West Middlesex University Hospital



**Date of Search:** 13 Apr 2017
**Sources Searched:** Embase, Medline

# Term Pregnancy and Partial Mole

---

**1. Live-born diploid fetus complicated with partial molar pregnancy presenting with pre-eclampsia, maternal anemia, and seemingly huge placenta: A rare case of confined placental mosaicism and literature review.**
**Author(s):** Kawasaki, Kaoru; Kondoh, Eiji; Minamiguchi, Sachiko; Matsuda, Fumihiko; Higasa, Koichiro; Fujita, Kohei; Mogami, Haruta; Chigusa, Yoshitsugu; Konishi, Ikuo

**Source:** The journal of obstetrics and gynaecology research; Aug 2016; vol. 42 (no. 8); p. 911-917

**Publication Date:** Aug 2016

**Publication Type(s):** Journal Article Review



**Abstract:**A partial molar pregnancy almost always ends in miscarriage due to a triploid fetus. We describe a rare case of a singleton, partial molar pregnancy with a seemingly huge placenta, which continued to delivery of a live-born diploid baby. A 27-year-old primigravida suffered from severe pre-eclampsia and progressive anemia. The uterus was enormously enlarged for the gestational age. A cesarean section was performed because of deterioration of maternal status at 25 weeks' gestation, when more than 3000 mL blood spouted concurrently with the delivery of the placenta. The histological examination showed congestion in the decidua, which indicated disturbance of maternal venous return from the intervillous space. The chromosome complement of the placenta and the neonate were 69,XXX and 46,XX, respectively. We also reviewed all published cases of a singleton, partial molar pregnancy. A literature search yielded 18 cases of a singleton, diploid fetus with partial molar pregnancy. The mean gestational age at delivery was 24.5 ± 6.2 weeks, and fetuses survived outside the uterus in only four cases (22.2%). Intriguingly, previous reports numbered 10 cases with diploid placenta as well as five cases with no karyotyping of the placenta, indicating that they may have included a complete mole in a twin pregnancy or placental mesenchymal dysplasia. In conclusion, this was the first case of placentomegaly that presented manifestations of excessive abdominal distension and maternal severe anemia, and the second case of a singleton, partial molar pregnancy confirmed by chromosome analysis resulting in a diploid living baby.

**Database:** Medline

**2. Successful Outcome of Twin Gestation with Partial Mole and Co-Existing Live Fetus: A Case Report.**

**Author(s):** Rathod, Setu; Rani, Reddi; John, Lopamudra B; Samal, Sunil Kumar

**Source:** Journal of clinical and diagnostic research : JCDR; Aug 2015; vol. 9 (no. 8); p. QD01

**Publication Date:** Aug 2015

**Publication Type(s):** Journal Article

Available in full text at Journal of Clinical and Diagnostic Research : JCDR - from National Library of Medicine

**Abstract:**Sad fetus syndrome comprising of a live twin gestation with a hydatidiform mole is a rare entity. The condition is even rarer when the co-existing live fetus is associated with a partial mole than a complete mole. We report the case of a 24-year-old G2P1L1 at 28 weeks gestation who presented to our casualty in the second stage of labour. She had a previous ultrasound scan at 13 weeks which showed a live fetus with a focal area of multicystic placenta. She delivered an alive preterm male fetus weighing 1.32 kg vaginally. Following expulsion of normal placenta of the live fetus, partial mole was expelled. The fetus was admitted to neonatal ICU and discharged after two weeks. Soon after delivery, β-hCG (human chorionic gonadotropin) was 1,21,993 mIU/ml which decreased to 30mIU/ml within two weeks. The patient was discharged with advice of regular follow up of β-hCG reports.

**Database:** Medline

**3. Pregnancy outcome with coexisting mole after intracytoplasmic sperm injection: A case series**

**Author(s):** Rao A.; Dafle K.; Padmashri G.; Rao D.; Sivakumar N.

**Source:** Journal of Human Reproductive Sciences; Jul 2015; vol. 8 (no. 3); p. 178-181

**Publication Date:** Jul 2015

**Publication Type(s):** Journal: Article

Available in full text at Journal of Human Reproductive Sciences - from Free Access Content

Available in full text at Journal of Human Reproductive Sciences - from ProQuest

Available in full text at Journal of Human Reproductive Sciences - from National Library of Medicine

**Abstract:**Partial/complete hydatidiform mole with coexisting fetus is a rare condition. Optimal management is a challenge that remains a dilemma since these pregnancies are associated with maternal as well as fetal complications including hemorrhage, preeclampsia, thromboembolic disease, intra uterine demise and increased risk of persistent trophoblastic disease. Here we report 2 cases of partial mole with live fetus after ICSI and a case of complete mole with coexisting fetus after ICSI in a turner mosaic that resulted in a live birth. 

**Database:** EMBASE

**4. The Baby and the mole**

**Author(s):** Knight L.; Bombieri L.; Montague I.

**Source:** BJOG: An International Journal of Obstetrics and Gynaecology; Nov 2014; vol. 121 ; p. 22-23

**Publication Date:** Nov 2014

**Publication Type(s):** Journal: Conference Abstract

Available in full text at BJOG: An International Journal of Obstetrics and Gynaecology - from John Wiley and Sons

**Abstract:**Background: Complete or partial hydatiform mole arises in approximately 1 in 1000 and 3 in 1000 pregnancies respectively. They are a premalignant condition. Twin pregnancies with an apparently healthy fetus and a hydatidiform mole are uncommon, arising in approximately 1 in 20 000-100 000 pregnancies. Survival beyond the neonatal period is documented at between 25% and 57% with no increased risk of malignant sequelae. Case: The authors present an interesting maternal medicine case of a 24-year-old multiparous woman who presented with recurrent early antepartum haemorrhage and the findings of a twin pregnancy, one being a complete hydatiform mole. This woman presents a number of obstetric risks and challenges. The pre-viability presentation of the molar pregnancy led to ethical discussions regarding continuing with the pregnancy given the threat to the patient's own health. The recurrent vaginal bleeding into the second trimester revealed low-lying molar tissue. This made threatened delivery an ongoing possibility with potential catastrophic bleeding. This patient developed thyrotoxicosis at 20 weeks of gestation secondary to high levels of beta-hCG hormone requiring admission to hospital. She finally gave birth at 26 weeks of gestation to a live male fetus. She is currently undergoing follow-up for persistent gestational trophoblastic disease via Charing Cross Hospital's referral centre. Conclusion: This case serves as an excellent reminder for trainees of all levels as to the obstetric management of what is a rare pregnancy condition. Lessons to be learnt include the differential diagnoses and management of early antepartum haemorrhage in a patient with a seemingly normal first trimester ultrasound scan. In addition we remind ourselves of the potential maternal sequelae of thyrotoxicosis and pre-eclampsia. Of particular interest will be a review of the follow-up protocols for this group of patients, for those trainees working outside of the Tertiary centre environment.

