PARTIAL MOLAR PREGNANCY WITH A COEXISTING LIVE FETUS LEADING TO INEVITABLE ABORTION: A CASE REPORT

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ABSTRACT

BACKGROUND: The coexistence of a molar pregnancy with a viable fetus is rare and poses significant diagnostic and management challenges. Common symptoms include vaginal bleeding, anemia, hyperemesis gravidarum, hypertension, thyrotoxicosis, and disproportionate uterine enlargement to gestational age. While most such cases involve a complete mole, partial molar pregnancies with a coexisting fetus are extremely rare and usually result in miscarriage due to fetal triploidy.

CASE PRESENTATION: WWe report a case of a unbooked 26 year-old G7 P5+1, 5 alive Fulani woman presenting with severe vaginal bleeding and lower abdominal pain at 16 weeks gestation. Ultrasound confirmed a live fetus and revealed a large heterogeneous cystic mass suggestive of molar changes. She progressed rapidly to expel the fetus that died within few minutes and the placenta while suction evacuation was done to remove the remnant molar pregnancy. Histopathology confirmed a partial hydatidiform mole. Postabortal recovery was uneventful. B-hCG levels normalized within a month without intervention, and no evidence of persistent trophoblastic disease was found at six-month follow-up.

CONCLUSION: The case illustrates the rare occurrence of a partial molar pregnancy coexisting with a viable fetus, complicated by inevitable miscarriage and hemorrhage. Early recognition and multidisciplinary management are critical for optimizing outcomes.

KEYWORDS: Partial molar pregnancy, live fetus, inevitable miscarriage, vaginal bleeding.

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INTRODUCTION

Gestational trophoblastic disease (GTD) refers to a group of conditions characterized by abnormal proliferation of trophoblastic tissue.[1] Serum measurement of human chorionic gonadotropin (B-hCG), a hormone produced by trophoblasts, is essential for the diagnosis, management, and monitoring of GTD. Histologically, GTD can be classified into two main categories: non-molar trophoblastic neoplasms, which lack chorionic villi, and hydatidiform moles, which are defined by the presence of villi.[1]

According to the revised World Health Organization (WHO) classification of gestational trophoblastic disease, GTD is categorized into three groups: first is Hydatidiform moles, which include complete, partial, and invasive moles; second is Trophoblastic tumor-like lesions, such as placental site nodules and exaggerated placental site reactions; third is Trophoblastic tumors, comprising choriocarcinoma, placental site trophoblastic tumor (PSTT), and epithelioid trophoblastic tumor.[2]

A complete mole is defined by the complete replacement of normal placental tissue with grossly enlarged, hydropic chorionic villi and absence of a fetus. In contrast, a partial mole involves partial replacement of placental tissue with hydropic villi and the presence of abnormal fetal parts. These pregnancies typically terminate during the first trimester.[3] In such cases, the fetus is rarely viable at the time of diagnosis and often presents with severe congenital anomalies due to triploidy. Prognosis is generally poor due to a limited functional placenta and significant intrauterine growth restriction.[3]

Partial molar pregnancy with a coexisting live fetus is extremely rare, particularly in singleton pregnancies, and excludes cases involving multiple gestations. The estimated incidence of a viable fetus with a partial molar placenta range from 0.005% to 0.01% of all pregnancies.[4] This rare entity has been classified into three distinct types: Twin pregnancy with one normal fetus and placenta, and a coexisting complete mole (most common); Twin pregnancy with one normal fetus and placenta, and a coexisting partial mole; Singleton pregnancy with a partial molar placenta and a live fetus (least common).

In this report, we present the case of a 26-year-old unbooked woman who presented at 16 weeks of gestation with severe vaginal bleeding and lower abdominal pain. Ultrasound examination confirmed the presence of a live fetus and a large heterogeneous cystic mass consistent with molar changes.

