pregnancy. Here, we describe the case of a recurrent partial hydatidiform mole after an initial healthy pregnancy. Both pregnancies were evacuated by suction curettage, and the patient was followed by serial monitoring of β -human chorionic gonadotropin levels. Recurrent molar pregnancy is not an indication for chemotherapy, and subsequent pregnancies do not have an increased risk for other obstetric complications.

Keywords: Partial hydatidiform mole, Pregnancy, Recurrent molar pregnancy.

Introduction

Hydatidiform mole (HM) is the most common form of gestational trophoblastic neoplasia and is characterised by atypical hyperplastic trophoblasts and hydropic villi.¹ There are two types of HM: complete and partial. Several epidemiological risk factors for the development of molar pregnancy are recognised, the most important of which appear to be geographical factors and extremes of maternal age.² It is also recognised that previous HMs increase the risk of HMs in future pregnancies.³ Approximately 1.3% to

2% of mothers who have had a molar pregnancy are expected to have a recurrence.⁴ However, recurrence in complete molar pregnancy have been reported earlier.⁵

Case Report

A 28-year-old-woman, gravida 3, para 1, presented to our hospital with abdominal pain and abnormal vaginal bleeding at 9 weeks of gestation. Her menstrual history was regular, and she had a history of partial HM in her second pregnancy. On examination, her vital parameters were normal. There was no clinical evidence of hyperthyroidism. Ultrasound was suggestive of an HM and a live 7-week, 3-



Figure: Ultrasonographic view of partial hydatidiform mole (white arrows).

day-old embryo. Results of renal and liver function tests, haemogram, and chest X-ray were all within normal limits. Suction curettage was performed 2 days later. A diagnosis of partial HM was made based on histological evaluation. Ploidy studies also supported this diagnosis. Initial serum concentrations of hCG decreased to normal after evacuation, and the patient had an uneventful follow-up. Furthermore karyotypic analysis of the patient and her husband was normal.

Discussion

The aetiology of HM is still unclear. Several epidemiologic risk factors for the development of molar pregnancy are recognized, but at present, the exact mechanism is not evident. Recurrent partial HM is very rare and the risk of recurrence increases with each new HM. The risk of recurrent trophoblastic disease ranges from 0.5% to 20%, including both complete and partial moles.⁶ Women having a pregnancy affected by a histologically confirmed complete or partial mole may be counselled that the risk of a repeat HM in a subsequent pregnancy is approximately 1 in 60, and if this were to occur, the majority of cases would be of the same type as that in the preceding pregnancy. Sebire et al. found that 25% of repeat moles in both groups were of different types. Both complete and partial mole are associated with similar recurrence risks as 1.9% and 1.7% respectively.⁴ The women who become pregnant following molar conception are not at increased risk of obstetric complications. Also molar pregnancy does not have any direct adverse effects for subsequent obstetric health.²⁻⁴

In the earlier reports treatment modality was only evacuation⁵ but Koc et al. reported a case of a third partial molar pregnancy that they considered to be at risk for an invasive mole after the previous evacuation, therefore, they treated the patient with prophylactic chemotherapy. Surgical treatment was not considered because of the patient's desire for a live birth and because she had not had a normal pregnancy.⁷ Ozalp et al. reported the case of a recurrent HM with seven consecutive complete HMs and inadequate attendance at follow-ups, the patient was prescribed prophylactic chemotherapy because of her desire for live birth.⁸ Lorigan et al. analysed the characteristics of women

who developed a second molar pregnancy after a previous episode of gestational trophoblastic disease and concluded that 5.7% of patients required chemotherapy for the second mole. Patient with partial mole also had a recurrent partial mole. However, patients who presented with a complete mole were at risk of a subsequent complete mole, partial mole, or choriocarcinoma.⁹

Recurrent HM are sporadic and familial cases have also been reported.¹⁰ A study investigating the genetic basis of HM recurrence in a familial case revealed that the women in the study most likely had autosomal recessive genetic defects.¹

Conclusion

Both complete and partial moles have similar recurrence risks and all possible combinations have been seen in these patients. Majority of the women experienced the same histological type in their recurrence. Because the requirement for chemotherapy is controversial, each case should be assessed on an individual basis. In our opinion, chemotherapy is an alternative to surgery if the patient desires a pregnancy in the future and is at high risk for gestational trophoblastic neoplasia.

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