Molar Pregnancy—Case report

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Abstract
Molar pregnancy is formed as a result of divergent fertilization process that leads to production of atypical tissue within the uterus. It categorized in two groups: partial and complete. Complete mole involves absence of the embryo, whereas partial mole demonstrates presence of fetal parts. Molar pregnancy does not result in viable fetus, early detection and treatment is essential for positive outcome.

Case Report
A 19-year-old female patient reported to OB-GYN clinic for annual examination during the initial interview she complained of very unusual menstrual bleeding, which began 3 days ago, patient has also reported abdominal cramping, nausea, vomiting and lower back pain. Patient admitted to be sexually active but was using calendar method as birth control. Her last menstrual period was exactly 5 weeks ago. Patients past medical and family history are unremarkable. She denied to have any allergies, denied drinking alcoholic beverages but admitted to be an active smoker; she currently smokes 0.5 packs of cigarettes per day. The patient was alert, oriented and in obvious distress. Her fundal height was 2 cm below umbilicus. Abdomen was soft and mildly tender on lower quadrants bilaterally. Her lower extremities were WNL. During Pelvic examination reported loose discharge of blood, clots and a large amount of brown-colored grapelike material. The cervical OS was dilated to approximately 2 cm with some cervical motion tenderness.

After patient has been transferred to ER blood was collected and sent to lab for analysis, laboratory results as follows: hemoglobin of 8.6 g/dL, hematocrit of 7.5%, white blood count at 16,000 with 78% neutrophils and 5% bands, platelets at 123,000, international normalized ratio of 1.5, and bicarbonate of 14 mmol/L. BUN was elevated at 38 mg/dL and creatinine was 0.7 mg/dL. Beta HCG was 360,514 mIU/mL. IV line was initiated; patient has received 1000 cc bolus of 0.9% of sodium chloride, which followed with infusion rate at 125 cc per hour. Case has been discussed with OB consult and Pelvic Sonogram was performed. Pelvic sonogram reviled a cloud like image, with absence for heartbeat. Patient was transferred to OR rapidly and two units of crossed matched blood were infused. Dilatation and curettage was performed in OR. Surgical pathology confirmed a complete hydatidiform mole. Patient's recovery was unremarkable; patient was discharged home after 48 hours. The patient was instructed on importance of using reliable method of birth control and monitoring of levels of HCG (first 48 hours post evacuation, weekly until hgc < 5 miu/ml, then monthly X 6-12 months).

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**Discussion**

Molar pregnancies are classified as nonviable conceptions and are medically termed hydatidiform moles [3]. They are masses of cysts or benign tumors with a grape-like appearance that grow rapidly in the womb [3]. The abnormality is caused by a problem at conception, manifested by an excessive presence of placenta with little or no fetal development [10].

Hydatidiform moles are the most common form of benign gestational trophoblastic disease [4]. Often fatal in past centuries, significant medical advances in recent years now permit most women with moles to be cured [6].

Depending on the imbalance of genetic material in the pregnancy, the two major types of hydatidiform moles are classified as either complete or partial [1].

Forming when the sperm fertilizes an egg having no chromosomal or genetic material, a complete molar pregnancy is characterized by the presence of the placenta without an embryo [3].

Normally, the fertilized ovum would die and not implant itself in the womb [3]. In rare instances, this egg implants, triggering the growth of the placenta and the production of human chorionic gonadotrophin (HCG), the pregnancy hormone, therefore all symptoms of pregnancy will be present [5].

Partial-molar pregnancies are formed when a normal ovum is fertilized by two sperms [3-5]. Instead of forming twins, the excessive presence of chromosomal material and trophoblastic tissue prevents normal fetal development [3]. The fetus does not survive more than three months and dies in the uterus [5-7].

As moles are rare, epidemiological studies vary in reporting incidences [6]. Vassilakos [11] states that the frequencies of moles vary by race and occur more among Asian women. Age is a known factor with moles to be cured [6].

Depending on the race and occurrence, the American college of Obstetricians and Gynecologists has recommended that after evacuation of a mole, serum HCG levels should be monitored every 1-2 weeks in all patients while the levels are elevated and then at monthly intervals for an additional 6 months once the levels become undetectable (5MIU per milliliter) [9].

**Management**

Patients who are diagnosed with molar pregnancy must be evaluated for possible complications such as: overactive thyroid, anemia, and toxemia of pregnancy. Patients should have a complete examination and laboratory testing [6].

After any medical complications have been addressed, a decision must be made concerning the best method of evacuation. Suction curettage is the optimal method of evacuation, regardless of uterine size, in patients who wish to retain reproductive function, because it carries a significantly lower risk of excessive bleeding, infection, and retained molar tissue then methods involving induction with oxytocin or prostaglandin. Rh immune globulin should be given to patients with RH conflict [7].

Patients are monitored to prevent the recurrence of benign moles and the development of malignant neoplasia, which can metastasize to the brain, liver or lungs [3]. Chest x-rays and the analysis of HCG levels for six months to one year are necessary [5]. Recurring moles are treated with methotrexate, a low-level chemotherapy [7].

**References**