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Choriocarcinoma Secondary to a Normal Pregnancy: About 2 Cases at University Hospital of Treichville (Côte d'Ivoire, West Africa)

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Abstract

A choriocarcinoma occurring during postpartum of a normal pregnancy is a rare situation and the foeto-maternal prognosis is unspecified. The report aims to focus on describing the diagnostic and therapeutic difficulties encountered in our African context. The first case is about a twenty-year-old primiparous who, following a normal childbirth, presented persistent metrorrhagias from the seventh day post-delivery. She benefited from 2 aspirations because of suspicion of placental retention, but the bleeding resumed six months later then she was transferred in our structure where we confirmed the diagnosis of choriocarcinoma FIGO stage III. The second case concerns a 29-year-old lady with Gestity: 2, Parity: 2, without particular story. She underwent caesarian for macrosomia of a full-term pregnancy. She delivered a new-born male gender, APGAR score: 8 - 9 and a placenta healthy macroscopically. The immediate postpartum period was normal. Two months later, she presented abundant metrorrhagias which were confirmed as choriocarcinoma with pulmonary metastases.

Keywords

Gestational Choriocarcinoma, Management, Normal Delivery

1. Introduction

Gestational choriocarcinoma (GC), which represents one of the malignant forms of GTDs, is an uncommon condition. It is classically associated with a molar preg-

nancy (75%), an ordinary abortion (22.5%), an ectopic pregnancy and exceptionally to a normal pregnancy [1]. Its management, which in the past posed a problem especially in unusual forms, is nowadays the subject of recommendations established by FIGO since 2000 [2].

The occurrence of this condition after a normal pregnancy, which is a rare situation, often poses problems of delayed diagnosis, which darkens the prognosis, especially in our countries with limited resources. We report our experience of the management of 2 rare cases of secondary choriocarcinoma during normal childbirth, with the aim of describing the diagnostic and therapeutic difficulties encountered.

2. Observation

2.1. Observation 1

Mrs. K D, 20 years old, G1P1, with no particular history, was referred to us for suspicion of gestational trophoblastic disease.

Her history revealed that she was a carrier of a pregnancy that proceeded normally and then at term she delivered vaginally, an apparently healthy child, weighing 3200g, with an APGAR 8.9 without macroscopic abnormalities of the placenta. She had not received postpartum contraception.

On D7 postpartum she consulted for profuse metrorrhagia which was attributed to placental remains after physical and ultrasound examination. A uterine evacuation was performed but the aspect of the evacuated tissues was not specified and the histological analysis was not done.

Two days later the bleeding resumed and a second uterine evacuation was performed causing uterine perforation. An emergency laparotomy with hysterorrhaphy was performed.

6 months after delivery, she presented again with metrorrhagia for which an ultrasound performed evoked a choriocarcinoma in front of the visualization of an intrauterine tissue mass. She was then transfused and evacuated to our service (**Figure 1**).

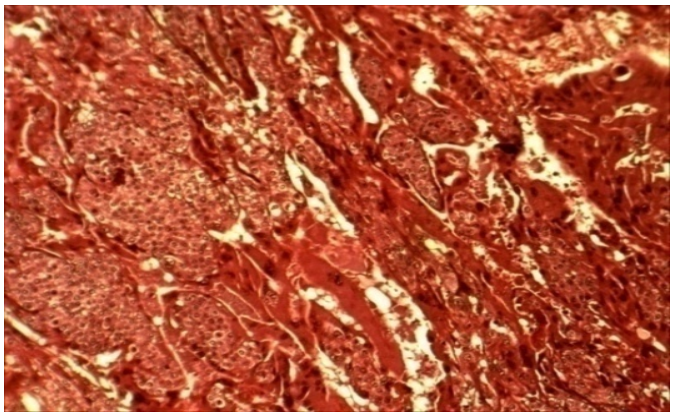

Figure 1. Histological aspect of the choriocarcinoma of observation 1.

When she was admitted to our service, she was in a state of shock. Speculum examination revealed minimal intrauterine bleeding, with a cervix invaded by necrotic tissue from the endocervix and an apparently healthy vagina.