**Database:** EMBASE

**5. Twin pregnancy with a partial hydatidiform mole and a coexistent viable fetus: A case report**

**Author(s):** Rato I.; Centeno M.; Susana S.; Pinto L.; Graca L.

**Source:** Journal of Maternal-Fetal and Neonatal Medicine; Jun 2014; vol. 27 ; p. 435-436

**Publication Date:** Jun 2014

**Publication Type(s):** Journal: Conference Abstract

**Abstract:**Brief Introduction: Twin pregnancy with a healthy fetus and an hydatidiform mole is extremely rare, occurring in 1:20.000-100.000 twin pregnancies. In the majority of cases it is associated with poor maternal and fetal outcomes. Materials & Methods: - Clinical Cases or Summary Results: A 30-year-old, nulliparous woman underwent an intra-uterine insemination with donor sperm. At 13 weeks of gestation the ultrasound examination showed a dichorionic twin pregnancy; twin A had an omphalocele and the placenta was enlarged, with multiple cystic and hyperechogenic areas, suggesting a trophoblastic disease; twin B had no major abnormalities and the placenta looked normal. Detailed counseling concerning maternal and fetal risks was provided. An amniocenteses was performed at 15 weeks of gestation and the kariotype was normal for both fetuses. At 18 weeks of gestation death of the affected fetus occurred. At 35 weeks, twin B showed fetal growth restriction and two weeks later tlabour was induced because of severe pre-eclampsia. A 2280 g healthy newborn was delivered. Histology of the placenta of the death fetus confirmed a

partial hydatidiform mole. Postpartum serial HCG follow-up showed a progressive decrease. Conclusions: In the rare event of a twin pregnancy with a partial hydatidiform mole coexisting with a viable fetus, proceeding the pregnancy may be an option although several complications such as pre-eclampsia and fetal growth restriction. Thus close surveillance is mandatory in order to detect early signs of maternal or fetal complications.

**Database:** EMBASE

**6. Partial mole with a coexistent viable fetus-A clinical dilemma: A case report with review of literature**

**Author(s):** Rathod A.D.; Pajai S.P.; Gaddikeri A.

**Source:** Journal of SAFOG; Apr 2014; vol. 6 (no. 1); p. 51-55

**Publication Date:** Apr 2014

**Publication Type(s):** Journal: Review

**Abstract:**Gestational trophoblastic disease encompasses a diverse group of lesions. If molar changes in the placenta are known along with an alive fetus, then situation is difficult for both obstetrician and parents. On one hand, there may be a normal pregnancy whereas on the other hand the mother may be threatened by numerous complications caused by the hydatid mole, if the pregnancy is continued. We present successfully managed case of partial molar pregnancy with an alive fetus at 1st stage of preterm labor with premature rupture of membranes with anemia with a live diploid female fetus with good neonatal out come. Follow-up till 1 year showed no progression to malignant gestational trophoblastic diseases. 

**Database:** EMBASE

**7. Partial hydatidiform mole and coexisting viable twin pregnancy.**

**Author(s):** Tay, Ee Tein

**Source:** Pediatric emergency care; Dec 2013; vol. 29 (no. 12); p. 1298-1300

**Publication Date:** Dec 2013

**Publication Type(s):** Case Reports Journal Article



**Abstract:**Twin partial hydatidiform molar pregnancy with a viable fetus is an uncommon occurrence. Presentations of molar pregnancies include vaginal bleeding, unusually elevated β-human chorionic gonadotropin level, and preeclampsia. Previous descriptions of twin molar and fetus pregnancies in the literature have been described in the outpatient obstetric setting. We present a case of partial molar pregnancy with a viable fetus detected with emergency ultrasound in a pediatric emergency department.

**Database:** Medline

**8. Diagnosis and outcome of partial hydatiform mole coexisting with a live fetus: case report**

**Author(s):** Cunzolo T.; Rabino V.; Bocci F.; Ragno P.; Lettieri C.; Barbero M.; Feyles E.

**Source:** Gazzetta Medica Italiana Archivio per le Scienze Mediche; May 2013; vol. 172 (no. 5); p. 405-409

**Publication Date:** May 2013

**Publication Type(s):** Journal: Article

**Abstract:**Partial mole is a form of gestational trophoblastic disease that may be associated with serious medical complications and occasionally progress to the second trimester of pregnancy. Current practices in screening and monitoring during early pregnancy allow for better identification of hydatidiform mole. Ultrasound is the initial imaging investigation of choice when gestational trophoblastic disease is suspected and also serial monitoring of serum human chorionic gonadotropin levels is warranted. We present a case report of a 32-year-old woman, with antecedents of 2 spontaneous abortion. She present a partial mole diagnosed on ultrasound for persistent vaginal bleeding at 19 weeks of gestation with a normal fetus in uterus. The couple wished to continued the pregnancy and a decision to accept was taken after having consulted the avaible literature. The preterm labour, at 34 weeks with cesarian section, resulted in the livebirth of a healthy female infant (Apgar 9-10). No persistent gestational trophoblastic neoplasia was observed during the follow-up at 6 months. Hydatiform mole with a live fetus is a rare obstetric occurrence. In the case of a normal fetal karyotipe, it is justifiable to await developments in the absence of maternal complications. However, treatment criteria still need improvement and diligent maternal follow-up is always warranted in the postpartum period.

**Database:** EMBASE

**9. Diploid karyotype partial mole coexisting with live term fetus-Case report and review of the world literature**

**Author(s):** Sak M.E.; Soydinc H.E.; Evsen M.S.; Sak S.; Firat U.

**Source:** Ginekologia Polska; 2012; vol. 83 (no. 10); p. 789-791

**Publication Date:** 2012

**Publication Type(s):** Journal: Article

Available in full text at Ginekologia Polska - from Free Access Content

**Abstract:**A partial molar pregnancy of diploid karyotype coexisting with live term fetus is a rare entity. Most instances of partial mole are triploid and only a few cases of diploid partial moles with term delivery have been reported. Here, we report a case of partial mole concomitant with a 37-week live fetus. Postpartum karyotype of the placenta and the fetus revealed both as 46XX. Histological examination of the placenta showed a partial hydatidiform mole. We discuss the diagnosis based on presenting clinical picture and proper management of signs and symptoms of partial molar pregnancy coexisting with live term fetus and diploid karyotype, coupled with a review of the literature. © Polskie Towarzystwo Ginekologiczne.

**Database:** EMBASE

**10. Twin pregnancy and partial hydatidiform mole following in vitro fertilization and embryos transfer: A novel case of placental mosaicism**

**Author(s):** Sun C.-J.; Zhao Y.-P.; Yu S.; Fan L.; Li G.-H.; Zhang W.-Y.; Wu Q.-Q.

**Source:** Chinese Medical Journal; Dec 2012; vol. 125 (no. 24); p. 4517-4519

**Publication Date:** Dec 2012

**Publication Type(s):** Journal: Article

**Abstract:**Twin pregnancy with mosaic partial hydatidiform mole (PHM) and survival of two healthy fetuses following in vitro fertilization and embryos transfer (IVF-ET) is a rare situation and is considered a challenge for management. A 32-year-old Chinese woman conceived twin pregnancy following IVF-ET. At 22 weeks' gestation, an additional intrauterine echogenic mass with features of PHM were shown by successive ultrasound examinations. At 35 weeks' gestation, two live male infants and two placentas were delivered by caesarean section (CS). Histologic examination of the abnormal placenta confirmed mosaic PHM. Genetic study showed the abnormal placental mosaicism (expressed in molar-69XXY and normal vili-46XY), co-existing with a hypospadia new-born (46XY) in one amniotic sac. However, the other one was normal. Serial serum beta-hCG levels showed a declining trend and serum beta-human chorionic gonadotropin (hCG) were undetectable at 6 months after delivery. The case demonstrated that it is possible to prolonged gestation by PHM under close surveillance during the entire pregnancy.