Case Presentation

A 26years old unbooked G7P5+1 5 Alive Fulani woman who presented with Amenorrhea of 16weeks, profuse vaginal bleeding and lower abdominal pain of a day duration. There was associated dizziness, generalized body weakness and palpitation. She had a history of one spontaneous complete miscarriage at 8 weeks' gestation two years previously but had no previous history of molar pregnancy or contraceptive use.

Examination revealed conscious but lethargic young woman, severe pallor, tachycardia with a pulse rate 120 beats/min and blood pressure of 110/60mmHg. Uterus was 28 weeks size and contractions felt. Vaginal examination revealed cervical dilatation was 5cm and fully effaced.

On admission, her packed cell volume (PCV) was 16%, indicating severe anaemia and necessitating immediate resuscitation. She received two units of compatible whole blood during initial resuscitation and a further two units following uterine evacuation. Transabdominal ultrasonography demonstrated a live intrauterine fetus and a large heterogeneous multicystic placental mass with diffuse cystic spaces, highly suggestive of molar degeneration [figure 1a & 1b]. The pre-evacuation β-hCG concentration was 21,260.9 IU/L, which decreased dramatically to 1,082.49 IU/L within 48 hours following suction evacuation and subsequently became undetectable within one month.

Other investigations, including liver function tests, serum electrolytes, urea and creatinine levels, and chest radiography, were within normal limits. She spontaneously expelled a female abortus within 5 hours of admission. The placenta and fetal membranes were expelled together, following which suction evacuation was performed, yielding copious grape-like vesicular tissue consistent with molar degeneration [Figure 2a & 2b].

