Statistical study of molar pregnancy patients by gender and age in Wasit Province

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Abstract :

Molar pregnancy is considered relatively a health problem in some regions, and although it is easy to diagnose and treat, some cases may be accompanied by serious complications, and molar pregnancy occurs in approximately ١/١٠٠٠ pregnancies in the United States of America and Europe, although it is more common in other countries, especially in regions of Asia; Most of this information was based on hospital studies. depending on research studies, the incidence rate in most parts of the world is perhaps similar to the United States, and the most common presentation is ٩٧٪. The molar tissues may separate from the deciduous membrane and rupture the blood vessels and cause dilation of the uterine cavity with retained blood. This study included ٥٦ patients with molar pregnancy who were taken randomly. From Al Zahra Teaching Hospitals and Al Karama Teaching Hospital. Their ages ranged between (١٤-٤٥) years. The patients were divided into four age groups (١-٤) with an interval of eight years. The first age group ranged from (١٤-٢١) years, the second age group (٢٢-٢٩), the third age group (٣٠-٣٧), while the last age group ranged from (٣٨-٤٥) years, and the estimation of the age groups of patients showed that (٢٠) (٣٦٪) patients were in the first age group (١٤ (١٧) (٢١) ٣٠٪ in the second age group (٢٢-٢٩), (١٠) (١٨) in the third age group (٣٠-٣٧), (٩) (١٦) in the fourth age group (٣٨-٤٥)) The minimum age was ١٤ years while the maximum age was ٤٥. According to these results, the highest incidence rate was in the first age group (١٤-٢١).Therefore, we found that the occurrence of HM in younger patients was the most common.

Keywords: Statistical study, molar pregnancy, molar pregnancy by age.

Introduction

Hydatid form mole

The molar pregnancy is called (hydatid form mole) or (Molar pregnancy) is known as one of the health problems or complications that may accompany the process of pregnancy. There are several names for this type of mole pregnancy, including a watery mole and also a molar pregnancy (HM). Hydatids is derived from the Greek word hydatids, which is watery crop. Mole comes from the Latin moles, meaning shapeless mass (Thomas, ١٩٩٧). HM is as a result of abnormal fertilization (Burton et al., ٢٠٠١). A molar pregnancy is an abnormal pregnancy in which the placenta contains sac-like cells (vesicles) that are usually visible to the naked eye.

Molar pregnancy is considered relatively a health problem in some areas, and although it is easy to diagnose and treat, some cases may be accompanied by serious complications. Vesicles arise by the expansion of the chorionic villi with fluid. When examined under a microscope, trophoblast tissue hyperplasia was observed (Abbas and Khawaja, ٢٠١٤). The HM is characterized by varying degrees of trophoblast hyperplasia and vesicular swelling of the chorionic villi associated with an abnormal fetus (Lorain, ٢٠١٠). Hydatid mole represents a disorder of embryonic imprinting (silent transcription), which genes are expressed in a single form from the copy of the gene derived from the mother or father (Fisher et al., ٢٠٠٢).

Overall, the hydatidiform mole looks like masses of thin-walled, translucent, saccular structures, resembling a grape seed. A molar pregnancy is represented by the abnormal growth of what is known as the trophoblast, which is formed when the sperm fertilizes the egg to start the pregnancy process. The trophoblast is the primitive tissue that will be the placenta later on. It is known, the placenta is the part responsible for nourishing the fetus. The human placenta is a unique organ. Although transient it has the potential to preserve the fetus. During pregnancy, it acts as a lifeline, mediating the physiological exchange between the mother and the fetus (Ray, ٢٠١٠; Der, ٢٠١٥). Abnormalities at any stage of this development due to altered proliferation, differentiation, or cell death may lead to abnormal placental function and subsequent pregnancy-related complications (Ray, ٢٠١٠). This high prevalence and rate of invasion may lead to invasive trophoblastic diseases (Hammond and Evans, ١٩٩٧). The placenta will come later. As it is known that the placenta is the part responsible for nourishing the fetus, the human placenta is a very unique organ. Although transient it has the potential to save the life of the fetus.

