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Case Report Open access

Recurrent Hydatiform Mole: A Rare Case Report

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Abstract

A 35 yr old female, p1 had a daughter aged 15 year. The patient had a hx of 11 time molar pregnancy (6 times partial, 5 times complete molar). She presented to our centre worried to have a normal pregnancy. All her molar pregnancies were documented by histopathology and treated with suction curettage and followed up by serial HCG titer. She is advice to have pregnancy by ART in our centre by using laser assisted sperm selection (LASS). She underwent ICSI and conceived with twins and she had uneventful pregnancy with 2 viable fetuses, but at 18 wks one of her fetuses had mild ventricuomegaly, other is completely NL. AT 32 WKS. She delivered alive completely NL female, and a male with down syndrome features.

Introduction

Recurrent hydatidiform mole occurs when women have at least two abnormal pregnancies described as hydatidiform moles. It is occurs early in pregnancy when an embryo does not fully develop and the placenta develops abnormally. The placenta is a solid structure in the uterus that normally provides nutrients to a growing fetus. If a hydatidiform mole occurs once, it is known a sporadic hydatidiform mole; if it happens again, the condition is known as recurrent hydatidiform mole [1-3].

A hydatidiform mole often causes vaginal bleeding in the first trimester of the pregnancy. In an ultrasound examination, the abnormal placenta appears as numerous small sacs, often described as resembling a bunch of grapes. In some cases, the ultrasound shows no fetus, umbilical cord, or amniotic sac (a fluid-filled sac that normally surrounds the fetus) [2,3].

Hydatidiform moles are not naturally discharged from the body and must be surgically removed, typically by the end of the first trimester. After removal, there is up to a 20 percent risk that any tissue left behind (persistent mole) will continue to grow and become a cancerous tumor called an invasive mole. The invasive mole can transform into a different form of cancer called gestational choriocarcinoma that can spread (metastasize) to other tissues such as the liver, lungs, or brain [3].

A molar pregnancy happens when tissue that normally becomes a fetus instead becomes an abnormal growth in the uterus. Even though it isn't an embryo, this growth triggers symptoms of pregnancy. Thus will fail to come grows into a mass in the uterus, that has swollen chronic villi [1]. These villi grow as clusters that resemble grapes [4]. About 1 out of 1,500 women with early pregnancy symptoms has a molar pregnancy [1,5]. There are two types of molar pregnancy: complete and partial. Complete molar pregnancy is an egg with no genetic information is fertilized by a sperm. It does not develop into a fetus, but continues to grow as a lump of abnormal tissue that looks a bit like a cluster of grapes and can fill the uterus [6]. Partial molar pregnancy is an egg is fertilized by two sperm. The genotype is typically 46, XX (diploid) due to subsequent mitosis of the fertilizing sperm, but can also be 46, XY (diploid). 46, YY (diploid) is not observed. In contrast, a partial mole occurs when an egg is fertilized by two sperm or by one sperm which reduplicates itself yielding the genotypes of 69, XXY (triploid) or 92, XXXY (tetraploid) [5].

Material and Methods

In the presented studied, the patient started IVF cycles in Bethlehem branch. Figure 1 below show the Palestinian map, red color where razan medical centers branches.

Figure 1: Map of Palestine, showing Razan medical centers branch (red circle), which distribution in Palestinian cites.

The antagonist protocol was based on the administration of daily on day 2/9 of the previous luteal phase of the stimulation cycle. Recombinant FSH at a dose of 150 IU/day for 6 days, (Gonal F, Merck Serono, Italy) and 225 150 IU/day (Menogon, Sweden) for 5 days subcutaneously was commenced when pituitary desensitization was achieved (11 days after the initiation of GnRH antagonists), as evidenced by the absence of ovarian follicles>10 mm and endometrial thickness<4 mm on transvaginal ultrasound examination, and then the dose was adjusted on day 6–7 of stimulation according to the ovarian response. When at least three follicles reached ≥18 mm, 6500 IU of hCG (Ovitrelle, Italy) were administrated intramuscularly and 34–36 hours later follicles were aspirated under patient sedation.

Intracytoplasmic sperm injection (ICSI) used were assigned a number of 4 retrieved oocytes, after 3 hours of retrieved injected the occytes by using leaser assisted sperm selection (LASS). We were succeed for 100% fertilization, and embryos cleavage divided to 2 (8-1), 6-1 and 4-1. We transferred tow embryos (8-1). Figure 2, below showing the gradating of embryos.

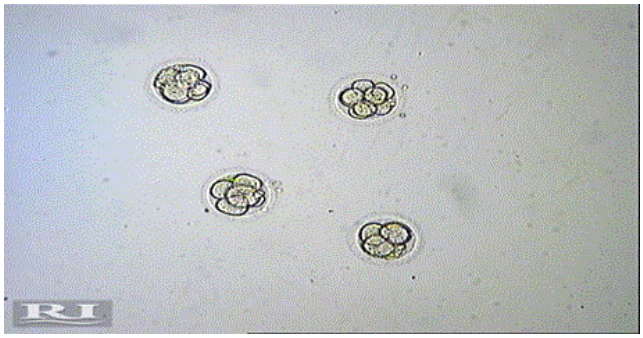

Figure 2: Show the gradating, and number of embryos.

Conclusion

The use of modern molecular biology techniques, preimplantation diagnosis and ICSI may provide further insights into the disease with possible strategies for prevention in women with recurrent molar pregnancies. Intracytoplasmic sperm injection (ICSI) coupled with preimplantation confirmation of diploidy (guards against partial moles), and selection against transfer of 46XX embryos (prevents complete moles) was employed to prevent a repeat molar pregnancy, Familial predisposition has recently been evaluated. Familial recurrent hyditiform molar are considered rare. Genetic studies revealed to have mutation in both alleles of NLR7, ON Chromosome 19. Existence of a chromosomal abnormality (down syndrome) may coincidental, but we can not rule out any relationship between genetically and chromosomal abnormalities.

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