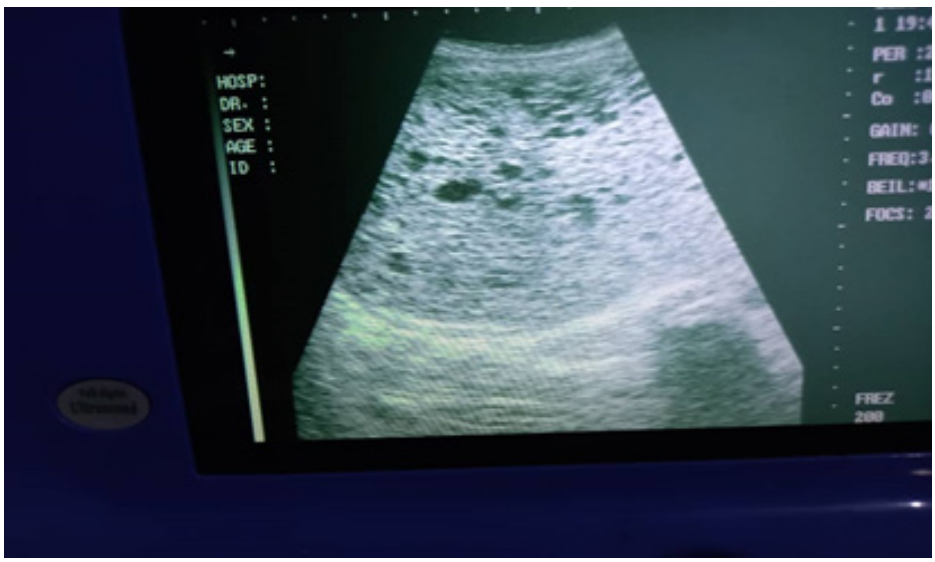

Figure 1a: Transabdominal ultrasonography picture of partial mole

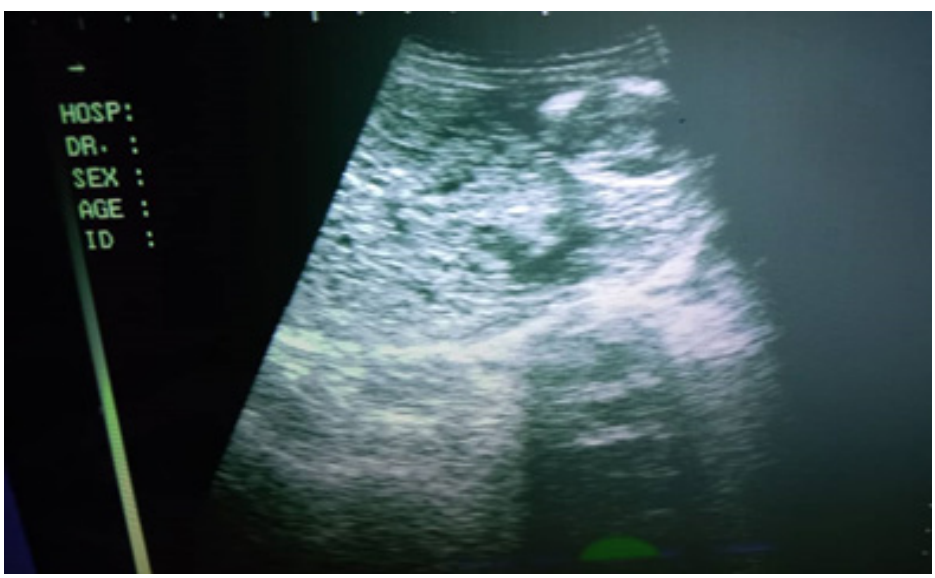

Figure 1b: Transabdominal ultrasonography at 16 weeks of gestation showing partial mole with fetal head

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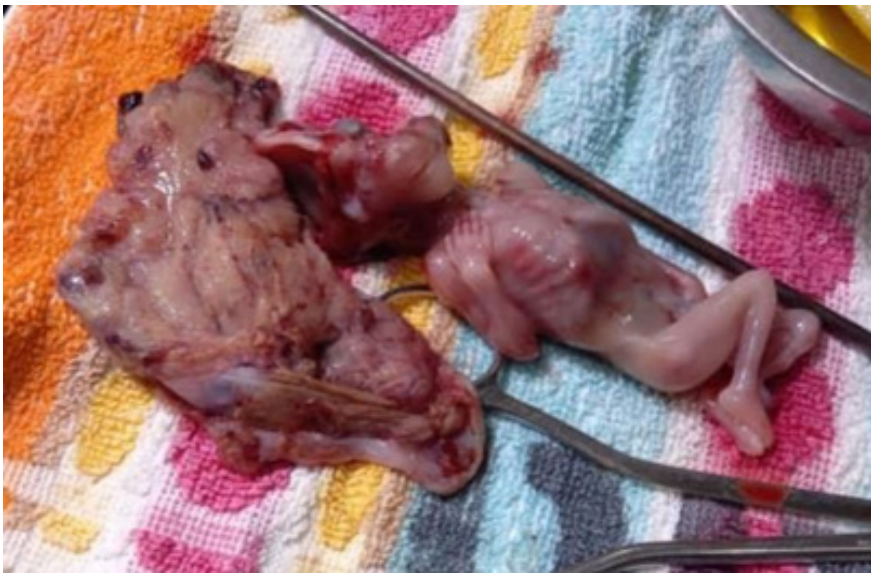

