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Case Report

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Mola with partial live fetus 20 weeks pregnancy case report

Abstract

Molar pregnancy with a live fetus after 20 weeks does not usually occur and is maternal and fetal associated with complications, preeclampsia and severe: such as intrauterine growth restriction. In the partial mole there are focal placental changes and the embryo survives rarely until the second trimester. We present a case of a partial mole coexisting with a pregnancy of 20 weeks.

Keywords: molar pregnancy, mola partial, hydropic degeneration, gravid uterus, uterine fundus, obstetrical pain, bleeding, polycystic kidney disease, encephalocele, spina bifida, microphthalmia, micrognathia

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Introduction

Molar pregnancy, Hydatidiform mole or vesicular mole, is the result of a genetic alteration that occurs at the time of fertilization. Is characterized according to the classical definition of Hertig, by hydropic degeneration and edema of the villous stroma, the absence of vascularization in the chorionic villi and proliferation of trophoblastic epithelium but differentiated villous structure is preserved. Is a localized disease, usually resolved with uterine evacuation and, in principle, should not be considered neither invasive nor neoplastic or maligna.[1] Gestational trophoblastic disease encompasses a range of disorders both premalignant: mola partial and complete, and malignant disorders: invasive mole, choriocarcinoma and tumor placental site. Partial and complete: Classically 2 types of hydatidiform are distinguished. The complete mole is characterized by the whole placenta tissue and formed by molar originates from fertilization of an oocyte by a sperm duplicate (46XX karyotype or 46XY). In the cool part of the placenta it becomes molar tissue, while the rest is able to nurture the fetus.[2]

In the partial mole exist focal histopathological changes; Once the embryo rarely survives until the second trimester, usually associated with dizygotic twin pregnancies and births are exceptional term. Its etiopathogenesis is considered a genetic origin, associated with a triploid karyotype, 69XXY (70%), 69XXX (27%) and 69XYY (3%), being a set of chromosomes maternal and two paternal games (diandrica Triploidy) and with rare cases mola partial aneuploid (haploid or tetraploid).[3,7] The partial mole has an incidence of 0.005% to 0.001% of pregnancies and the incidence of partial mole with live fetus ranges from 1 to 22,000 1 per 100,000 births. In partial mola two types of hydatidiform observed associated with an egg or a fetus: egg dispermico triploid partial mole and fetus, or gemelar true. In the first example, the fetus is malformed generally is not feasible and the risk of malignancy is weak. In the second case, chromosomally normal fetus is associated with mola, having 40% Odds of and 10 born alive% proliferation sensitive trofoblastica.[4]

In the partial mole, fetuses are small for gestational agea disharmonious growth, which may present defects of the central nervous system defects neural tube (encephalocele, spina bifida), holoprosencephaly, agenesis of bulbs and tracts olfactory (arrienencefalia), hypoplasia of the cerebellum, agenesis of the corpus callosum, facial abnormalities such as microphthalmia, micrognathia, flattened nasal bridge, cleft lip and palate, low-set of auruiculares pavilions, short neck; in male fetuses can be seen hypospadias, cryptorchidism and micropene; They have also been described as internal alterations intestinal atresia, diaphragmatic hernia or inguinal, bile abnormalities, congenital heart disease and polycystic kidney disease.[5] The presence of partial mole with live fetus is unusual for the variety of clinical complications maternal-fetal that can arise, among others associated with trophoblast proliferation such as the development of early preeclampsia, hemorrhage of the first quarter and maternal hyperthyroidism etc.[5,6] The finding of hypertensive disorder associated with early pregnancy development can lead to suspicion of hydatidiform mole.[7,8]

Clinical case

The case is presented of a female patient 15 years old, without prenatal care, primipara with 20 weeks of gestation for pregnancy amenorrhea, with labor in second stage. Go presenting severe headache and presence of tinnitus, phosphenes, type obstetrical pain, bleeding transvaginal moderate dark red. On admission an average blood pressure of 130mmHg is detected. Physical examination, normocefala