During pregnancy, it acts as a lifeline mediating physiological exchange between mother and fetus (Ray ٢٠١٠). The placenta is the interface between the fetus and the mother in a normal pregnancy. The placenta plays a vital role in transporting oxygen and nutrients to the fetus for

growth, development and waste disposal (Der, ٢٠١٥). Abnormalities at any stage of this development due to altered proliferation, differentiation, or cell death may result in abnormal placental function and subsequent pregnancy-related complications (Ray, ٢٠١٠). Characteristics of this abnormal placenta are the trophoblasts that appear hyperproliferative and highly invasive. Invasiveness may lead to invasive trophoblastic disease (١٩٩٧) German mole (HM) is the most common type of gestational trophoblastic disease (GTD). It is called molar pregnancy is an abnormal pregnancy characterized by large manifold enlargement and variable trophoblast proliferation involving part or all of the chorionic villi (Wagner et al. ٢٠٠٨).

A molar pregnancy is represented as a pre-malignant form of gestational trophoblastic neoplasia) Shaklee ٢٠١٢. In trophoblastic disease there is an abnormal overgrowth of all or part of the placenta causing what is called a molar pregnancy (Jubilee et al., ٢٠١٧). In normal pregnancy, blood vessels do not develop in the placenta, in some cases it develops into malignant disease such as invasive mole, trophoblastic tumor of the placenta site and placental carcinoma. Placental cancer can have effects on women's health even years later (Candelier ٢٠١٦). According to epidemiological and clinical studies, HM should be considered as an epidemiology of pregnancy and as a public health issue (Burette et al., ٢٠١١).

١-٢ Prevalence and epidemiology of the disease

Molar pregnancies occur in approximately ١/١٠٠٠ pregnancies in the USA and Europe. They are more common in other countries, especially in Asia. Most of this information was based on hospital studies. Based on research studies, the incidence in most parts of the world is probably similar to the United States. In other studies of different countries, cities and hospitals, it was reported that molar pregnancy occurs differently in different geographical areas and in targeted population groups. The presence of molar tumor in the hospital found the number of infections (١) for every (٤٥) live births.

Another study, after collecting data spread during the period (١٩٣٢-٢٠١١) in Turkey, showed that the incidence of molar pregnancies was increasing, so that cases reached from ١٦- ٦٣ per ١٠٠٠ pregnancies and ١-٢٤.٥ per ١٠٠٠ the state of his birth. In Finland, the results showed that the number of infections was ١٠ per ٩٨٤ births from the year (١٩٧٥-٢٠٠١), at the same time other rates were reported in different parts of Iran for the occurrence of molar pregnancy in a hospital during ١٠ years, the incidence of the disease being ١٣ per ١٠٠٠ births live births.

١-٣ Classification of hydatidiform mole

There are two types of hydatidiform mole:

١-A complete hydatidiform mole

٢-Partial hydatidiform mole

Molar pregnancy is divided into two subtypes: complete and partial, which represents a major advance in our understanding of molar pregnancy. These two forms of hydatidiform mole have different cell patterns, different clinical profiles, and different degrees of risk for developing GTD. Both forms are usually presented in the first trimester (Shih et al., ٢٠٠٢). Classifying a hydatidiform mole as complete and partial is important not only for clinical management, but also for accurate ascertainment of the risk of GTD. HM carries a high risk of developing persistent gestational trophoblastic neoplasia with a high incidence in CHM-٣٠ disease (١٠٪ and patients with Super ٢٠٠٦) (٥٪-٠.٥٪) PHM.

