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From Challenges to Discovery: A Case Report on Recurrent Molar Pregnancy in a 30-Year-Old Woman with Multiple Pregnancy Losses

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Abstract

This case report presents the unique case of a 30-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).

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 12 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 (251717 mlU/mL), but after the procedure, they decreased to 29883 mIU/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. 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. The patient was discharged and advised to monitor her Beta HCG levels monthly.

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 [2].

In this case report, we present the rare occurrence of recurrent molar pregnancy in a 30-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 [3].

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 [4]. 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 [5]. 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 [6].

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 [7].

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, 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.

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