Case Report

TWIN PREGNANCY – ONE SAC WITH MISSED MISCARRIAGE, SECOND WITH MOLAR PREGNANCY

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ABSTRACT

A 32 years old lady $G_4P_2A_1$, presented with gestational amenorrhoea of 13 weeks and complain of vaginal bleeding one week back. Ultrasound examination revealed an irregular gestational sac with no fetal pole and another well circumscribed mixed echogenecity lesion filling the whole of uterine cavity. Features were consistent with molar pregnancy. Suction curettage was done. Histopathology report revealed complete hydatidiform mole and missed miscarriage.

KEY WORDS: Twin Pregnancy, Missed, Molar Pregnancy.

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INTRODUCTION

Twin gestation is commonly seen in Nigeria[1] and is least common in the Far East. Twins can be monozygotic or dizygotic. In case of monozygotic twins, depending upon the time of cleavage.[2,3]

* The twins can be diamniotic, dichorionic if the division occur with in 72 hours after fertilization.
* They can be diamniotic, monochorionic, monozygotic twin pregnancy, if division occurs between the 4th and 8th day after fertilization.
* They can be monoamniotic, monochorionic, monozygotic twin pregnancy with occurs about 8 days after fertilization.
* If division is initiated even later, conjoint twins result.

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Case Report: Mrs. S. M. married for 5 years, presented to outpatient department on 17th January 2006 with history of amenorrhoea of 13 weeks and complains of vaginal spotting one week earlier. She had no history of associated abdominal pain, vaginal bleeding or vaginal discharge, urinary or bowel complaints. Two of her ultrasonography reports revealed missed miscarriage at 8 weeks and 3rd ultrasound report revealed molar pregnancy in the second sac. A repeat scan was done which revealed a twin pregnancy with one missed miscarriage and another with molar pregnancy.

The patient had two spontaneous vaginal deliveries at home and one first trimester miscarriage three months back followed by D & C at a local clinic. The patient was not addicted to any drug and there was no significant past medical history.

Clinical examination revealed a young lady with average height and weight, looking relatively pale and anxious. Her pulse was 80bpm, regular, with good volume. Blood pressure was 110/80mmHg. Temperature was 98°F. Thyroid was not enlarged. No significant findings were seen on breast examination. Abdomen was flabby with a bulge in the lower part with no area of tenderness. Fundal height was 18cm.

Pelvic examination revealed healthy vulva and vagina. Cervix was healthy looking, os admits tip of finger with slight bleeding. On bimanual examination, uterus was the size of 18 weeks of gestation. It was soft and doughy in consistency.

Investigations: Routine laboratory investigations were done which showed:

Blood Group:	A +ve
Hb%:	9 gm/dl
Blood Sugar R:	130 mgs/dl
Serum Creatinine:	0.9 mg/dl
Serum Fibrinogen:	238 mg/dl
HbsAg:	Negative
Anti HCV:	Negative
Serum TSH:	3 iu/ litre
Serum â hCG:	1376 iu/ litre
Platelet Count:	$325x10^9$/litre
Urine C/E:	NAD

Ultrasonography: Anteverted uterus measuring 11.3 x 9.1 x 8.6 cm shows an irregular gestational sac 37 mm corresponding to 8 weeks 4 days of gestation. No fetal pole/ yolk sac noted. A well circumscribed mixed echogenecity lesion measuring 7.5 x 6.6 x 8.3 cm fills whole of the uterine cavity. Features are consistent with molar pregnancy.

A diagnosis of twin gestation with one sac having missed abortion and the other having molar pregnancy was made.

MANAGEMENT

Preoperative transfusion of a unit of blood was carried out. Suction curettage was done under general anaesthesia. A syntocinon infusion with 30 iu was put up and the patient was shifted to recovery. Three units of blood were transfused. Two tablets of Cytotec (Misoprestone 400 mgs) were inserted in the rectum.

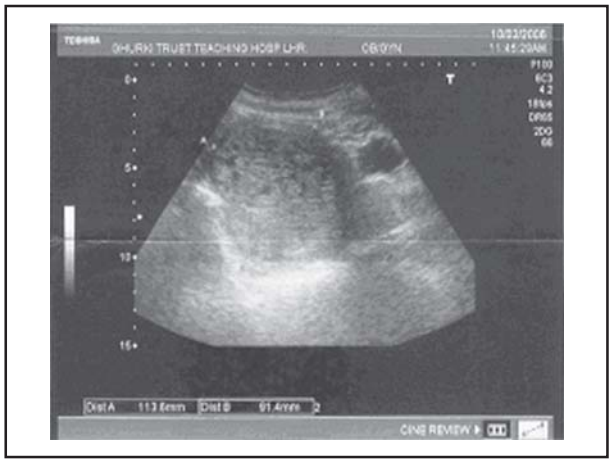
Histopathology Report: Numerous dilated chorionic villi with loose, avascular odematous cores, surrounded by hyperplastic cytotrophoblast features consistent with complete hydatidiform mole. Products of conception – missed abortion were also seen.

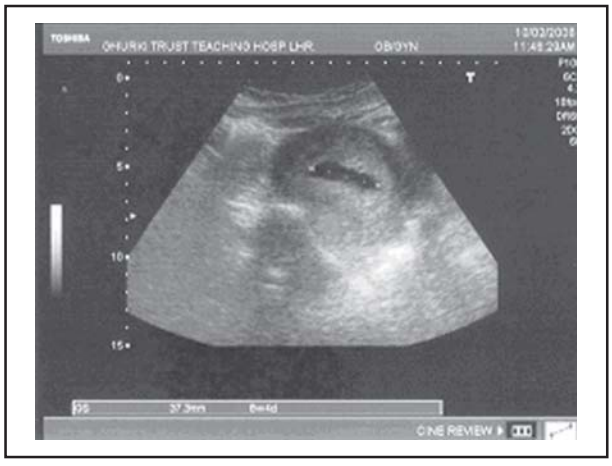
Follow Up: â hCG level on 2nd post operative day was 525 iu/ litre. She was discharged and advised to report after 1 week with â hCG report. Her â hCG level on 9th post operative day was 100 iu/ litre. The couple was counseled for contraception with barrier method.

DISCUSSION

Chorionocity was not determined in this case. Ultrasound examination in the prenatal period can usually determine the time when cleavage took place by determining the chorionicity.[1] Structural abnormalities are more common in monozygotic twins as compared to singleton pregnancy.[2,3] The presence of molar pregnancy in one sac with the other sac containing a live fetus is an unusual finding.[4]

Complete molar pregnancy in one with a normal placenta in one twin is a different entirely from partial molar pregnancy. The distinction between complete and partial mole is





important because persistent trophoblastic tumour occurs more commonly after complete mole.[5] Approximately 60% of women with complete molar twining will require chemotherapy for persistent gestational trophoblastic tumours.[6] This requires regular follow up by measuring â hCG levels and instituting treatment with chemotherapeutic agents if the level rises.

CONCLUSION

It is an unusual finding to have twin gestation with one molar pregnancy and missed miscarriage in the other sac. Follow up of molar pregnancy is similar to that of singleton molar pregnancy and contraception by barrier method is advised, for at least 2 year in uncomplicated molar pregnancy.

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