**Database:** EMBASE

**11. A rare case of partial mole and co-existing normal fetus originated from one embryo shows preeclampsia-like symptoms at 19 weeks gestation: Angiogenic imbalances in molar placenta leading to hypertension, proteinuria and pleural effusion**

**Author(s):** Shiozaki A.; Takemura K.; Yonezawa R.; Yoneda N.; Fukuda K.; Ito M.; Yoneda S.; Saito S.; Miura K.; Masuzaki H.

**Source:** Placenta; Sep 2012; vol. 33 (no. 9)

**Publication Date:** Sep 2012

**Publication Type(s):** Journal: Conference Abstract

**Abstract:**Case Report:We present a very rare case of single embryo-derived partial mole with placental triploidy (69, XXX) and a 46, XX fetus. A 30-year-old Japanese woman, gravida 0 para 0, was transferred to our hospital with hypertension, proteinuria, weight gain, and respiratory discomfort at 19 weeks. A detailed ultrasonography depicted a large multicystic placenta without dilated vessels around the cyst. Labor was induced at 20 week because of clinical deterioration, followed by a vaginal delivery of a normal female fetus and a molar placenta. After delivery, the patient's blood pressure rapidly normalised and the proteinuria resolved. An expelled placenta macroscopically demonstrated villi with multiple hydropic cysts and vesicles. The nuclei of the villous stroma and cytotrophoblastic cells were positive for p57kip2 and cell culture showed placental triploidy (69, XXX). A female fetus had normal karyotype (46, XX). The genetic profiles using fifteen polymorphic DNA markers demonstrated that the fetus and the cord consisted of monospermic paternal allele and one maternal allele, and that all examined genotypes of the placenta were consistent with those of the fetus, showing that partial mole was originated from monospermic fertilization and first in the world both the partial mole and the fetus have their origin in a single embryo. The maternal serum level of sFlt-1 (14,393 pg/mL), sEndoglin (127 ng/mL), and the sFlt-1: PlGF ratio (476) were extremely high that have been reported. The levels of sFlt-1 and sEndoglin in the cystic fluid from placental mole were also extremely high (104,000 pg/mL and 54 ng/mL, respectively). This report confirmed the hypothesis that preeclamptic symptoms are mediated by circulating factors of placental origin.

This is a first report that showed paternal isodisomy in partial mole might contribute to angiogenic imbalances in the placental tissue even in the absence of fetal triploidy.

**Database:** EMBASE

**12. Cerclage improves neonatal outcomes in molar pregnancy and coexistent fetus?**

**Author(s):** Aguin E.J.; Aguin T.J.; Aguin V.J.; Bahado-Singh R.

**Source:** Reproductive Sciences; Mar 2012; vol. 19 (no. 3)

**Publication Date:** Mar 2012

**Publication Type(s):** Journal: Conference Abstract

**Abstract:**Background: Complete hydatiform mole and coexistent viable fetus is very rare. The probability of carrying a coexistent fetus to term is low due to the risks of miscarriage, preterm delivery, hyperthyroidism, preeclampsia, vaginal bleeding and persistent trophoblastic disease. The use of a cervical cerclage in a patient with cervical insufficiency or advanced cervical dilation in presence of this condition has never been reported. The objective is to show a unique case with a good neonatal outcome in a patient who had a cerclage for cervical incompetence. Case: A 27 year-old, gravida 7, para 0423, presented with vaginal spotting at 23 weeks and 2 days. Her cervix was 4-5 cm dilated with a bulging bag. Current pregnancy complicated with short cervix (14 mm) and history of 4 preterm deliveries. Ultrasound reported a placental mass versus chorioangioma. Amniocentesis was negative for infection and karyotype 46XY. A cerclage was placed using McDonald technique. Patient received betamethasone for fetal lung maturity and was discharged in stable condition. She then presented with vaginal bleeding and PPROM at 25 weeks and 5 days. She went into spontaneous preterm labor and vaginal delivery of a viable female fetus weighting 625 g and APGAR scores of 7 and 8. D&C was performed after delivery, showing grape-like structures. Placental pathology reported complete hydatidiform mole. Today, this girl is a healthy 4 year old. Conclusion: The dilemma in the management of molar pregnancy with a coexisting viable fetus is whether to follow them expectantly or to terminate the pregnancy. Partial mole with coexisting live fetus has a high chance of fetal malformation and growth restriction because of associated triploidy. Testing the fetal karyotype is therefore essential. Informing parents about the potential risks and poor outcomes in complete mole and coexistent fetus is necessary. In those patients who understand the risks and still desire all potential interventions, such as cerclage for cervical indications, its placement could be considered.

**Database:** EMBASE

**13. Preterm gestation along with partial hydatidiform mole and alive foetus.**

**Author(s):** Tamrakar, S R; Chawla, C D

**Source:** Kathmandu University medical journal (KUMJ); 2011; vol. 9 (no. 35); p. 222-224

**Publication Date:** 2011

**Publication Type(s):** Case Reports Journal Article

**Abstract:**Gestational trophoblastic disease encompasses a diverse group of lesion. If molar changes in the placenta are known along with an alive fetus then the situation is difficult to manage. We present successfully managed case of partial degeneration of placenta in molar pregnancy with an alive fetus at second stage of preterm labour.

**Database:** Medline

**14. Partial molar pregnancy with a chromosomically and phenotypically normal embryo: Presentation of an extremely rare case and review of literature**

**Author(s):** Papoutsis D.; Mesogitis S.; Antonakou A.; Goumalatsos N.; Daskalakis G.; Papantoniou N.; Antsaklis A.; Papaspyrou I.; Zirganos N.

**Source:** Journal of Maternal-Fetal and Neonatal Medicine; Oct 2011; vol. 24 (no. 10); p. 1289-1293

**Publication Date:** Oct 2011

**Publication Type(s):** Journal: Review

**Abstract:**We present an extremely rare case of partial molar pregnancy with a chromosomically and phenotypically normal embryo and review of the literature. A 31-year-old nulliparous was referred to us at 30 weeks of gestation due to absence of fetal movements and subsequent ultrasound examination revealed intrauterine demise. Prenatal amniocentesis due to raised maternal serum alpha-fetoprotein had shown a karyotypically normal female embryo and second trimester ultrasound demonstrated no anatomic abnormalities. Upon induction of labor with misoprostol, a phenotypically normal embryo was delivered and the placenta showed intermixed areas of marked hydatidiform villous change and normal parenchyma. Pathologic examination of the placenta confirmed the molar change of placenta. Two are the main theories discussed herein that explain the placental molar changes in singleton pregnancies: confined placental mosaicism (one case reported to date) and placental mesenchymal dysplasia (70 cases reported). Differential diagnosis is based on histopathologic features and genetic analysis of placenta. © 2011 Informa UK, Ltd.