١-A complete hydatidiform mole

A complete mole also known as a 'classical' hydatidiform mole has been identified and studied for many years (Hertig and Mansell, ١٩٥٦). Complete moles are diploid and of androgenic origin with no evidence of fetal histology. Usually (٧٥-٨٠) complete moles arise as a result of the reproduction of a single sperm after fertilization of an empty ovum. Some complete nevi (٢٠-٢٥) can arise after the intermittent fertilization of an empty ovum (Tham et al., ٢٠٠٣). A complete molar pregnancy (CHM) is an abnormal pregnancy characterized by villous hyperplasia as well as gross trophoblastic hyperplasia without any evidence of a fetus. The CHMS phenotype includes swelling of the choroidal lesions with cistern formation and early embryonic death usually before the fetal circulation is established (Fan et al., ٢٠٠٢). Approximately ٩٠٪ of complete nevi are ٤٦, XX. It arises from the duplication of chromosomes in haploid sperm following fertilization of an egg in which the mother's chromosomes are inactive or absent. The remaining ١٠٪ of complete moles are ٤٦ XY, or ٤٦ XX as a result of fertilization of an empty ovum by ٢ sperms (Kklc et al., ٢٠١٢).

٢. Partial hydatidiform mole

Partial nevi (٩٠) are usually triploid in origin with two sets of paternal haploid genes, and one set of maternal haploid genes. Partial nevi occur in almost all cases, after the interrupted fertilization of the egg. Ten percent of partial nevi represent a tetraploid pregnancy. Partial mole is usually here as evidence of fetal red blood cells (Tham et al., ٢٠٠٣). Partial (incomplete) nevi syndrome has an identifiable live or dead fetus and a triploid karyotype (٦٩ XXX or XXY) after fertilization of a normal ovum (Matsuda and Wake, ٢٠٠٣).

Distinctive morphological features of PHMS include the presence of two groups of villi (large, irregular, watery and small, immature fibrous villi), cisterns in some enlarged villi (Seiber et al., ٢٠٠٣). Less than ٥٪ of PHM will develop into GTN, Metastases occur rarely and the histological diagnosis of choriocarcinoma has not yet been confirmed (Seiber et al., ٢٠٠٣).

١-٤ Distinguish between a complete and partial mole genetically

Genetic analyzes show differences between partial and complete molar pregnancies. A complete mole is usually diploid. In most cases, it is of androgenic origin among androgenic moles. The majority has two identical sets of paternal chromosomes homozygous in a small portion of diploid nevi; the nuclear genome consists of two different sets of paternal chromosomes (heterozygotes). It was commonly assumed that androgenetic diploid nevi in homozygotes arise from fertilization of an "empty ovum cell" with centenarian cells.

Homozygous moles arise from fertilization of an “empty ovum cell” with a single sperm cell followed by duplication of the sperm genome (Golubovsky, ٢٠٠٣). Besides the increasing knowledge of the human genome, many other factors that could be important in our understanding of molar pregnancy are being investigated. Epigenetic changes are of particular interest because the genome contains information in two forms. However, genetic information (DNA sequences contain a blueprint for the synthesis of all proteins providing epigenetic information) one of the major forms of epigenetic information in mammalian cells is DNA methylation, in which methylated genes are generally inactive (Robertson, ٢٠٠١).

In some genes, the maternal and paternal alleles are differentially methylated. Since the genome of most moles has an unbalanced paternal origin, it seems plausible that an abnormal methylation pattern contributes to the development of the mole. Therefore, examination of the methylation pattern could lead to the identification of genes involved in the development of moles (Perrin et al., ٢٠٠٧).

١-٥ Causes of molar pregnancy

A molar pregnancy occurs as a result of a genetic defect in the ovum in a woman or the sperm in a man, which leads to abnormal tissue growth in the uterus. A molar pregnancy occurs as a result of an abnormally fertilized egg, as human cells contain ٢٣ pairs of chromosomes. One chromosome in each pair comes from the father and the other from the mother. In cluster pregnancy factors, these are some of the factors that increase the probability of cluster pregnancy. There is a relatively high frequency of molar pregnancies in childbearing age (Semer,

١٩٩٥). The most pronounced effect is seen in women over the age of ٤٥ years, where the relative frequency of patients is ١٠ times more than in those between the ages of ٢٠ and ٤٠ years. The maternal age of more than ٣٥ years is always a risk factor for complete molars, as the egg in the elderly woman becomes more susceptible to abnormal fertilization. This risk is twice as high in women of > ٣٥ years of age and from ٥-٧ times in the age of ٤٠ years (Pyrazine et al., ١٩٨٦).

