Journal of
Gynecology and Women's Health
ISSN 2474-7602

Juniper Publishers
key to the Researchers

Case Report
Volume 26 Issue 1 - October 2023
DOI: 10.19080/JGWH.2023.26.556179

J Gynecol Women's Health

From Challenges to Discovery: A Case Report on Recurrent Molar Pregnancy in A 31-Year-Old Woman with Multiple Pregnancy Losses

Moosa Abdur Raqib[1]*, Aliya Nasim[2], Muhammad Ashir Shafique[3], Muhammad Saqlain Mustafa[3] and Abdul Haseeb[3]

1Department of Medicine, Liaquat College of Medicine & Dentistry/Darul Sehat Hospital, Pakistan

2Department of Obstetrics and Gynecology, Liaquat College of Medicine & Dentistry/Darul Sehat Hospital, Pakistan

3Department of Medicine, Jinnah Sindh Medical University, Pakistan

Submission: September 13, 2023; **Published:** October 06, 2023

***Corresponding author:** Moosa Abdur Raqib, Department of Medicine, Liaquat College of Medicine & Dentistry/Darul Sehat Hospital, Pakistan

Abstract

This case report presents the unique case of a 31-year-old woman with a recurrent molar pregnancy, a condition characterized by abnormal growth of placental trophoblasts. The patient, with a gravidity of 3 and parity of 0+2, experienced difficulties in conceiving a viable fetus despite ovulation induction drug treatment. Molar pregnancy is rare, and cases with recurrent miscarriages are even more uncommon. Common symptoms of molar pregnancy include vaginal bleeding, abdominal pain, and pelvic pressure during the first trimester. Diagnosis typically involves assessing HCG serum levels, performing an ultrasound of the uterus, and conducting a biopsy of the aborted specimen. Miscarriage is a common outcome, and in cases of diagnosis, dilation, and curettage are often performed. This report highlights the rarity of recurrent molar pregnancy and emphasizes its potential occurrence.

Keywords: Case report; Molar pregnancy; Recurrent incidence; Multiparous; Gestational trophoblastic disease

Introduction

Gestational trophoblastic disease (GTD) encompasses a range of conditions resulting from abnormal placental trophoblast growth. Among these, molar pregnancy, which includes complete and partial moles, is the most frequently diagnosed GTD. Complete moles have a higher risk of malignant transformation (15%) compared to partial moles (1%) [1]. The worldwide incidence of molar pregnancy is estimated to be between 0.6 and 8 per 1000 individuals. However, due to its rarity and challenges in early recognition, determining the actual incidence is difficult. In Pakistan, the reported incidence of gestational trophoblastic disease was 28 per 1000 live births. Furthermore, Indian/Pakistani women show a higher probability of second molar pregnancy compared to Caucasian women (relative risk, 2.4).

Women who have experienced a pregnancy affected by a histologically verified complete or partial hydatidiform mole can receive counseling indicating that there is approximately a 1 in 60(overall recurrence risk of about 2%) chance of a recurrence in a subsequent pregnancy. Furthermore, in the event of a recurrence, the majority of cases are expected to be of the same type of mole as the previous pregnancy [2]. Our patient has presented with indications of experiencing two molar pregnancies. If her second pregnancy had not ended at home, there would have been a considerable likelihood that it could have been molar. Notably, this patient had no family history of this condition. Additionally, her husband had a normal semen analysis report and is in good physical health. This uniqueness characterizes this particular case.

Current Guidelines state that Pathology may be required to identify a whole or partial mole following dilatation and evacuation (D&E) for a suspected mole. Abortion that is not complete. Patients in these situations should be followed up on using serum quantitative monitoring B-HCG levels. When the mole is suspected ahead of time should be removed as quickly as possible following a short necessary medical workup and stabilization complications. The recommended method of evacuation is suction D&E [3].

Patient and Case Report

A 31-year-old woman with no comorbidities was admitted to Darul Sehat Hospital Karachi. She experienced abdominal pain and amenorrhea for 6 weeks, prompting further investigation. High levels of Beta HCG were observed during her regular antenatal visit, indicating a pathology. Subsequent investigations at Darul Sehat Hospital led to a scheduled suction evacuation. The patient's Beta HCG levels at admission were significantly elevated (251717mlU/mL), but after the procedure, they decreased to 29883mIU/mL. Histopathology confirmed the diagnosis of molar pregnancy. The patient had a previous history of two miscarriages, one of which was confirmed as a molar pregnancy through biopsy and other was lost at home which was not reported. Her family had no history of recurrent molar pregnancy. Other test results were normal, including blood group, complete blood count, renal and liver function tests, and chest X-ray. On discharge patient was advised Capsule Cefspan (cefixime) 400mg for 2 days, Syrup iron folate for once daily for 3 months, Ponstan (mefenamic acid) Tablet 3 times daily for 5 days, Calcira (Calcium supplement) once daily for 3 months. The American College of Obstetricians and Gynecologists advises measuring BhCG levels in patients with HM 48 hours after evacuation and every 1 to 2 weeks until levels are undetectable. Following the achievement of undetectable levels, followup measures are taken at monthly intervals for a further 6 months. She was advised to report weekly for 6 months B HCG level to opd for follow up at Darul sehat Hospital to Dr Aliya Nasim. In the event of Molar Pregnancy, patients are recommended not to become pregnant for at least 6 months after their B-HCG levels have stabilized [4]. She was also counselled to avoid pregnancy for 6 months. According to the doctor's recommendation, the patient followed all management procedures on time. Following molar pregnancy, the frequency of developing pregnancy-induced hypertension/pre-eclampsia was 1.5% and 1.9%, respectively, in future pregnancies [2] This was not observed in our patient.