Figure 2a: shows the picture of the abortus and the placenta

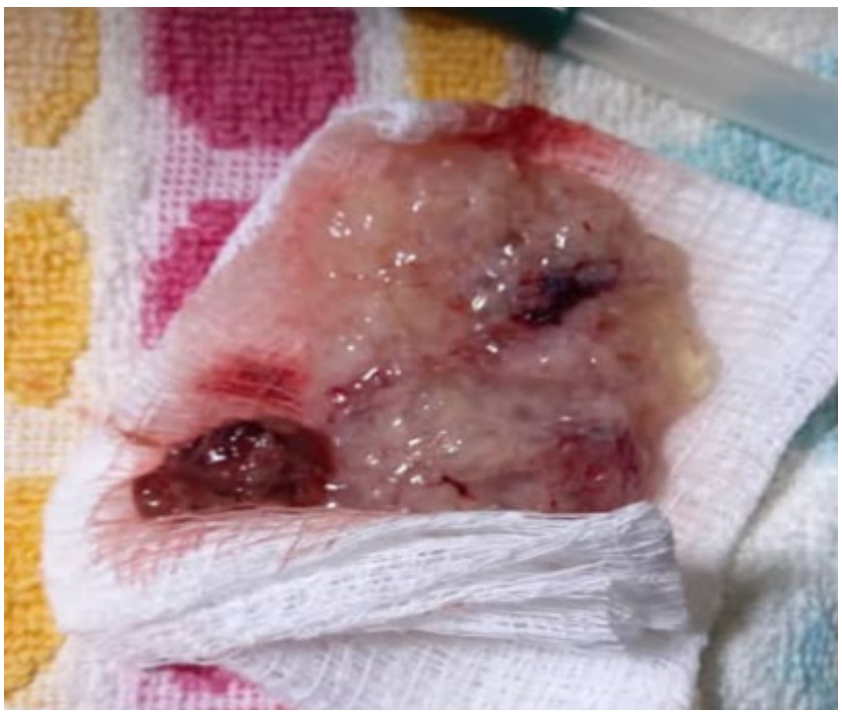

Figure 2b: Shows picture of the cystic mass (partial mole)

The mother's vital signs became normal and stable after resuscitation. Histopathological examination demonstrated two distinct tissue components. The placental tissue associated with the fetus showed normal villous architecture (figure 3), whereas the separately evacuated vesicular tissue demonstrated hydropic chorionic villi with focal trophoblastic hyperplasia consistent with a partial hydatidiform mole (figure 4). These findings were suggestive of a twin gestation comprising a normal fetus with a separate coexisting partial hydatidiform mole.

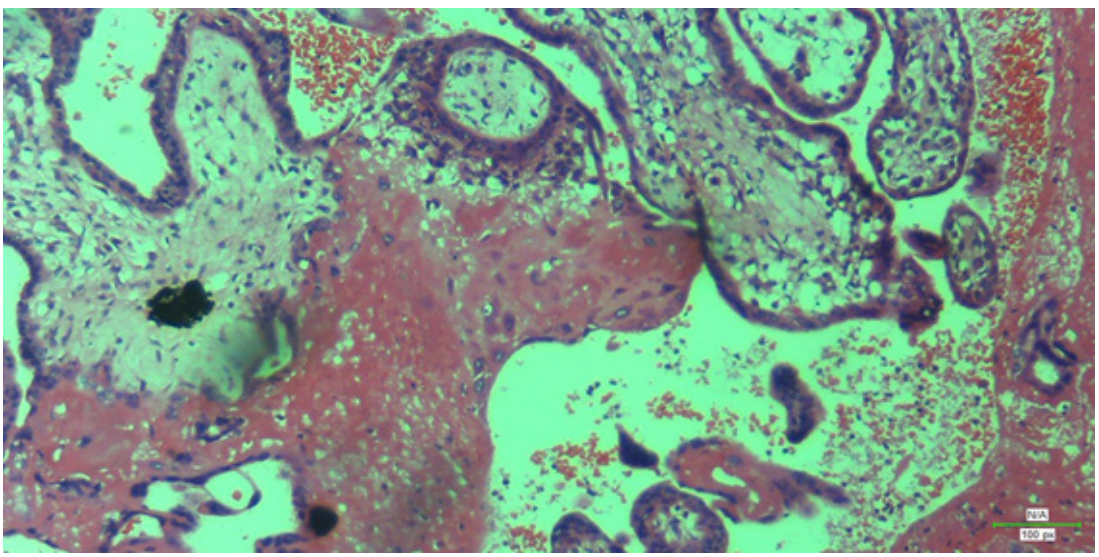

Figure 3: Histopathological picture of the placenta showing normal chorionic villi