**Database:** EMBASE

**15. Triplet pregnancy with partial hydatiform mole.**

**Author(s):** Sundari, M Siva; Agarwal, Preet; Mohan, Jayanthi

**Source:** Journal of the Indian Medical Association; Feb 2011; vol. 109 (no. 2); p. 116-117

**Publication Date:** Feb 2011

**Publication Type(s):** Case Reports Journal Article

**Abstract:**Triplet pregnancy with a coexisting mole is extremely rare. A 26 years old primigravida with multiple gestation and severe pre-eclampsia at 32 weeks gestation was brought to Sri Ramachandra University casualty. In view of abnormal Doppler study with discordant twins emergency lower segment caesarean section was done six days later. Part of the placenta showed molar changes. Histopathology confirmed partial mole. Patient received three cycles of methotrexate in view of rising titres of betahCG. Three months after delivery both babies are alive and well and betahCG for the mother became normal. This pregnancy continued beyond 32 weeks gestational age with both babies being alive. Hence this case is being reported to highlight its rarity.

**16. Gestational trophoblastic disease I: Epidemiology, pathology, clinical presentation and diagnosis of gestational trophoblastic disease, and management of hydatidiform mole**

**Author(s):** Lurain J.R.

**Source:** American Journal of Obstetrics and Gynecology; Dec 2010; vol. 203 (no. 6); p. 531-539

**Publication Date:** Dec 2010

**Publication Type(s):** Journal: Review

**Abstract:**Gestational trophoblastic disease includes hydatidiform mole (complete and partial) and gestational trophoblastic neoplasia (invasive mole, choriocarcinoma, placental site trophoblastic tumor, and epithelioid trophoblastic tumor). The epidemiology, pathology, clinical presentation, and diagnosis of each of these trophoblastic disease variants are discussed. Particular emphasis is given to management of hydatidiform mole, including evacuation, twin mole/normal fetus pregnancy, prophylactic chemotherapy, and follow-up. 

**Database:** EMBASE

**17. Dizygotic twin pregnancy with a normal fetus and a nodular embryo associated with a partial hydatidiform mole**

**Author(s):** Copeland J.W.; Stanek J.

**Source:** Pediatric and Developmental Pathology; Nov 2010; vol. 13 (no. 6); p. 476-480

**Publication Date:** Nov 2010

**Publication Type(s):** Journal: Article



**Abstract:**Although twin pregnancies complicated by a coexisting complete hydatidiform mole are uncommon, those with partial hydatidiform mole (PHM) are exceedingly rare; there are only several well-documented cases diagnosed antenatally. Here we present the first case of a twin placenta containing a nodular embryo associated with PHM diagnosed on routine placental examination. This dizygotic twin pregnancy featured viable embryos at 8 weeks' gestation, death of 1 embryo at 12 weeks, and delivery of a healthy infant by caesarean section at 28 weeks because of worsening maternal reflux nephropathy. Macroscopic and microscopic placental examination and fluorescence in situ hybridization showed one part of the placenta to be diploid and the other to contain a vanishing triploid embryo and a PHM, which had eluded antenatal ultrasound diagnosis. Careful pathologic examination of vanishing twins and their placentas may disclose an unexpected PHM, which can be associated, albeit infrequently, with persistent gestational trophoblastic disease or a trophoblastic tumor. 

**Database:** EMBASE

**18. Case report: Two moles with living healthy fetuses**

**Author(s):** Allgayer D.; Lattrich C.; Holschbach V.; Ortmann O.; Germer U.

**Source:** Archives of Gynecology and Obstetrics; Oct 2010; vol. 282

**Publication Date:** Oct 2010

**Publication Type(s):** Journal: Conference Abstract

Available in full text at Archives of Gynecology and Obstetrics - from Springer Link Journals

**Abstract:**Objective: Partial moles arise from the trophoblastic epithelium of the placenta. The availability of ultrasonography has led to early diagnosis. Materials and methods: We present two cases with a partial mole and different pregnancy outcome. Results: In both cases an abnormal placental structure was diagnosed at second trimester ultrasound examination. The first patient presented with transient vaginal bleeding. The fetus had normal anatomy and size for gestational age. An echogenic placenta was located on the right and a normal placenta on the left uterus wall. Amniocentesis revealed a normal karyotype. hCG was 449503 mlU/ml. After pregnancy with decrease of the mole part of the placenta, a healthy child was spontaneously born at 40 weeks of gestation. The histologic examination showed a regressive hydatidiform mole combined with a placental retardation in dichorionic twin pregnancy. Invasive growth did not appear. The second patient had an echogenic placenta with cystic structures and a normal fetus. At 27 + 0 the fetus showed a significant growth retardation and massive increase of the cystic part of the placenta. With normal uterine and umbilical doppler parameters. Vmax in the middle cerebral artery was elevated. A distinct anemia with hemoglobin 4.7 g/dl, thrombopenia and signs of consumptive coagulopathy was found. Fetal blood transfusions were performed twice. A maximum of hemoglobin 6.8 g/dl was achieved. The preterm delivery through cesarean section was performed because of persistent anaemia and thrombopenia. Blood transfusion after birth was necessary. The histologic examination showed a partial mole with a hypertrophic placenta with no signs of invasive growth. Conclusions: Our examples show that in case of moles with vital fetuses a close follow-up of the fetal and placental development should be done by ultrasound. Patients have to be counseled about severe complications. In case of growth restriction or anemia a preterm delivery might save the child.

**Database:** EMBASE

**19. Internal iliac artery embolisation in the treatment of uncontrolled haemorrhage associated with placenta accreta and partial hydatidiform mole.**

**Author(s):** Unsal, M A; Aran, T; Dinc, H; Cekic, B

**Source:** Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology; Apr 2010; vol. 30 (no. 3); p. 310-311

**Publication Date:** Apr 2010

**Publication Type(s):** Case Reports Journal Article

**Database:** Medline

**20. Twin pregnancy, partial hydatidiform mole coexist with persistent trophoblastic disease in one fetus: A case report**