The previous molar

A molar return is seen in about ١-٢٪ of cases (Pyrazine et al., ١٩٨٦). A case was reported in ١٩٧٣ of a woman who had nine consecutive molar pregnancies (Lorain, ١٩٨٧).

Nutritional, economic and social factors

A case-control study in Italy and the United States showed that a low-carotene diet was associated with an increased risk of complete molars (Pyrazine et al., ١٩٨٨). As well as areas with a high percentage of vitamins a deficiency and lack of fat necessary for its absorption (Berkowitz, ١٩٩٦). In addition, to the lack of protein in the diet, the incidence is high in groups with a low economic and social level, and high population density. It has been suggested that vascular aplasia occurs as a result of folic acid deficiency, which increases the incidence. The role of reproductive status, i.e. number of births, estrogen status, and oral contraceptives with regard to the risk of gestational trophic disease is not clear (Semer, ١٩٩٥). Likewise, for partial molars, there is limited information about the risk factors and their epidemiological characteristics.

١-٦ Clinical signs and symptom

It appears around the week (٦-٨) of pregnancy. it is the studied picture, and includes the following:

١- Vaginal bleeding

The most common symptom is ٩٧٪. The molar tissues may separate from the decidual membrane, rupture the blood vessels, and cause dilation of the uterine cavity with retained blood. Since vaginal bleeding can be profuse, half of these patients develop anemia (haemoglobin < ١٠ g/dl) (Berkowitz, ١٩٩٦). Macrocytic anemia is seen uncommonly because

nausea and vomiting are associated with the increased need for folate imposed by rapid multiplication of cells of the feeder layer.

٢- The uterus is enlarged in relation to the gestational age

It is present in only ٥٠٪ of the uterine cavity extending with both villi and trapped blood and is usually associated with a marked elevation of HGG due to an overgrowth of trophic tissue. Sometimes it is difficult to distinguish clinically between an enlarged uterus and large cysts and ovaries (Berkowitz, ١٩٨١).

٣- Preeclampsia

It is present in ٢٧٪ and develops exclusively in hypersized uteri ٨١٪ with significant HGG elevation and tonic seizures rarely occur (Cunningham et al., ١٩٩٧). The development of pre-return early in pregnancy (second trimester before ٢٤ weeks) should be alert to the possibility of molar pregnancy or to changes in molars and expansion capacity.

٤- Hyperemesis Gravid arum

It is especially severe in complete molars with uterine hyperextension and a high (HGG) ratio (١٤), and severe disorders require treatment with interstitial fluids and antiemetic treatment (Rose, ١٩٩٥).

٥- Hyperthyroidism

The clinically proven incidence rate is ٧٪ of complete molars. The most important manifestations are tachycardia, warm skin, and tremor (Pyrazine et al., ١٩٨٦). Laboratory elevations of (free thyroxine) and (triiodothyronine) in the serum and that the elevation of T٤ may be due to the effect of estrogen essentially the same as in normal pregnancy, but in this case free thyroxine is not elevated (Berkowitz, ١٩٩٦).

٦- Trophoblastic Embolization

Dyspnea occurs in ٢٪ of complete molars, usually in cases of large uterus with high HGG. It is believed that drug induction before emptying or hysterectomy may exacerbate the risk of trophic rupture (Lorain, ١٩٨٧).

٧- Theca Lutein Ovarian Cysts

They range from microscopic sizes to several centimeters in diameter. They have smooth surfaces, often yellowish, and are covered with luteinized cells. Their appearance ratio is (٢٥-٦٠) (Jones, ١٩٩٠).