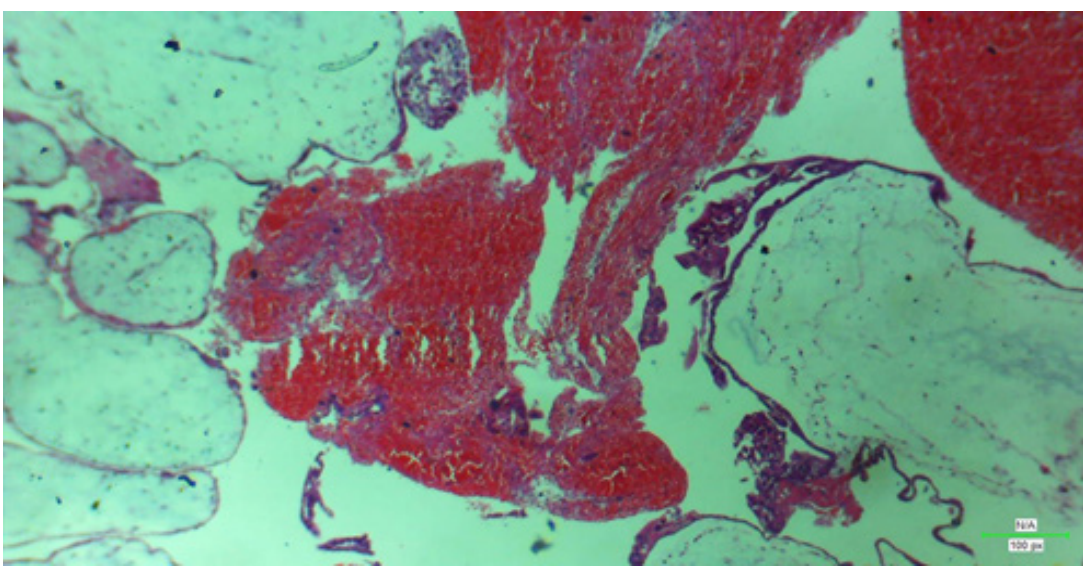

Figure 4: Histopathological picture of the cystic mass (partial mole)

Following uterine evacuation, the patient was enrolled in a post-molar surveillance programme in accordance with current FIGO recommendations. Serial serum β-human chorionic gonadotropin (β-hCG) measurements showed a marked decline from a pre-evacuation level of 21,260.9 mIU/mL to 1,082.49 mIU/mL 48 hours after evacuation. The weekly β-hCG concentration continued to decrease steadily and became undetectable (<5 mIU/mL) within 4 weeks. An intrauterine contraceptive device (IUCD) was inserted after serum β-hCG levels had returned to normal. After three consecutive weekly undetectable β-hCG results, surveillance was continued at 4-week intervals for six months. Throughout the follow-up period, serum β-hCG levels remained undetectable, and pelvic ultrasonography demonstrated complete resolution of the uterine lesion with no retained products of conception or evidence of recurrent or persistent gestational trophoblastic disease. The patient remained clinically well throughout follow-up and required no additional treatment.

DISCUSSION

The present case involved a 26-year-old Fulani woman, gravida 7 para 5+1, who presented at 16 weeks' gestation with heavy vaginal bleeding and lower abdominal pain. Although extremes of maternal age (<20 years and >40 years) have traditionally been associated with GTD, recent systematic reviews indicate that partial molar pregnancies with coexisting fetuses can occur in women within the normal reproductive age group, similar to our patient[10,13]. Likewise, while ethnicity has not been established as an independent risk factor, reports from sub-Saharan Africa remain scarce, making this case an important contribution to the limited African literature on this uncommon condition.

Our patient had experienced one spontaneous miscarriage at 8 weeks' gestation two years before presentation. Although a previous molar pregnancy is the strongest recognised reproductive risk factor for recurrence, women with previous spontaneous pregnancy losses may also have a slightly increased risk of abnormal conceptions[9,10]. Nevertheless, most reported cases of partial mole with a coexisting fetus, including ours, occur without a preceding history of gestational trophoblastic disease[10,14].