**Author(s):** Luo Y.-B.; Zhu T.-Y.; Wang S.-H.

**Source:** Academic Journal of Second Military Medical University; Mar 2010; vol. 31 (no. 3); p. 348-349

**Publication Date:** Mar 2010

**Publication Type(s):** Journal: Article

**Database:** EMBASE

**21. Dizygotic twin pregnancy with a normal fetus and a nodular embryo associated with a partial hydatidiform mole**

**Author(s):** Copeland J.; Stanek J.

**Source:** Pediatric and Developmental Pathology; Mar 2010; vol. 13 (no. 2); p. 148

**Publication Date:** Mar 2010

**Publication Type(s):** Journal: Conference Abstract

Available in full text at Pediatric and Developmental Pathology - from ProQuest

**Abstract:**Background: While twin pregnancies complicated by co-existing complete mole are uncommon, those with partial mole (PM) are exceedingly rare, only several well documented cases diagnosed antenatally. Well documented (triploid) PM, albeit rarely, can be complicated by persistent gestational trophoblastic disease (<3%), intraplacental (.0001%) and even metastatic choriocarcinoma (one case). Detection rates of PM by sonography even in singleton pregnancies are more than three times lower than that for complete moles. Design: A 29 year old female, G3P3, with chronic renal impairment secondary to reflux nephropathy, had a dichorionic twin pregnancy with viable embryos diagnosed at 8 weeks gestation. At 12 weeks, sonography showed death of one embryo with an "essentially empty" gestational sac. A healthy fetus was delivered by caesarean section at 28 weeks because of worsening maternal renal function. Results: The dichorionic diamniotic fused placenta contained a normal 156g part and a flattened fibrotic 39g part with an intact chorionic sac, absent umbilical cord, calcified yolk sac remnant, and a 0.4cm embryo fused with the chorionic plate, the latter studded with up to .8cm vesicles. Microscopically, the embryonal tissue contained disorganized skin and cartilage, and the placenta a double population of chorionic villi with features suggestive of PM. p57 was positive in the molar and normal placental parts. FISH of molar and embryonal tissue showed trisomy 13, 18, 21, and X therefore a presumed 69,XXX karyotype, and a 46,XY karyotype of the normal placenta. Retrospective evaluation of the 8 weeks prenatal ultrasounds revealed a dichorionic pregnancy with two viable embryos and cystic structures in one placenta, both disappearing on the 12 weeks ultrasounds which showed a twin pregnancy with vanished embryo. This is a case of a twin pregnancy with a normal diploid fetus and placenta and a vanishing triploid embryo with PM that eluded antenatal diagnosis due to apparent lack of clinical, ultrasonographic or biochemical (bhCG) indicators of molar pregnancy. Diagnosis was made by gross and microscopic placental examination and fluorescence in-situ hybridization (FISH). Follow up with maternal blood betahCH showed its level <2.0 IU/L a year after delivery. Conclusion: To our knowledge, this is the first case of a triploid vanishing embryo with PM diagnosed on placental examination. Careful gross and histological examination of vanishing twins and their placentas may disclose an unexpected PM which rarely can be associated with a trophoblastic tumor. Retrospective studying of sonography images in such cases may help to refine diagnostic criteria for very early partial moles.

**Database:** EMBASE

**22. Partial mole with a diploid fetus: case study and literature review.**

**Author(s):** Sánchez-Ferrer, María Luisa; Ferri, Belén; Almansa, María Teresa; Carbonel, Pablo; López-Expósito, Isabel; Minguela, Alfredo; Abad, Lorenzo; Parrilla, Juan José

**Source:** Fetal diagnosis and therapy; 2009; vol. 25 (no. 3); p. 354-358

**Publication Date:** 2009

**Publication Type(s):** Case Reports Journal Article Review

Available in full text at Fetal Diagnosis and Therapy - from ProQuest

**Abstract:**OBJECTIVETo describe an extremely rare case of a partial hydatidiform mole with a normal fetus. The etiology and clinical management of this entity are discussed.METHODCase report.RESULTSWe describe a rare case of partial mole and a living fetus of diploid karyotype and biparental origin confirmed by flow cytometry and PCR techniques. No malformations were observed, beta-hCG levels were high (>100,000 mIU/ml) and persistent trophoblastic disease did eventually occur.CONCLUSIONA suspected partial mole on ultrasound with increased beta-hCG and a sonographically normal living fetus of a diploid karyotype poses a dilemma for clinical management. Termination of pregnancy is not indicated if the fetus is normal; in fact, continuation to birth is possible in nearly 60% of cases with no increase in maternal risks when the patient is closely monitored after birth until beta-hCG is negative. In the case presented, however, a spontaneous abortion occurred at 21 weeks' gestation, possibly as a result of the amniocentesis.

**Database:** Medline

**23. Management of a partial molar pregnancy: A case study report**

**Author(s):** Drummond S.; Fritz E.

**Source:** Journal of Perinatal and Neonatal Nursing; 2009; vol. 23 (no. 2); p. 115-123

**Publication Date:** 2009

**Publication Type(s):** Journal: Article

Available in full text at Journal of Perinatal and Neonatal Nursing - from Ovid

**Abstract:**Partial molar pregnancy with coexisting fetus is a rare complication of pregnancy and carries significant risks to both the mother and the fetus. Maternal risks include abnormal bleeding and the development of preeclampsia. The fetus frequently develops abnormally, often due to abnormal karyotype. This case presents a woman with a partial molar pregnancy with coexisting fetus, including diagnosis, plan of care, and delivery information. © 2009 Wolters Kluwer Health.

**Database:** EMBASE

**24. Transient early preeclampsia in twin pregnancy with a triploid fetus: a case report.**

**Author(s):** van der Houwen, Clasien; Schukken, Tineke; van Pampus, Mariëlle

**Source:** Journal of medical case reports; May 2009; vol. 3 ; p. 7311

**Publication Date:** May 2009

**Publication Type(s):** Journal Article

Available in full text at Journal of Medical Case Reports - from BioMed Central

Available in full text at Journal of Medical Case Reports - from National Library of Medicine

**Abstract:**INTRODUCTIONTriploid pregnancies have an increased risk of early preeclampsia. Twin pregnancies consisting of one healthy fetus and one complete or partial molar, with or without a triploid fetus, are rare and management is complex.CASE PRESENTATIONA 33-year-old Caucasian woman presented with a dichorionic diamniotic twin pregnancy. One fetus showed early growth restriction resulting in fetal death at 20 weeks. The placenta was enlarged with some cysts. Chorionic villus biopsy confirmed triploidy. At 21 weeks, the patient developed preeclampsia with a blood pressure of 154/98 mmHg and proteinuria (24 hour protein excretion of 2.5 g/L), for which she was hospitalized. Without pharmacological interventions, the blood pressure normalized and proteinuria disappeared. At 35 weeks, she again developed preeclampsia. A cesarean section was performed at 38 weeks and a healthy child was born.CONCLUSIONSSurvival of the healthy fetus is possible in a twin pregnancy with a triploid fetus complicated by early preeclampsia. The pregnancy should not be terminated if the triploid twin has died and as long as conservative management is safe.

**Database:** Medline

**25. Twin pregnancy with partial hydatidiform mole and alive fetus: case report**

**Author(s):** Navarro Amezcua, Mónica Edith; Castellanos Reyes, Julissa; Cardona González, Oscar; Torres Gómez, Luis Guillermo

**Source:** Ginecologia y obstetricia de Mexico; May 2008; vol. 76 (no. 5); p. 275-279

**Publication Date:** May 2008

**Publication Type(s):** Case Reports English Abstract Journal Article

Available in full text at Ginecología y Obstetricia de México - from Free Access Content

**Abstract:**We report a case of a pregnant patient with a twin of 29 gestational weeks, and partial hydatidiform mole with coexistent living fetus. She was admitted at gyneco-obstetric urgencies due to a mild preeclampsia that evolves to severe. She has a complicated vaginal delivery with obstetric bleeding and there was practiced a total abdominal hysterectomy. Newborn dies 30 days later due to secondary complications (extreme prematurity). Patient evolution was satisfactory and she is currently under follow-up therapy to gestational trophoblastic disease without clinical or biochemical evidence of persistence or recurrence.

**Database:** Medline

**26. Bichorial bioamniotic twin pregnancy with one live fetus and a partial hydatiform mole**

**Author(s):** Garcia Rodriguez R.; Garcia L.G.; Castellano M.M.; Cros E.C.; Naya M.A.N.; Pineda A.Z.

**Source:** Progresos en Obstetricia y Ginecologia; Feb 2008; vol. 51 (no. 2); p. 104-108

**Publication Date:** Feb 2008

**Publication Type(s):** Journal: Article

**Abstract:**Twin pregnancy with one sac containing a live fetus and a second sac containing a partial embryonic mole is an extremely rare entity. A 22-year-old nulliparous woman was admitted to our hospital at 16 weeks' gestation due to persistent hyperemesis unresponsive to the usual medication. Ultrasound examination revealed a bichorial biamniotic twin pregnancy with one live fetus and another fetus with absent fetal heart rate and a biometry of 12-13 weeks. The placenta of the second fetus showed signs of diffuse molar changes. The diagnosis was made with chorionic villus sampling biopsy. The patient wanted to continue with the pregnancy and was followed-up as a high risk pregnancy. Labor was induced at 38 weeks' gestation due to preeclampsia. Outcome was favorable and the patient remains asymptomatic.