without cardio alterations - lung, globose abdomen expense of gravid uterus, uterine fundus of 19 cms, fetal heart rate of 140 beats per minute, vaginal examination with presence of little bleeding not active, with dilation and effacement complete, intact membranes, tendon reflexes increased ++/+++, without the presence of edema. We performed ultrasound finding only living product of fetometria 22 weeks, weighing 449 grams, no congenital malformations apparent. Sonographically normal placenta and cord. It atiendio delivery and non-viable, male, weighing 440 grams, of 20 weeks only, immature, live product is obtained, no congenital malformations apparent (Figure 1). Placenta and cord dropsical presence of vesicles (Figure 2).[10,11] He requested fraction of human chorionic gonadotropin beta immediately after birth, finding levels 32.816 mU/mL; in the preeclamptic profile, lactic dehydrogenase of 1,033 U/L and proteinuria 500 mg/dL in the urinalysis, other normal preeclamptic profile, Group O and RH negative. It began handling with neuroprotection with magnesium sulfate, hydralazine antihypertensive 30 mg orally every 8 hours. It evolved satisfactorily and was discharged by appointment for consultation aimed to monitor postpartum to detect early forms of trophoblastic disease control persistent and hypertensive disease associated with pregnancy.[12–15]

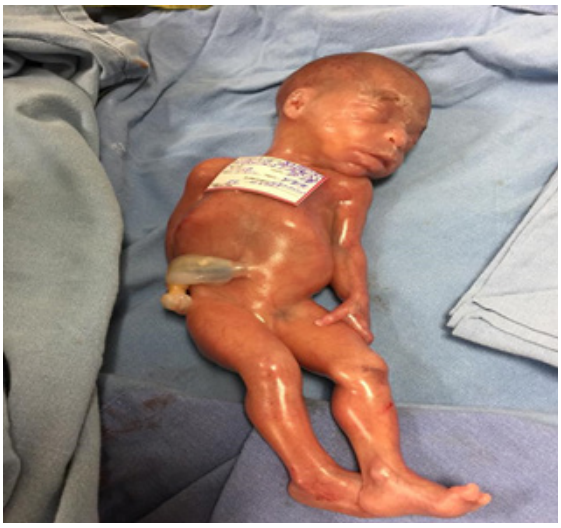

Figure 1 Fetus 20 weeks gestation.

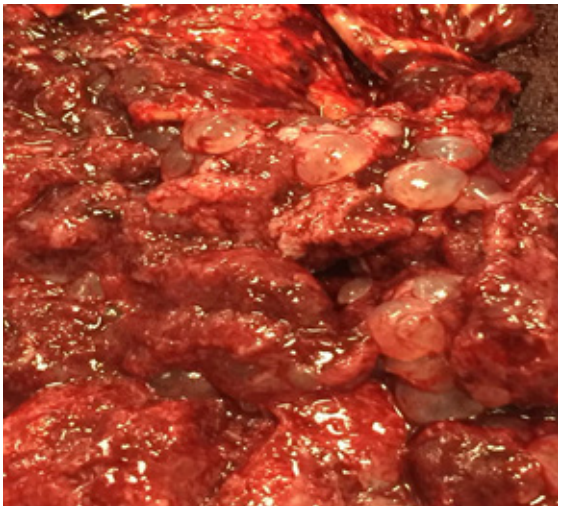

Figure 2 Placenta with hydropic presence of vesicles.

Discussion

The fetuses in partial moles, they have normal karyotypes. They represent from 0.001 to 0.01% of all pregnancies; most of them culminate in abortions in the first trimester. The clinical case is partial mole or incomplete, with live fetus of 20 weeks gestation without congenital malformations. Ultrasound has contributed to the early diagnosis of molar pregnancy. This method is more sensitive to diagnose complete molar pregnancy because it has a characteristic sonographic derived from edema and chorionic villi known as the "sign of the snowstorm." This, coupled with the presence of excessive uterine growth, characteristic of the mole, and especially high levels of hCG beta subunit, configured molar pregnancy diagnosis. In this case, were not detected by ultrasound images suggestive of cool. The diagnosis was made during the resolution of pregnancy, observing dropsical vesicles in cotyledons and umbilical cord, which was confirmed by histopathology. In addition to a hypertensive disease of pregnancy, where the natural history of the disease, led to the patient's own expected complication of mola, as it is early preeclampsia severity data. Faced with an atypical presentation of preeclampsia before the twentieth week of gestation, it is necessary to establish the differential diagnosis of preeclampsia, to give proper treatment and thus reduce maternal and fetal morbidity and mortality.

Conclusion

The molar pregnancy fetus after 20 weeks live gestation, are generally associated with severe fetal and maternal complications, such as severe preeclampsia and intrauterine growth on restriction. Embrionada resolution mola is the interruption of the pregnancy spontaneous or provoked. In cases of atypical or early preeclampsia severity data, it suggested intentionally discard the possibility of placental alteration. Treatment should be multidisciplinary in order to improve results.

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Conflicts of interest

The author declares there is no conflict of interest.

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