The clinical presentation observed in this case is consistent with findings reported in recent systematic reviews. Vaginal bleeding remains the most frequent presenting symptom, occurring in more than 80% of patients with molar pregnancy, while abdominal pain and excessive uterine enlargement are also common manifestations resulting from rapid trophoblastic proliferation and placental degeneration[10,11]. Our patient presented with profuse vaginal bleeding, abdominal

pain, severe anaemia requiring transfusion of four units of blood, and a Symphysiofundal height corresponding to 28 weeks despite a gestational age of only 16 weeks. The marked discrepancy between uterine size and gestational age was attributable to the large volume of molar tissue occupying the uterine cavity and has been consistently reported in similar cases[10,12].

Ultrasonography plays a pivotal role in the antenatal diagnosis of molar pregnancy. In the present case, transabdominal ultrasonography demonstrated a viable 16-week fetus together with a distinct heterogeneous multicystic intrauterine mass suggestive of molar degeneration. This characteristic appearance has been described in several recent case reports and systematic reviews and should alert clinicians to the possibility of a coexisting molar pregnancy, particularly when accompanied by vaginal bleeding and uterine enlargement greater than expected for gestational age[10–12]. Nevertheless, differentiation from placental mesenchymal dysplasia or a complete mole with a coexisting normal fetus may remain difficult on imaging alone, underscoring the importance of histopathological confirmation[9,10].

Unlike many reported cases in which conservative management is attempted to improve fetal viability, our patient presented with inevitable miscarriage, evidenced by heavy vaginal bleeding, cervical dilatation, and complete cervical effacement. She spontaneously expelled a fresh stillborn female fetus and placenta within five hours of admission, while the remaining grape-like vesicular tissue required suction evacuation. Similar pregnancy losses have been reported in the literature, where extensive molar degeneration compromises placental function, ultimately resulting in spontaneous miscarriage or fetal demise before fetal viability[10,13,14]. This case therefore reinforces the poor fetal prognosis associated with partial molar pregnancy complicated by significant placental involvement.

Histopathological examination remains the gold standard for diagnosing and differentiating partial from complete hydatidiform mole[9]. In our patient, examination of the placenta demonstrated normal placental tissue, whereas the separately evacuated vesicular tissue showed features consistent with a partial hydatidiform mole. These findings strongly suggest a twin gestation comprising a normal fetus coexisting with a partial molar pregnancy, a phenomenon that has been described only rarely in the literature[10,14]. Correlation between clinical findings, ultrasonography, and histopathology was therefore crucial in establishing the diagnosis.

Serial serum β-human chorionic gonadotropin (β-hCG) monitoring is fundamental in post-molar surveillance because persistent gestational trophoblastic neoplasia may occur despite successful uterine evacuation[9]. Although β-hCG concentrations in partial moles are generally lower than those observed in complete moles, the rate of decline following evacuation is a more reliable indicator of disease resolution[9,10]. In this case, the pre-evacuation β-hCG concentration was 21,260.9 IU/L, which decreased dramatically to 1,082.49 IU/L within 48 hours following suction evacuation and subsequently became undetectable within one month. This rapid biochemical resolution is comparable to findings reported in recent case reports, in which complete remission occurred following prompt evacuation and careful follow-up without progression to gestational trophoblastic neoplasia[10,14]. Furthermore, pelvic ultrasonography

performed six months after treatment demonstrated no retained products of conception or evidence of recurrence, confirming successful management.

This case underscores the importance of maintaining a high index of suspicion for molar pregnancy in women presenting with uterine enlargement disproportionate to gestational age, heavy vaginal bleeding, and a viable fetus with a multicystic placental lesion on ultrasonography. Early recognition, prompt haemodynamic stabilisation, appropriate uterine evacuation, histopathological confirmation, and serial β-hCG surveillance remain the cornerstones of management and are essential for reducing maternal morbidity and ensuring early detection of persistent trophoblastic disease[9,11].

Conclusion

Partial hydatidiform mole with a coexisting viable fetus is an exceptionally rare and diagnostically challenging obstetric condition. This case demonstrates that the coexistence of a viable fetus should not exclude the diagnosis of molar pregnancy when clinical features such as excessive uterine enlargement, heavy vaginal bleeding, and characteristic ultrasonographic findings are present. Early diagnosis, prompt maternal stabilisation, appropriate evacuation of molar tissue, histopathological confirmation, and diligent serial β-hCG surveillance are critical to achieving favourable maternal outcomes and preventing persistent gestational trophoblastic neoplasia. Greater awareness among obstetricians, particularly in low-resource settings, may facilitate earlier recognition and improve both maternal and fetal outcomes.