**Database:** EMBASE

**27. Triploidy partial mole and proteinuric hypertension**

**Author(s):** Wong L.F.A.; Stuart B.; Gleeson N.

**Source:** Journal of Obstetrics and Gynaecology; 2007; vol. 27 (no. 4); p. 424-425

**Publication Date:** 2007

**Publication Type(s):** Journal: Article

**Database:** EMBASE

**28. Twin pregnancy with partial hydatidiform mole and coexistent normal fetus.**

**Author(s):** Ingec, M; Borekci, B; Altas, S; Kadanali, S

**Source:** Journal of obstetrics and gynaecology : the journal of the Institute of Obstetrics and Gynaecology; May 2006; vol. 26 (no. 4); p. 379-380

**Publication Date:** May 2006

**Publication Type(s):** Case Reports Journal Article

**Database:** Medline

**29. The partly molar pregnancy that is not a partial mole**

**Author(s):** Thaker H.M.

**Source:** Pediatric and Developmental Pathology; 2005; vol. 8 (no. 2); p. 146-147

**Publication Date:** 2005

**Publication Type(s):** Journal: Article

**Database:** EMBASE

**30. Partly molar pregnancies that are not partial moles: Additional possibilities and implications**

**Author(s):** Sebire N.J.; Fisher R.A.

**Source:** Pediatric and Developmental Pathology; Dec 2005; vol. 8 (no. 6); p. 732-733

**Publication Date:** Dec 2005

**Publication Type(s):** Journal: Letter

Available in full text at Pediatric and Developmental Pathology - from ProQuest

**Database:** EMBASE

**31. Prenatal diagnosis and management of twin pregnancies complicated by a co-existing molar pregnancy.**

**Author(s):** Wee, Ling; Jauniaux, Eric

**Source:** Prenatal diagnosis; Sep 2005; vol. 25 (no. 9); p. 772-776

**Publication Date:** Sep 2005

**Publication Type(s):** Journal Article Review

Available in full text at Prenatal Diagnosis - from John Wiley and Sons

**Abstract:**Recent advances in ultrasound and molecular genetics have increased our understanding and hence enhanced the perinatal management of complete and partial hydatidiform mole. By contrast, the management of a twin pregnancy combining a normal pregnancy with a normal fetus and a complete hydatidiform mole (CHM) remains complex and controversial due to conflicting data from different parts of the world. The aim of this review is to analyse the international literature on twin pregnancies that include a mole, present the complications and outcome of pregnancy and to discuss the perinatal management. Management is complicated and women should be counselled about the maternal and fetal complications, and the pregnancy monitored carefully by a perinatal team with experience in high-risk obstetrics and access to neonatal care. The data reviewed here suggest that a woman who decides to continue with the pregnancy including a CHM must be aware that, overall, she only has a one in four chance of live birth and in around 35% of cases she will develop persistent trophoblastic disease (PTD) after delivery. In ongoing pregnancies, there will be, in at least 20% of the cases, an early onset of pre-eclampsia (PET) and a 29% risk of fetal loss due to late miscarriage, intrauterine death and neonatal death. Maternal serum human chorionic gonadotrophin (MShCG) could be useful in predicting outcome in twin pregnancy combining normal pregnancy and CHM, but this needs to be investigated prospectively.

**Database:** Medline

**32. Diploid partial mole with neonatal survival--a case report**

**Author(s):** Agarwal R.; Agarwal S.; Roy K.K.; Kumar S.

**Source:** Indian journal of pathology & microbiology; Apr 2005; vol. 48 (no. 2); p. 225-227

**Publication Date:** Apr 2005

**Publication Type(s):** Journal: Article

Available in full text at Indian Journal of Pathology and Microbiology - from Free Access Content

**Abstract:**Partial mole is a gestational neoplastic disorder with a reported incidence of 0.005 - 0.01% of all pregnancies. The karyotype in such cases is usually triploid, baring a few exceptions. The diploid partial mole is an extremely rare entity with only few cases being documented in literature. The fetal outcome in such cases is usually poor. We describe a case of partial mole, which terminated at 28 weeks with a live diploid male fetus with good neonatal outcome. Follow-up showed no progression to malignant gestational trophoblastic disease.

**Database:** EMBASE

**33. Partial hydatidiform mole along with term gestation and alive baby**

**Author(s):** Parveen Z.; Bashir R.; Jadoon T.; Qayum I.

**Source:** Journal of Ayub Medical College, Abbottabad : JAMC; 2004; vol. 16 (no. 4); p. 84-85

**Publication Date:** 2004

**Publication Type(s):** Journal: Article

**Abstract:**Gestational trophoblastic disease consists of a broad spectrum of conditions ranging from an uncomplicated partial hydatidiform molar pregnancy to stage-IV choriocarinoma with cerebral metastases. We describe a partial molar change in the placenta that was associated with a normal female fetus that was delivered at term and is alive and healthy.

**Database:** EMBASE

**34. Twin pregnancy with partial hydatidiform mole and coexistent fetus.**

**Author(s):** Chu, Wenjiang; Chapman, Julia; Persons, Diane L; Fan, Fang

**Source:** Archives of pathology & laboratory medicine; Nov 2004; vol. 128 (no. 11); p. 1305-1306

**Publication Date:** Nov 2004

**Publication Type(s):** Case Reports Journal Article

Available in full text at Archives of Pathology & Laboratory Medicine - from EBSCOhost

Available in full text at Archives of Pathology and Laboratory Medicine - from ProQuest

**Database:** Medline

**35. Term pregnancy with partial molar changes of placenta**

**Author(s):** Gupta A.; Gupta Y.V.

**Source:** JK Science; 2003; vol. 5 (no. 2); p. 89-90

**Publication Date:** 2003

**Publication Type(s):** Journal: Article

**Abstract:**A rare case report of successful term pregnancy with partial molar changes of placenta is being reported. The patient was 2nd gravida with twin pregnancy with pregnancy induced hypertension (PIH). Patient under went LSCS and gave birth to two healthy looking babies. She was followed up and serum HCG (Human Chorinic Gouadotrophin) level returned to normal within 4 weeks after delivery.