On vaginal examination the cervix was irregular, infiltrated, open 1 finger wide, with perception of intracavitary tissue and a uterus of approximately 18 - 20 weeks. The recto vaginal septum was free on digital rectal examination coupled with vaginal examination. The diagnosis of gestational choricarcinoma was evoked in view of these signs.

The biological assessment requested, revealed a hemoglobin level of 4 g/dl, the prothrombin at 30%, the βHCG at 37,800 IU. The chest x-ray performed revealed left paracardiac alveolar pneumonitis raising suspicion of metastasis. The other explorations requested in urgency MRI, CT, and Histology could not be made in front of the unstable hemodynamic state of the patient. She immediately benefited from a blood transfusion but the day after her admission she presented with a cataclysmic hemorrhage causing her death. Post-mortem autopsy confirmed the diagnosis of choriocarcinoma by histology.

2.2. Observation 2

Mrs T S aged 29 G2P2, with no particular history, was evacuated to us for suspected trophoblastic tumour.

During her last pregnancy, she only performed 2 PNCs and did not present any particular abnormalities. At term, she was cesareaned for macrosomia with the birth of an apparently healthy newborn weighing 4300 g, male, APGAR 8.9 and a macroscopically healthy placenta. The immediate follow-up was simple and she was discharged on D4 under a contraceptive implant. Two months later she consulted for profuse metrorrhagia for which the physical and ultrasound examination revealed intrauterine ovular debris. She then benefited from a uterine aspiration which brought back tissues of the type of a bunch of grapes raising the suspicion of a gestational trophoblastic disease, motivating her transfer to our structure.

On admission to our department (2 months post caesarean section), the clinical examination revealed severe non-decompensated anemia, the cervix and vagina apparently healthy on the speculum, a uterus of size 12 SA, traces of blood on the fingertip.

The biological assessment carried out objectified an Hb level at 6.5 g/dl, βHCG at 314,012 mIU/ml. The thoraco-abdominopelvic MRI came back in favor of lung metastases in balloon release, low abundance ascites, invasion of the cervix, uterus, parameters, bladder and rectum. The histology of the uterine evacuation product was consistent with a choriocarcinoma, which was classified FIGO staging III and high-risk gestational trophoblastic neoplasia.

She received blood transfusions, then polychemotherapy based on EMA-CO (Etoposide, Methotrexate, Actinomycin D, Cyclophosphamide and Oncovin).

Bleeding stopped and βHCG negativation was confirmed after 5 courses of polychemotherapy. After this confirmed negativation, the βHCG level remained

negative during the 6-monthly monitoring assays. This monitoring should continue over the next 6 months.

3. Discussion

Gestational choriocarcinoma is an uncommon condition, and the subject of few publications. In Senegal, Cissé found that it represented only 5.5% of GTDs in his series, and in London, Jiao found an even lower frequency (0.03%) [3] [4]. This condition typically occurs following a molar pregnancy, and rarely after a full-term pregnancy with the birth of a live child. In Morocco, Boufettal observed only 2 cases of choriocarcinoma secondary to normal pregnancy over a period of 6 years, and elsewhere different authors reported observations of 1 clinical case [5]-[7].

The mechanism of occurrence of this condition in the aftermath of a normal pregnancy is unknown but the theory of dizygotic twinning mentioned by some authors is plausible. This theory describes a pregnancy with one twin having a normal placenta and the other having complete mole-like cystic degeneration of her trophoblast [7] [8]. The evolution of the twin with the normal placenta is towards the possibility of a live birth and that of the other towards a GTT observed in the postpartum.

During pregnancy, the diagnosis of this particularity is difficult, because it can be asymptomatic or marked by mild clinical signs not specific to a molar pregnancy. Ultrasound is of little contribution, visualizing a normal fetus and placenta, which may be associated with a cystic mass attached to the placenta representing the complete mole of the 2nd twin.

Faced with the presence of this atypical mass, an MRI should be performed for diagnostic and prognostic purposes because it can look for early signs of invasion of the myometrium.

Diagnosis after delivery is also difficult. Macroscopic examination of the placenta may be normal or marked by the presence of non-specific lesions which must require histological examination.

In immediate childbirth suites, the early onset of bleeding is often set against retained cotyledons, as were the 2 observations reported.

Also, in the FIGO recommendations, this condition should be considered in the presence of any persistent postpartum bleeding, especially beyond 6 weeks, and in the presence of any metastasis without a known primary cancer [2].

