Case Report



# Complete Molar Cervical Previal Pregnancy with Second Healthy Twin and Placental Percretism after Corporeal Hysterotomy One Year Ago

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*Article*

# Complete Molar Cervical Previal Pregnancy with Second Healthy Twin and Placental Percretism after Corporeal Hysterotomy One Year Ago

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**Abstract:** Background: Coexisting monozygotic twin molar pregnancies with a living second fetus are known in the literature, with various outcomes and treatment options. Methods: Clinical praesentation of two separate throphoblastic diseases that became directly conditioned. Results: A 33-year-old nuliparous woman, after autolog insemination one blastocysts with extremely high MoM free BHCG, and in the 17th week of pregnancy, bled profusely where ultrasound found a dilated cervix filled with a mass similar to molar tissue with intact second gestational sac. The gynecologists decided on a laparotomy, so they performed a corporeal hysterotomy at the 19th week of pregnancy. A year later, the patient became pregnant spontaneously with an orderly course of pregnancy until the 30th week. Due to the acute abdomen, an emergency caesarean section is indicated, and after the laparotomy, 1000 mL of fresh blood and clots are found with a 5 cm zone of cicatricial percretism. A freshly dead male newborn 1530 g/ 44 cm, without the effect of the resuscitation procedure. With regard to cicatricial percretism, the gynecologist on duty decides on a supracervical hysterectomy.; Conclusions: The treatment approach to molar pregnancy that influenced the outcome of the second pregnancy and the overall poor reproductive outcome is discussed.

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## 1. Introduction

Cases of coexisting twin molar pregnancies with a living second fetus are known in the literature, with various outcomes and treatment options [1-4]. Prompted by a recently published case [1], I present a similar example but with another trophoblastic entity in a second pregnancy and comment on the treatment procedures in both pregnancies.

## 2. Case report

A 33-year-old healthy nuliparous woman with a history of one artificial abortion, was treated for infertility: hysteroscopic endometral polypectomy and laparoscopic chromopertubation were performed five months before successful artificial homologous insemination (AIH – one blastocyst). Early biochemical screening indicated the absence of significance for chromosomal abnormalities with extremely high MoM free BHCG, and in the 14th week ultrasound showed inhomogeneous chorial tissue cervicoisthmically with a live vital fetus in a separate gestational sac in the uterus, so it was decided to perform early amniocenthesis. In the 17th week of pregnancy, the pregnant woman bled profusely and was admitted to the clinic, where ultrasound found a dilated cervix filled with a mass similar to inhomogeneous molar tissue with numerous anechoic inclusions with an unclear border towards the wall of the cervix (Figure 1) with an intact second gestational sac with morphologically healthy fetus. The ultrasound findings suggested a suspected complete mole probably after a missed abortion of the first twin with a preserved pregnancy of the second twin. Due to laboratory findings of hyperthyroidism, propylthiouracil 3x200 mg and propranolol 2x20 mg were prescribed. Considering the above, the gynecologists, in agreement with the patient, decided on a laparotomy approach to evacuate both pregnancies, so they performed a corporeal hysterotomy and

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evacuation of the uterus under general anesthesia at the 19th week of pregnancy. The surgical procedure and the postoperative course went well with the prescribed 3 doses of concentrated erythrocytes (KE) without bleeding from the cervix. The pathohistological findings indicated complete molar degeneration of the first conceptus, and the kariogram of the healthy twin was normal. A year later, the patient became pregnant spontaneously with an orderly course of pregnancy until the 30th week, when she was admitted to the clinic due to peracute and continuous abdominal pain without vaginal hemorrhage. On admission, signs of an acute abdomen are evident, free fluid in the abdomen is found on ultrasound, along with an orderly biophysical profile of the fetus and cardiotocography and the finding of anterior invasive malplacentation – placental percretism. Due to the acute abdomen, an emergency caesarean section is indicated, and after the laparotomy, 1000 mL of fresh blood and clots are found in the abdomen with a 5 cm zone of percretism in the scar from the previous corporeal hysterotomy, which is actively bleeding. A fundal hysterotomy was performed on a freshly dead male newborn 1530 g/ 44 cm, without the effect of the resuscitation procedure. With regard to cicatricial placental percretism, the gynecologist on duty decides on a supracervical hysterectomy, which is performed with the transfusion of 4 KE, 2 fresh frozen plasm and 2 cryoprecipitates. The pathohistological findings of the uterus indicated a placenta percreta through the scar, and the autopsy findings of the stillborn showed a premature morphological finding of the organs with signs of asphyxia.

## 3. Discussion

I present the case of these two separate trophoblast entities that became directly conditioned: molar cervical pregnancy in first pregnancy and placenta accreta spectrum (PAS) in the next pregnancy from the clinical and forensic aspects with the approval of the Hospitals Ethics Committee. In modern literature, cervical ectopic pregnancies, even if they are rare or molar, are solved very successfully with preservation procedures, such as cerclage with evacuation curettage, evacuation curettage with gauze or balloon tamponade [4-6], and hysterectomy is reserved only for severe refractory hemorrhage and invasive cervical malplacentation [7-8]. PAS is today an iatrogenically conditioned modern disease of the 21st century in direct correlation with the extremely high incidence of caesarean sections and other uterine procedures, and thus increased maternal morbidity and mortality due to hemorrhage and peripartum hysterectomies [8]. This extremely rare case of previal cervical molar pregnancy in a twin pregnancy and primary completion by laparotomy is directly related to the occurrence of placental percretism with hematoperitoneum at 30 weeks of pregnancy due to distension and rupture of a placental blood vessel. Although there were no consequences in terms of litigation, as a clinician and gynecological-obstetrical forensic expert, I am of the opinion that a transvaginal procedure to evacuate the cervical molar pregnancy should have been performed after placement of the cerclage with local anemization and ligation of the cervical branches, when the integrity of the second twin would have been preserved with a high probability. Furthermore, even when percretism was noticed during relaparotomy and caesarean section with unfortunately a recently deceased child due to most likely asphyxia, resection of the uterine wall and sutures with preservation of the uterus should have been performed. Thus, these problems became professional failures with an irreversible “domino effect”. Because of the above, I consider sharing this presentation as a contribution to the importance of a collegial approach and the apparently forgotten Hippocrates' "primum nil nocere".

**Supplementary Materials:** Figure S1: Ultrasound pictures of cervical previal molar pregnancy: inhomogenous mass with multiple anechogenic areas in dilated cervix

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**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:**

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**Conflicts of Interest:** The authors declare no conflict of interest.

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