**Database:** EMBASE

**36. Delayed-interval delivery in a quadruplet pregnancy after intrauterine death of a partial molar pregnancy and preterm delivery. A case report.**

**Author(s):** Marinoff, D N; Spitzberg, E H; Chueh, J T; Goldman, J M; Downs, T

**Source:** The Journal of reproductive medicine; Dec 1998; vol. 43 (no. 12); p. 1051-1054

**Publication Date:** Dec 1998

**Publication Type(s):** Case Reports Journal Article

**Abstract:**BACKGROUND Delayed-interval delivery is infrequent in twin gestation and more rare in triplet and quadruplet gestation. Coexistence of a triploid pregnancy with a normal fetus has not previously been reported to have resulted in survival of the normal fetus.CASEA 26-year-old woman, gravida 2, para 0-0-1-0, was diagnosed with a quadruplet pregnancy. At 16 1/2 weeks' gestation she developed preeclampsia and severe hyperemesis. Ultrasound was consistent with partial molar pregnancy in quadruplet D. Quadruplet D died in utero, and the preeclampsia and hyperemesis resolved. At 19 5/7 weeks, spontaneous rupture of the membranes and preterm labor occurred, and quadruplet A, stillborn female weighing 260 g, was delivered. With the use of antibiotic therapy, tocolysis and bed rest, the remaining two fetuses were maintained in utero until 32 6/7 weeks' gestation, when quadruplet B, a 1,470-g female, and quadruplet C, a 1,700-g female, were delivered.CONCLUSIONThis was the first reported case of surviving fetuses coexisting with a partial molar pregnancy. This case was also complicated by preterm delivery and successful delayed-interval birth in a quadruplet pregnancy.

**Database:** Medline

**37. Eclampsia complicating hydatidiform molar pregnancy with a coexisting, viable fetus: A case report**

**Author(s):** Ramsey P.S.; Van Winter J.T.; Gaffey T.A.; Ramin K.D.

**Source:** Journal of Reproductive Medicine for the Obstetrician and Gynecologist; May 1998; vol. 43 (no. 5); p. 456-458

**Publication Date:** May 1998

**Publication Type(s):** Journal: Article

**Abstract:**BACKGROUND: Eclampsia is a rare and serious complication of pregnancy. The occurrence of preeclampsia prior to the 20th week of gestation has been associated with concurrent hydatidiform molar pregnancy. We present a case of eclampsia complicating a partial molar pregnancy associated with a viable fetus. CASE: A 22-year-old white woman, gravida 1, para 0, at 14 weeks' gestation, presented with an excruciating headache associated with hypertension, proteinuria and a viable intrauterine fetus with gastroschisis. Subsequently the patient had a generalized tonic-clonic seizure which resolved with magnesium sulfate therapy. Markedly elevated quantitative human chorionic gonadotropin and a moderately thickened placenta were the sole clinical features suggestive of a molar gestation. Dilation and evacuation was performed revealing unremarkable products of conception. Pathologic and cytogenetic analyses revealed a triploid fetus (69,XXX) consistent with partial molar pregnancy. CONCLUSION: Development of preeclampsia/eclampsia prior to 20 weeks of gestation should prompt a clinical evaluation to exclude the possibility of an underlying hydatidiform molar pregnancy.

**Database:** EMBASE

**38. How to deal with a rare entity: the coexistence of a complete mole and a healthy egg in a twin pregnancy?**

**Author(s):** Garbin, O; Favre, R; Weber, P; Arbogast, E; Gasser, B

**Source:** Fetal diagnosis and therapy; 1995; vol. 10 (no. 5); p. 337-342

**Publication Date:** 1995

**Publication Type(s):** Case Reports Journal Article

**Abstract:**The association of a normal and a molar egg within a twin pregnancy is extremely rare. The key to diagnosis is the fetal karyotype, thus allowing elimination of its principal differential diagnosis: partial triploid mole. We report a case where the evolution of the pregnancy was complicated by severe toxemia. Interruption of pregnancy was then necessary, even though a conservative attitude had first been considered. Throughout this case, we discuss the means of diagnosis and the clinical handling of this rare entity.

**Database:** Medline

**39. Partial hydatidiform molar pregnancy presenting with severe preeclampsia prior to twenty weeks gestation: A case report and review of the literature**

**Author(s):** Brittain P.C.; Bayliss P.

**Source:** Military Medicine; 1995; vol. 160 (no. 1); p. 42-44

**Publication Date:** 1995

**Publication Type(s):** Journal: Article

**Abstract:**A previously healthy 37-year-old Latin American female presented at 17 6/7 weeks gestation with clinical manifestations of preeclampsia. Ultrasound revealed a growth-retarded fetus with hypoechoic bowel, a thickened cystic placenta, bilateral multicystic adnexal masses, and oligohydramnios. The patient had laboratory evidence of hyperthyroidism and the maternal serum alpha-fetoprotein was 12.3 multiples of the mean. Subclinical disseminated intravascular coagulation rapidly ensued and an induction of labor was performed. This was productive of a 110-g female fetus with a markedly distended abdomen and syndactyly. The placenta weighed 650 g with gross hydropic changes throughout. The clinical aspects of this case and review of the literature on partial molar pregnancies will be discussed.

**Database:** EMBASE

**40. Partial hydatidiform mole and hypertension associated with a live fetus--variable presentation in two cases.**

**Author(s):** Nwosu, E C; Ferriman, E; McCormack, M J; Williams, J H; Gosden, C M

**Source:** Human reproduction (Oxford, England); Sep 1995; vol. 10 (no. 9); p. 2459-2462

**Publication Date:** Sep 1995

**Publication Type(s):** Case Reports Journal Article

**Abstract:**Partial hydatidiform mole associated with live births is a rare condition. There are not enough cases in the literature to allow the assessment of comprehensive risks to be made and upon which management policies can be based. Several clinical dilemmas arise following diagnosis of a viable pregnancy associated with molar tissue. We present two cases demonstrating the problems and suggest management based on outcome and a review of the literature.

**Database:** Medline

**41. Coexistent complete and partial hydatidiform moles in a twin pregnancy.**

**Author(s):** Dalrymple, C; Russell, P; Murray, J

**Source:** Journal of obstetrics and gynaecology (Tokyo, Japan); Aug 1995; vol. 21 (no. 4); p. 325-330

**Publication Date:** Aug 1995

**Publication Type(s):** Case Reports Journal Article

**Abstract:**A case of twin pregnancy with complete and partial molar disease is presented. Aspects of diagnosis, ploidy studies and management are discussed.

**Database:** Medline

**42. Partial molar pregnancy with fetal survival: an unusual example of confined placental mosaicism.**

**Author(s):** Sarno, A P; Moorman, A J; Kalousek, D K

**Source:** Obstetrics and gynecology; Oct 1993; vol. 82 (no. 4)

**Publication Date:** Oct 1993

**Publication Type(s):** Case Reports Journal Article

**Abstract:**BACKGROUNDA pregnancy with a partial molar placenta and a normal fetus is a rare condition. Few guidelines exist for antenatal evaluation and management, particularly with respect to selecting cases for conservative management.CASECytogenetic analysis of chorionic villi showed a triploid placenta, and both amniotic fluid and blood indicated a diploid fetus. The pregnancy resulted in a normal newborn.CONCLUSIONThis disorder appears to be due to confined placental mosaicism.

**Database:** Medline

**43. Persistent gestational trophoblastic disease after a diploid partial hydatidiform mole coexisting with a normal living fetus.**

**Author(s):** Cheung, N Y; Ngan, H Y; Ghosh, A

**Source:** International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics; Jul 1992; vol. 38 (no. 3); p. 238-239

**Publication Date:** Jul 1992

**Publication Type(s):** Letter Case Reports

**Database:** Medline

**44. Partial hydatidiform mole with a coexistent live full-term fetus. A case report.**

**Author(s):** Pool, R; Lebethe, S J; Lancaster, E J

**Source:** South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde; Feb 1989; vol. 75 (no. 4); p. 186-187

**Publication Date:** Feb 1989

**Publication Type(s):** Case Reports Journal Article

**Abstract:**A patient with a partial hydatidiform mole, who had a coexistent normal fetus, is described. The pregnancy proceeded to term and ended in the spontaneous, vaginal delivery of a normal baby. The placenta showed areas of macroscopic cystic degeneration with the histological features of hydatidiform mole.

