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HYDATIDIFORM MOLE

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INTRODUCTION

Definition

It is an abnormal condition of the placenta where there are partly degenerative and partly proliferative changes in the young chorionic villi. These result in the formation of clusters of small cysts of varying sizes. Because of its superficial resemblance to hydatid cyst, it is named as hydatidiform mole. It is best regarded as a benign neoplasia of the chorion with malignant potential.

Incidence

There is wide range of geographical and ethnic variation of the prevalence of the condition. The molar pregnancy is common in original countries- Philippines, china Indonesia, Japan, India, central and latin America and Africa. The highest incidence is in Philippines being 1 in 80 pregnancies and lowest in European countries 1 in 752 and USA Being About 1 In 2000 the incidence, in India, is about 1 in 400.

Causes

Several risk factors for Hydatidiform mole may be contributing causes but increase the chances of getting molar pregnancy very little. These include

- Diets low in protein, fat and vitamin A
- Age – most often affecting women of childbearing age
- An earlier molar pregnancy
- Prior miscarriages
 - A or AB blood types, compared to B or O blood types

Signs And Symptoms

- Vaginal bleeding
- Varying degree of lower abdominal pain may be due to
 - a) over stretching of the uterus
 - b) concealed haemorrhage
 - c) Rarely perforation of the uterus by the invasive mole
 - d) infection
 - e) uterine contractions to expel out the contents.
- Abdominal swelling, caused by the uterus becoming larger, that occurs more rapidly than expected for the first trimester of pregnancy

- Excessive vomiting during pregnancy
- Fatigue, often caused by anaemia from heavy bleeding
- Sudden severe abdominal pain caused by internal bleeding
- Pelvic cramping or vaginal discharge
- Shortness of breath, coughing or blood in coughed-up secretions because chorio carcinoma very rarely spreads to the lungs before it is diagnosed.
- Expulsion of grape like vesicles per vagina is diagnostic of vesicular mole.
- Pallor

Diagnostic Evaluation

A pelvic examination may show signs similar to a normal pregnancy, but the size of the womb may be abnormal and the baby's heart sounds are absent. There may be some vaginal bleeding. A pregnancy ultrasound will show an abnormal placenta with or without some development of a baby.

Tests may include

- ❖ HCG blood test
- ❖ Chest x-ray
- ❖ CT or MRI of the abdomen
- ❖ Complete blood count, ABO and Rh grouping.
- ❖ Blood clotting tests
- ❖ Kidney and liver function tests

Differential Diagnosis

The following conditions are often confused with molar pregnancy; estimation of serum hCG and ultrasonography are diagnostic.

Threatened abortion: persistence of dark coloured vaginal bleeding with mistaken date showing disproportionate increase in size of the uterus is quite confusing on clinical examination.

Fibroid or ovarian tumour with pregnancy; Disproportionate enlargement of the uterus is the confusing point.

Multiple pregnancy: presence of pre-eclampsia in early months, disproportionate enlargement of the uterus and unusually high hCG titre in the urine are confusing features.

Twin pregnancy with one normal fetus and placenta and the other with complete mole is differentiated from partial mole by cytogenetic and high resolution USG studies.

Treatment

1. If your doctor suspects a molar pregnancy, a suction curettage may be performed.
2. A hysterectomy may be an option for older women who do not wish to become pregnant in the future.
3. After treatment, serum HCG level will be followed. It is important to avoid pregnancy and to use a reliable contraceptive for 6 - 12 months after treatment for a molar pregnancy. This allows for accurate testing to be sure that the abnormal tissue does not grow back. Women who get pregnant too soon after a molar pregnancy have a high risk of having another molar pregnancy.

Diet and activity

- ❖ No special diet is required, and patients may resume activity as tolerated.
- ❖ Pelvic rest is recommended for 2-4 weeks after evacuation of the uterus, and the patient is instructed not to become pregnant for 6 months. Effective contraception is recommended during this period.
- ❖ Monitor serial beta-hCG levels to identify the rare patient who develops malignant disease. If a pregnancy does occur, the elevation in beta-hCG would be confused with development of malignant disease.

Possible Complications

Complications of molar pregnancy include

- ❖ Pre-Eclampsia
- ❖ Thyroid problems
- ❖ Molar pregnancy that continues or comes back
- ❖ Complications related to the surgery to remove a molar pregnancy include:
 - ❖ Excessive bleeding
 - ❖ Side effects of anesthesia

References

1. American College of Obstetricians and Gynecologists. Clinical management guidelines of obstetrician-gynecologists. Diagnosis and treatment of gestational trophoblastic disease. *Obstet Gynecol.* 2004; 103:1365. Practice Bulletin No. 53.
2. Copeland LJ, Landon MB. Malignant diseases and pregnancy. In: Gabbe SG, Niebyl JR, Simpson JL, eds. *Obstetrics - Normal and Problem Pregnancies.* 6th ed. Philadelphia, PA: Elsevier Saunders; 2012:chap 47.
3. Goldstein DP, Berkowitz RS. Gestational trophoblastic disease. In: Abeloff MD, Armitage JO, Niederhuber JE, Kastan MB, McKenna WG, eds. *Abeloff's Clinical Oncology.* 4th ed. Philadelphia, PA: Elsevier Churchill Livingstone; 2008:chap 94.
4. Kavanagh JJ, Gershenson DM. Gestational trophoblastic disease: hydatidiform mole, nonmetastatic and metastatic gestational trophoblastic tumor: diagnosis and management. In: Katz VL, Lentz GM, Lobo RA, Gershenson DM, eds. *Comprehensive Gynecology.* 6th ed. Philadelphia, PA: Elsevier Mosby; 2012:chap 35.
5. Gestational Trophoblastic Disease at American Cancer Society. Last Medical Review: 04/14/2011
6. Hydatidiform mole. Merriam Webster. Retrieved May 7, 2012.
7. Cotran RS, Kumar V, Fausto N, Nelso F, Robbins SL, Abbas AK (2005). *Robbins and Cotran pathologic basis of disease 7 th ed.* St.louis ed.). St. Louis, Mo: Elsevier Saunders. p. 1110. ISBN 0-7216-0187-1.
8. Kumar, Vinay, ed. (2010). *Pathologic Basis of Disease* (8th ed.). Saunders Elsevier. pp. 1057-1058. ISBN 1-4377-0792-0.
9. Ganong WF, McPhee SJ, Lingappa VR (2005). *Pathophysiology of Disease: An Introduction to Clinical Medicine* (Lange). McGraw-Hill Medical. p. 639. ISBN 0-07-144159-X.
10. MedlinePlus Encyclopedia Hydatidiform mole.