Discussion

Gestational trophoblastic disease (GTD) encompasses a spectrum of conditions arising from abnormal growth of placental trophoblasts. Molar pregnancy, consisting of complete and partial moles, is the most common form of GTD. While both types have the potential for malignant transformation, complete moles carry a higher risk. The reported incidence of molar pregnancy worldwide ranges between 0.6 and 8 cases per 1000 individuals. However, accurately determining the true prevalence remains challenging due to early detection difficulties and the resemblance of molar pregnancies to spontaneous abortions on ultrasound [3].

In this case report, we present the rare occurrence of recurrent molar pregnancy in a 31-year-old woman with a history of two previous miscarriages. The patient had been undergoing ovulation induction treatment in an attempt to conceive a viable fetus. During the first trimester, she experienced symptoms of vaginal bleeding, abdominal pain, and pelvic pressure, which prompted further investigation. Elevated levels of beta human chorionic gonadotropin (β-HCG) during routine antenatal visits raised concerns of a pathological condition. Subsequent diagnostic evaluations, including ultrasound and histopathology, confirmed the diagnosis of molar pregnancy [5].

Hydatidiform mole (HM) is characterized by the hydropic growth of placental villi, hyperplasia of the villous trophoblast, and deficient or absent fetal development. There are two types of HM: complete and partial. Complete HM is most likely the result of a single haploid (23X) sperm fertilizing an empty egg, leading to the loss or inactivation of the nuclear material [6]. The resulting entire mole is homozygous and of paternal origin, with a haploid set of chromosomes multiplying to 46XX. Partial HM occurs when an unfertilized egg is fertilized by two different sperms, resulting in either a 46XX or a 46XY heterozygous chromosomal makeup [7]. In the case of partial HM, triploidy develops when maternal chromosomes and a pair of paternal chromosomes are present. Although any of these variations can progress to malignancy, complete moles are more frequently affected [8].

Recurrent molar pregnancy poses significant emotional distress for couples and is associated with an increased risk of malignancy. It is crucial to consider genetic inheritance in such cases. Genetic testing should be offered to patients with recurrent molar pregnancy to provide better insights into their future reproductive prospects and enable more effective counselling and guidance. By identifying potential genetic factors contributing to recurrent molar pregnancy, healthcare providers can offer personalized management strategies and assist patients in making informed decisions regarding their reproductive options [9].

Risk factors for Hydatidiform mole includes maternal age and previous history of molar pregnancy [10]. The risk factors which are relevant to our case include low socioeconomic status of the mother which may have a role [11] and physical job of the husband involving guard duty at Darul sehat hospital for average 8 hrs per day [12] and previous history of molar pregnancy that increases risk of reoccurrence upto 20 fold [2]. It is worth noting that the rarity of recurrent molar pregnancy presents challenges in conducting large-scale studies to investigate the underlying mechanisms and risk factors associated with its recurrence. Additionally, the influence of ethnicity and geographical factors on the incidence and recurrence rates of molar pregnancy warrants further investigation.

Conclusion

Recurrent molar pregnancy poses significant emotional distress for couples and is associated with an increased risk of malignancy. It is crucial to consider genetic inheritance in such cases. Genetic testing should be offered to patients with recurrent molar pregnancy to provide better insights into their future reproductive prospects and enable more effective counselling and

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guidance. By identifying potential genetic factors contributing to recurrent molar pregnancy, healthcare providers can offer personalized management strategies and assist patients in making informed decisions regarding their reproductive options [9].

Due to low socioeconomic status of the patient further genetic testing could not be done which could have revealed more significance. According to a research on incidence of Molar pregagncy done at D G khan hospital, patients with this disease presented with pre evacuation β-HCG value between 1,00,000-10,00,000 IU/L. 36.5% of the patients had β-HCG values between 10,000-1,00,000 and their main presenting complain was 98.1% of the women had a history of amenorrhea. In 65.4% of cases, vaginal bleeding was a symptom [13] our patient present with amenorrhea and abdominal pain with no vaginal bleeding and with B HCG 251717 mlU/mL. Similarly, according to a study done on molar pregnancy in tertiary care hospital In Karachi only 5 (11.1%)had previous history of Molar Pregancy [14] as compared to our case which is a unique. In conclusion this case is unique in many different aspects especially risk factors which must be addressed in diagnosis of molar pregnancy.

The unusual result in our patient indicates that some risk factor relationships existing in this case may be a causal component and should be studied further. Based on this case, the author, Dr. Aliya Nasim, would want to develop a questionnaire about the risk factors for molar pregnancy that are prevalent and found in this instance in order to better decrease recurrence and improve diagnosis.

Recurrent molar pregnancy, although rare, causes significant emotional distress to couples and increases the risk of malignancy. Considering genetic inheritance, genetic testing should be offered to patients with recurrent molar pregnancies to provide insights into their future outlook and facilitate more effective patient guidance.

Patient Perspective

The patient did not share any statements or comments regarding the intervention since they did not want due to perosnal privacy.

Author Contribution

Dr Aliya Naseem supervised the whole process. Moosa Abdur raqib did conceptualization and editing. Muhammad Ashir Shafique and Abdul Haseeb wrote content of manuscript. Muhammad Saqlain Mustafa Reveiwed and contributed in editing and finalizing our case report.

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