Abbreviations

B -hCG	Beta human chorionic gonadotropin;
GTD	Gestational Trophoblastic Disease;
PSTT	placental site trophoblastic tumors;
PCV	Packed Cell Volume;
WHO	World Health Organization;
BPD	Biparietal Biameter

Ethics Approval and Consent to Participate

Ethical approval was waived by the ethical committee of Bowen University Teaching Hospital, Ogbomoso, Oyo State, Nigeria. Written informed consent was obtained from the patient for the publication of this case report and accompanying images.

REFERENCES

1. Cunningham FG, Leveno KJ, Bloom SL, Dashe JS, Hoffman BL, Casey BM, Spong CY, et al. Williams Obstetrics. 27th ed. New York: McGraw Hill; 2024.
2. Akhtar N, Karim S. Molar pregnancy along with normal fetus – a case report. Bangladesh J Obstetrics Gynaecol. 2015;30(2):113–115.
3. Hsieh CC, Hsieh TT, Kuo DM, Lo LM, Hung TH. Delivery of a severely anaemic fetus after partial molar pregnancy: clinical and ultrasonographic findings. Hum Reprod 1999; 14:1122- 1126.
4. Agarwal R, Agarwal S, Roy KK. Diploid partial mole with neonatal survival: a case report. Indian J Pathol 2005 April; 48:225-227.
5. Kurman RJ et al. Gestational Trophoblastic Disease. Mills S.E. (ed) Sternberg's Diagnostic Surgical Pathology. 6th edition. Wolters Kluwer; 2015. pp. 2297-2319.
6. Guevara BF. Molar pregnancy with co-existing viable foetus delivered molar pregnancy with co-existing viable foetus delivered preterm at 27 weeks gestation. Waqainabete. 2021;22–25.
7. Sma A. Delivering a live fetus at 24th week gestational week: a case of partial imedpub journals delivering a live fetus at 24 th week gestational week: a case of partial hydatidiform molar pregnancy abstract. Gynecol Obstet Case Rep. 2021; 7:137.
8. Suzuki M, Matsunobu A, Vakita K, Osanai K. Hydatidiform mole with surviving co-existent fetus. Ombt Gynecol 1980; 56:384-388.
9. Ngan HYS, Seckl MJ, Berkowitz RS, Xiang Y, Golfier F, Sekharan PK, et al. Update on the diagnosis and management of gestational trophoblastic disease. Int J Gynaecol Obstet. 2021;155(Suppl 1):86-93.
10. Mangla M, Kaur H, Khoiwal K. Partial mole with coexistent live fetus: A systematic review of case reports. J Turk Ger Gynecol Assoc. 2022;23(2):83-94.
11. Wang G, Cao J, Xu X, Han X, Cui H. Delivery management of a complete hydatidiform mole with co-existing viable fetus: A systematic review and meta-analysis. J Gynecol Obstet Hum Reprod. 2022;51(1):102269.
12. Hajri T, Massoud M, Vergne M, Descargues P, Allias F, You B, et al. Multiple pregnancy with complete hydatidiform mole and coexisting normal fetus: Cohort analysis and maternal and fetal outcomes. Am J Obstet Gynecol. 2024;230(3): 362.e1-362.e8.
13. Zorzato PC, Ricci A, Bosco M, Galli L, Luka L, Porcari I, et al. Hydatidiform mole with coexisting normal pregnancy: a systematic review and individual participant data meta-analysis. Medicina (Kaunas). 2025;61(10):1781. doi:10.3390/medicina61101781.
14. Karimi M, Alizadeh A. Partial hydatidiform mole coexists with a living fetus: a case report. J Med Case Rep. 2025; 19:638. doi:10.1186/s13256-025-05646-9.