٨- Spontaneous ejection

Sometimes, the molar vesicles that look like grapes pass spontaneously through the neck before the molar is surgically emptied, or spontaneous emptying of the vesicles occurs (spontaneous projection (Semer, ١٩٩٥).

١-٧ diagnosing a molar pregnancy

Diagnosis of a Germanic mole is very important because it has a high potential to cause choriocarcinoma (Cheung, ٢٠٠٣). The use of abdominal ultrasound in combination with a BHCG series is the best method for preventing morbidity and mortality from early pregnancy loss (Dresang, ٢٠٠٥). There is significant overlap in histological features between complete and partial hydatidiform mole. This leads to a large discrepancy in diagnosis (Fukunaga, ٢٠٠٤) and routine molecular analysis is impractical, thus immunohistochemistry is necessary to establish the correct diagnosis of molar pregnancy.

Diagnostic hydridosis mole can be detected early in two ways. Using ultrasonic and human chorionic gonadotropin (HCG) monitoring, however, it can be difficult to distinguish HM and residual products of pregnancy (RPOC) although there are some specific features which can differentiate HM types (Betel et al., ٢٠٠٦).

١- Ultrasound

Ultrasound is widely used in the diagnosis of molar pregnancy. Ultrasound is usually performed between (١٢-١٤) weeks of pregnancy in the first trimester of pregnancy. However, prior diagnosis of HMS with ultrasound is not always accurate, and the sample must be sent for histological examination for further evaluation. In some cases, complete and partial moles can be distinguished using ultrasound. However, diagnosing a partial mole using ultrasound is difficult compared to a complete mole (Reddy, ٢٠١٣). The hallmark of diagnosing a septate mole is a positive B-HCG pregnancy test (Hunter Christopher and Jay, ٢٠١١).

Titer HCG is considered high in the urine and has been reduced to ١ because ٢٠٠ to ١ in ٥٠٠ post ١٠٠ days of pregnancy is highly suggestive (Dutta, ٢٠١١). Approximately ٥٠٪ of patients are known to have high complete mole levels of human chorionic gonadotropin (HCG) more than ١٠٠,٠٠٠ IU/ML (Moon et al., ٢٠١٢). A retrospective analysis of molar pregnancies reported that

٧٥٪ of patients presented with vaginal bleeding with an enlarged uterus of ٥٤٪, and B-HCG levels were ١٠٠٪ excessively high.

١-٨ treatment

A molar pregnancy cannot continue as a normal. To prevent complications, the abnormal placental tissue must be removed. Millstones are recently terminated in small sizes and in good conditions due to improved diagnostic and management methods. Treatment usually consists of one or more of the following steps:

- Hysterectomy

It is possible to remove the uterus with the molar contained within it, if the patient desires surgical sterilization and does not wish to have children, and the ovaries can be preserved despite the presence of prominent cysts. Larger cysts may be aspirated. Hysterectomy is a logical procedure in a woman of ٤٠ years or older in the event that she does not want to have children due to the frequency with which malignant cancerous diseases arise in this age group. Although hysterectomy does not remove the trophic layer tumor and does not prevent metastases, it decreases significantly. The risk of disease recurrence is significant, and serum hGG levels should be monitored after surgery.

-Vacuuming by sucking

The dilatation and emptying by suction is the preferred technique for emptying the molar regardless of the size of the uterus. It is a safe, fast and effective procedure. Most of the molar tissues are removed with a simple rotation of the suction technique, with a decrease in the size of the uterus during emptying and the sample is sent for histopathology. After emptying, oxytocin is released. The surgeon can assist in uterine fusion with gentle stroking of the uterus during emptying, which also allows assessment of uterine size during emptying. Ultrasound during voiding can help determine complete emptying. It is also recommended to use ergotamine in the form of metrigine (٠.٢) with every (٢-٤) hs after emptying. Anti-D aminoglobulin should be given to A-negative patients. Frequent uterine emptying is not recommended because it does not reduce the risk of post-molar trophic neoplasia and can cause uterine perforation.