**Database:** Medline

**45. Sonographic diagnosis of a pregnancy with a diffuse hydatidiform mole and coexistent 46,XX fetus: a case report.**

**Author(s):** Feinberg, R F; Lockwood, C J; Salafia, C; Hobbins, J C

**Source:** Obstetrics and gynecology; Sep 1988; vol. 72 (no. 3); p. 485-488

**Publication Date:** Sep 1988

**Publication Type(s):** Case Reports Journal Article

**Abstract:**Placental molar change with a coexistent live fetus is an unusual entity, particularly when diagnosed in the second trimester of pregnancy. In this case report, the sonographic findings of an abnormally enlarged, diffuse molar placenta with a normal living fetus in the second trimester prompted karyotype analysis. Although triploidy was anticipated, a normal 46,XX chromosomal complement was identified. Histopathology of the placenta after delivery confirmed the rare syndrome of diploid partial mole. Antenatal management of this unusual pregnancy complication is addressed.

**Database:** Medline

**46. A partial hydatidiform mole, dispersed throughout the placenta, coexisting with a normal living fetus. Case report.**

**Author(s):** Crooij, M J; Van der Harten, J J; Puyenbroek, J I; Van Geijn, H P; Arts, N F

**Source:** British journal of obstetrics and gynaecology; Jan 1985; vol. 92 (no. 1); p. 104-106

**Publication Date:** Jan 1985

**Publication Type(s):** Case Reports Journal Article

**Database:** Medline

## **Strategy** 180779

| # | Database | Search term | Results |
|---|---|---|---|
| 1 | Medline | (partial ADJ2 mol*).ti,ab | 1613 |
| 2 | Medline | (twin*).ti,ab | 51392 |
| 3 | Medline | ("multiple gestation*").ti,ab | 1767 |
| 4 | Medline | exp "MULTIPLE BIRTH OFFSPRING"/ | 26339 |
| 5 | Medline | (2 OR 3 OR 4) | 58139 |
| 6 | Medline | (1 AND 5) | 60 |
| 7 | Medline | (labour OR labor).ti,ab | 84848 |
| 8 | Medline | (labour OR labor).ti,ab,af | 129142 |
| 9 | Medline | (7 OR 8) | 129142 |
| 10 | Medline | (1 AND 9) | 16 |
| 11 | Medline | (pregn* ADJ2 molar).ti,ab | 953 |
| 12 | Medline | exp "HYDATIDIFORM MOLE"/ | 4821 |
| 13 | Medline | (11 OR 12) | 5112 |
| 14 | Medline | (1 AND 13) | 735 |
| 15 | Medline | (uterotonic*).ti,ab | 950 |
| 16 | Medline | (ecbolic*).ti,ab | 76 |
| 17 | Medline | exp OXYTOCICS/ | 62452 |
| 18 | Medline | (15 OR 16 OR 17) | 62984 |
| 19 | Medline | (1 AND 18) | 5 |
| 20 | Medline | exp "PREGNANCY | 13187 |

| | | | |
|---|---|---|---|
| | | TRIMESTER, THIRD"/ | |
| 21 | Medline | (1 AND 20) | 6 |
| 22 | Medline | ("living fetus" OR "viable fetus" OR "viable fetuses").ti,ab | 630 |
| 23 | Medline | (1 AND 22) | 18 |
| 24 | Medline | ("sad fetus syndrome").ti,ab | 2 |
| 25 | EMBASE | *"HYDATIDIFORM MOLE"/ | 4396 |
| 26 | EMBASE | (partial).ti,ab | 447815 |
| 27 | EMBASE | (partial ADJ2 mol*).ti,ab | 2155 |
| 28 | EMBASE | (25 AND 26) | 885 |
| 29 | EMBASE | ("sad fetus syndrome").ti,ab | 2 |
| 30 | EMBASE | (27 OR 28 OR 29) | 2255 |
| 31 | EMBASE | (labour OR labor).ti,ab | 104189 |
| 32 | EMBASE | exp "LABOR STAGE 3"/ | 963 |
| 33 | EMBASE | (31 OR 32) | 104394 |
| 34 | EMBASE | (30 AND 33) | 22 |
| 35 | EMBASE | ("sad fetus syndrome").ti,ab | 2 |
| 36 | EMBASE | (twin*).ti,ab | 61330 |
| 37 | EMBASE | ("multiple gestation*").ti,ab | 2905 |
| 38 | EMBASE | exp "MULTIPLE PREGNANCY"/ | 23401 |
| 39 | EMBASE | (36 OR 37 OR 38) | 73494 |
| 40 | EMBASE | (30 AND 39) | 124 |

| | | | |
|---|---|---|---|
| 41 | EMBASE | (uterotonic*).ti,ab | 1454 |
| 42 | EMBASE | (ecbolic*).ti,ab | 80 |
| 43 | EMBASE | exp "UTEROTONIC AGENT"/ | 101099 |
| 44 | EMBASE | (41 OR 42 OR 43) | 101620 |
| 45 | EMBASE | (30 AND 44) | 23 |
| 46 | EMBASE | exp "INTRAPARTUM CARE"/ | 1734 |
| 47 | EMBASE | (30 AND 46) | 0 |
| 48 | EMBASE | exp "OBSTETRIC DELIVERY"/ | 124499 |
| 49 | EMBASE | (30 AND 48) | 73 |
| 50 | EMBASE | exp "PREGNANCY OUTCOME"/ | 48514 |
| 51 | EMBASE | (30 AND 50) | 36 |
| 52 | Medline | exp "PREGNANCY OUTCOME"/ | 47163 |
| 53 | Medline | (1 AND 52) | 47 |
| 54 | Medline | exp "OBSTETRIC LABOR COMPLICATIONS"/ | 60150 |
| 55 | Medline | (1 AND 54) | 9 |
| 56 | EMBASE | exp "LABOR COMPLICATION"/ | 177438 |
| 57 | EMBASE | (30 AND 56) | 60 |
| 58 | Medline | (incomplete ADJ3 mol*).ti,ab | 105 |
| 59 | Medline | (9 AND 58) | 0 |
| 60 | EMBASE | ("living fetus" OR "viable fetus" OR "viable fetuses").ti,ab | 826 |
| 61 | EMBASE | (30 AND 60) | 34 |

| | | | |
|---|---|---|---|
| 62 | EMBASE | exp FETUS/ | 200587 |
| 63 | EMBASE | (30 AND 62) | 219 |
| 64 | EMBASE | ("co existing" OR coexisting).ti,ab | 29914 |
| 65 | EMBASE | (30 AND 64) | 66 |
| 66 | EMBASE | (viable OR viability).ti,ab | 284989 |
| 67 | EMBASE | (63 AND 66) | 22 |
| 68 | Medline | ("co existing" OR coexisting).ti,ab | 23246 |
| 69 | Medline | (1 AND 68) | 43 |
| 70 | Medline | (viable OR viability).ti,ab | 222799 |
| 71 | Medline | (1 AND 70) | 27 |