In France Mailly reported a case revealed by pulmonary metastases 3 weeks after a normal delivery [7].

Also, the assay of βHCG, which is not systematic after a normal delivery, must be carried out in the event of any suspicious case and its kinetics must be checked and interpreted according to the recommendations of FIGO.

Regarding the treatment, it is well codified by FIGO, and is based on chemotherapy with well-established indications and modalities. A hysterectomy may be associated with it in the event of resistance to chemotherapy or in the event of difficulty in controlling bleeding.

The monitoring which must be done under oral contraception is done by the regular dosage of HCG according to a pattern identical to all MTG.

The maternal prognosis depends on the time taken for treatment, the abundance of bleeding and the precocity of metastases (lung-liver-brain).

Berkowitz estimates that 5-year survival is 100% at the stage of localized disease and 85% at the stage of metastasis [9].

Subsequently, pregnancies are possible, but there is a risk of gestational trophoblastic diseases.

As for the newborn, it is exposed to malformations and a risk of neonatal choriocarcinoma. He will have to be under surveillance for up to 6 months in search of visceral involvement. Mailly observed the occurrence of digestive hemorrhage with pulmonary involvement at 5 weeks of life in newborns [7].

4. Conclusion

GC occurring in the aftermath of a normal pregnancy is a rare event and is generally diagnosed late. Maternal and fetal prognosis depends on the precocity of management requiring a good knowledge of the suggestive signs. The treatment is well codified and is based on chemotherapy as for all persistent trophoblastic tumors (PTT).

Patient Consent

Written informed consent was obtained from the patient for the presentation of her case and the publication of the associated images, in accordance with the journal's ethical guidelines.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] El Mesbahi, O., El Ghissassi, B., Tournigand, C. and Errihani, H. (2007) Choriocarcinome trophoblastique. *La Lettre du Cancérologue*, **16**, 136-140.

[2] FIGO Oncology Committee (2002) FIGO Staging for Gestational Trophoblastic Neoplasia 2000. *International Journal of Gynecology & Obstetrics*, **77**, 285-287. https://doi.org/10.1016/s0020-7292(02)00063-2

[3] Cisse, C.T., Lo, N., Moreau, J.C., Fall-Gaye, C., Mendez, V. and Diadhiou, F. (2002) Choriocarcinome au Sénégal: Épidémiologie, pronostic et prévention. *Gynécologie Obstétrique & Fertilité*, **30**, 862-869. https://doi.org/10.1016/s1297-9589(02)00456-3

[4] Jiao, L., Ghorani, E., Sebire, N.J. and Seckl, M.J. (2016) Intraplacental Choriocarcinoma: Systematic Review and Management Guidance. *Gynecologic Oncology*, **141**, 624-631. https://doi.org/10.1016/j.ygyno.2016.03.026

[5] Boufettal, H., Khalkane, L., Noun, M., Hermas, S. and Samouh, N. (2014) Le choriocarcinome gestationnel à l'hôpital Ibn rochd de casablanca, 2004-2010. *Eastern Mediterranean Health Journal* (*EMHJ*), **19**, 208-212.

[6] Iloki, L.H., Gbala-Sapoulou, M.V. and Kocko, I. (1996) Choriocarcinome après un

accouchement normal. A propos d'un cas observé à Brazzaville. *Médecine Tropicale*, **56**, 170-172.

[7] Mailly, N., Delord, J., Dubois, A. and Gandia, P. (2008) Choriocarcinome placentaire métastatique chez la mère et son nouveau né: À propos d'un cas. *Journal de Radiologie*, **89**, 517-520. https://doi.org/10.1016/s0221-0363(08)71458-6

[8] Sauvestre, F., Carles, D., Faure, M., Taillat, F., Le Boulanger, F., Castain, C., *et al.* (2014) Choriocarcinome gestationnel intra-placentaire de découverte fortuite sur un placenta à terme. *Annales de Pathologie*, **34**, 119-123. https://doi.org/10.1016/j.annpat.2014.02.009

[9] Berkowitz, R.S. and Goldstein, D.P. (1996) Chorionic Tumors. *New England Journal of Medicine*, **335**, 1740-1748. https://doi.org/10.1056/nejm199612053352306