- Chemotherapy

Referral to specialized centers is generally preferred. Chemotherapy given as a single agent of no translocation or a low risk transgenic metastasis (Patient Score Total WHO ٦ or less). Metorex

and echinomycin are as effective as their combination, but Metorex is less toxic. Both of them achieve recovery. It needs hospitalization to start treatment. Theoretically, all women without transmission or at low risk are cured by these drugs if treated early. The patient is classified as high risk (total patient evaluation score according to WHO ٧ and more), combined chemotherapy with increased toxicity achieves cure rates between (٦٧-٨٥٪).

-Other emptying methods

Hysterectomy is used to empty the uterus only in rare cases. It causes greater blood loss and an increase in the incidence of persistent disease. In specific cases, In specific cases, a hysterectomy may be required.

Materials and methods

Patient samples:

The samples were ٥٦ randomly selected samples from patients with molar pregnancy (hydatid mole) between the ages of (١٤) and (٤٥) years. The samples include ٢٦ samples of complete molar pregnancy (CHM) and ٣٠ samples of partial molar pregnancy. ((PHM) Patient samples were collected from Al-Karama Teaching Hospital and Al-Zahra Teaching Hospital in Wasit Province, Iraq. The histological sections of the patients were examined with hematoxylin and eosin to confirm the type of disease. Clinical information including clinical examination and histopathological criteria including gender and age were obtained.

Results and Discussion

The number of samples was ٥٦ during the study period, with a description of patients' data by gender and age. Distribution of molar pregnancy patients according to tissue variables for patients (type of disease and age groups):

١.١ Distribution of molar pregnancy patients according to age group

This study included ٥٦ patients with molar pregnancy that was randomly taken from Al Zahraa Teaching Hospitals and Al Karama Teaching Hospitals. Their ages ranged between (١٤-٤٥) years. The patients were divided into four age groups (١-٤) with an interval of eight years. The first age group ranged from (١٤-٢١) years, the second age group (٢٢-٢٩), and the third age group (٣٠) - ٣٧), while the last age group ranged from (٣٨-٤٥) years.

Table (١) distribution of molar pregnancy patients according to age groups

Age group	Number	%
١-(١٤-٢١)	**٢٠**	٣٦٪
٢-(٢٢-٢٩)	**١٧**	٣٠٪
٣-(٣٠-٣٧)	**١٠**	١٨٪
٤-(٣٨-٤٥)	**٩**	١٦٪
TOTAL	**٥٦**	١٠٠٪

Estimating the age groups of the patients showed that (٢٠) (٣٦٪) patients were in the first age group (١٤-٢١), (١٧) (٣٠٪) were in the second age group (٢٢-٢٩), (١٠) (١٨) were in the third age group (٣٠-٣٧), (٩) (١٦) In the fourth age group (٣٨-٤٥), the minimum age was ١٤ years, while the maximum age was ٤٥ years. According to these results, the highest infection rate was in the first age group (١٤-٢١). We therefore found that HM was more common in younger patients.

Our results are consistent with the result of Katanga (٢٠١٣), when it was found that the prevalence of HM was high (٢٧.٥%) in the age group <٢٠ years, in which it was concluded that age between ١٥-٢٠ years was the only risk factor associated with the development of molar pregnancy. Also, our results were similar to (Shazly et al., ٢٠١٢), they showed that the incidence is higher in women younger than ٢٠ years of age, and contrasted with it in that the incidence is higher in women older than ٤٠ years of age. however. In contrast to these studies, which also showed increased risk in people over ٤٠ years of age, this pattern was not observed in this study. It has found that the incidence rate in the third and fourth age groups was low, perhaps due to early marriage in our society, and by the age of forty, most women completed their families. These contradictory results underscore the need for further studies involving a larger cohort of female patients with knowledge of the relationship between molar pregnancy and advanced maternal age.

The above results also showed that the incidence of the disease was also high in the second age group (٢-٢), and this means that the disease was more common in the reproductive age. Jaffer et al., (٢٠١١) mentioned in their study that the reproductive age of the mother is the most common risk factor for molar pregnancy in every region and ethnic group (Them et al., ٢٠٠٣). It was also mentioned that molar pregnancy is more common in the maximum reproductive age. However, the activity of the sex hormone and the maturation of the egg in the period between ١٤-٢٩ years may lead to a watery mole and constitute two risk factors mainly to increase the possibility of developing molar pregnancy, to be The woman is either too young or too old for

pregnancy (less than ٢٠ years old, or over ٣٥ years old), and has a previous history of molar pregnancies (Savage, ٢٠٠٨).

The causes of this condition are not fully understood but potential risk factors may include defects in the ovaries, intrauterine abnormalities, or nutritional deficiencies such as a diet low in protein, folic acid, and carotene (Jaffar, ٢٠١١). Another study was conducted in Singapore by Karachi and Nawabshah who suggested that German moles arise as a result of defective oocytes as they stated that the low socio-economic status of the patients plays an important role in the etiology of this disease (Jaffar, ٢٠١١). A study conducted by Tham also found that low socioeconomic status and malnutrition are the general cause of this disease (Nizamet el al., ٢٠٠٩).

Table (٢) Distribution of molar pregnancy patients by type of disease

Cases	Number	%	Total
CHM PATIENTS	٢٦	٤٦٪	٢٦
PHM PATIENTS	٣٠	٥٤٪	٣٠
TOTAL	٥٦	١٠٠٪	٥٦

Fifty-six female patients with molar pregnancy who were taken randomly, ٢٦ patients (٤٦) of them were found to have a complete Germanic mole (CHM), and ٣٠ patients (٥٤) had a partial Germanic mole (PHM) Table (٢). From the results, it was found that the percentage of patients with a complete Germanic mole to patients with a partial Germanic mole was (٤٦٪ - ٥٤٪), where the PHM was higher compared to CHM. This result agrees with the results of (Kitenge, ٢٠١٣) who noted that the prevalence of partial Germanic mole and partial Germanic mole. The full score was ١١.١ (١٨٠/٢٠) and ١.٧ (١٨٠/٣), respectively. However, Jaffaret et al., (٢٠١١) recorded that the CHM is higher compared to the PHM, and they found from ٦٠ cases of a Germanic mole, ٤٠ cases of a complete Germanic mole and ٢٠ cases of a partial Germanic mole. The above results are consistent with Abbas and Al-Khafaji (٢٠١٤) (Baghdad / Iraq) where sixty cases of molar pregnancies were obtained and classified into ٣٠ patients for each complete and partial mole.

Gupta (٢٠١٢) found that the incidence of CHM patients was equal to PHMS. Ali et al. (٢٠١٤) conducted another study during the period between January ٢٠١١-June ٢٠١٣ in Erbil/Iraq, on the pathology archives. In the teaching maternity hospital and some private pathological laboratories that proved that the number of partial molar pregnancies (n = ٢٤) is the same as the number of complete molar pregnancies (n = ٢٤).

Conclusions

The study was concluding that the age group under ٣٠ years is the most common type of German mole. A partial German mole is the most common type of German mole. Determination of risk factors associated with the occurrence of a Germanic mole in Wasit Province. The use of modern techniques as a routine test in hospitals to assist in the early diagnosis of HM disease. More studies with a large number of cases are needed to determine whether HM progresses to malignancy using molecular examinations. Early diagnosis before the molar size and age of pregnancy increase, improves prognosis; therefore, emphasis must be placed on training physicians and health workers to clarify the symptoms and signs of the disease and its initial management, with media support in order to make it known to the general public. Placement of patients who have had a molar evacuation through the abdomen under special observation, due to their need for chemotherapy at a high rate.

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