MANAGEMENT OF MOLAR PREGNANCIES - FULL CLINICAL GUIDELINE

Reference No.: UHDB/Gynae/03:24/M3

Contents

1. Introduction

Gestational trophoblastic disease (GTD) forms a group of disorders spanning the conditions of complete and partial molar pregnancies through to the malignant conditions of invasive mole, choriocarcinoma and the very rare placental site trophoblastic tumour (PSTT).
Molar pregnancies can be subdivided into complete (CM) and partial moles (PM) based on genetic and histopathological features. Complete moles are diploid and androgenic in origin, with no evidence of fetal tissue. Partial moles are usually (90%) triploid in origin, with two sets of paternal haploid genes and one set of maternal haploid genes. In a partial mole, there is usually evidence of a fetus or fetal red blood cells.
Trophoblastic disease is an uncommon complication of pregnancy; about one in every 700–800 pregnant women will develop a molar pregnancy. Women from Asia having a higher incidence compared with non-Asian women (1/387 versus 1/752 live births).

2. Purpose and Outcomes

To provide guidance on the management of suspected partial or complete molar pregnancy and management of confirmed molar pregnancy on histology within the gynaecology speciality.

3. Abbreviations

BhCG - Beta Human Chorionic Gonadotrophin
ERPoC - Evacuation Retained Products of Conception
CM - Complete Mole

GOPD	-	Gynaecology Outpatient Department
GTD	-	Gestational Trophoblastic Disease
PM	-	Partial Mole
PSTT	-	Placental Site Trophoblastic Tumour
USS	-	Ultrasound Scan

4. Definitions Used

Molar pregnancy	Proliferation of trophoblastic tissue (hydatidiform mole) within the uterus as a result of abnormal fertilization. Usually benign, but occasionally can progress to the highly invasive choriocarcinoma.
USS	Ultrasound Scan
OCP	Oral Contraceptive Pill
IUCD	Intra-Uterine Contraceptive Device

5. Management of Molar Pregnancies

5.1 Diagnosis

Molar pregnancies may present with irregular vaginal bleeding in early pregnancy, hyperemesis, excessive uterine enlargement, and early failed pregnancy. Ultrasound may have characteristic appearances. Diagnosis can only be confirmed following histological assessment of curetting's. Occasionally there may be a twin pregnancy; one of which is molar or partial moles may be seen with a fetus present. In these cases USS should be repeated by a fetal medicine consultant. Management of these cases may be discussed with the regional trophoblastic centre (Sheffield). The majority of histologically proven complete moles are associated with an ultrasound diagnosis of delayed miscarriage or anembryonic pregnancy.

If a molar pregnancy is suspected on ultrasound scan, do a serum HCG estimation to aid diagnosis

5.2 Initial management

In confirmed/suspected partial or complete molar pregnancy; surgical evacuation of uterus should be undertaken by a Consultant or an experienced registrar.

Suction curettage is the method of choice of evacuation for complete molar and partial molar pregnancies except when the size of the fetal parts deters the use of suction curettage and then medical evacuation can be used.

Preparation of cervix immediately prior to evacuation is safe; however prolonged cervical preparation, particularly with prostaglandins, should be avoided where possible to reduce the risk of embolisation of trophoblastic cells.
The use of oxytocin infusion prior to completion of the evacuation is not recommended
If the woman is experiencing significant haemorrhage prior to evacuation, surgical evacuation should be expedited, however if significant haemorrhage occurs prior to or during evacuation, and the need for oxytocin infusion considered against the risk of tumour embolisation.

There is almost always a role for urgent surgical management for the women who is experiencing heavy or persistent vaginal bleeding causing acute haemodynamic compromise, particularly in the presence of retained tissue on ultrasound.

Anti-D prophylaxis is required for Rhesus negative patients following evacuation of a molar pregnancy. Click here for full guidelines if woman is Rhesus D Negative
All women who have treatment for a miscarriage or termination should be advised to perform a urinary pregnancy test after 3 weeks and contact the GAU/EPAU if the test is positive.

All curetting's must be sent for histological examination, ensure that HCG result, gestational age & USS findings are included on the histopathology request form.

The histological assessment of material obtained from the medical or surgical management of all failed pregnancies is recommended to exclude trophoblastic neoplasia and this also includes re-evacuation after any type of pregnancy.

There is no clinical indication for a 2nd routine evacuation in a confirmed molar pregnancy. There may be a role for a second evaluation in selected cases where the HCG is less than 5000 U/L, it is prudent to discuss these cases with Sheffield.
Where symptoms persist or where concerns remain; repeat an USS and BHCG and consult Sheffield about the need for surgical intervention.

Referral to a GTD centre should be considered for all women with persistently elevated hCG either after an ectopic pregnancy has been excluded, or after 2 consecutive treatments with methotrexate for a pregnancy of unknown location.

A urine hCG test should be performed in all cases of persistent or irregular vaginal bleeding lasting more than 8 weeks after a pregnancy test.

5.3 Follow up

All women with molar pregnancy should be seen in GAU 2 weeks after ERPC and care discussed with the Consultant.

All women diagnosed with molar pregnancy should be provided with written information about the condition and the need for referral for follow-up to a trophoblastic screening centre should be explained.

Registration of women with molar pregnancy represents a minimum standard of care.

Registration forms for the Sheffield Trophoblastic Disease Centre should be completed by the Consultant responsible or a delegated junior doctor; register on line – nww.h-mole.nhs.uk

Women should be advised to adhere to requests from Sheffield for any further investigations and to their advice on when to try to conceive again, should they wish to.

Give information & contact details of Trophoblastic centre:
Trophoblastic Screening & Treatment Centre
Weston Park Hospital
Waltham Rd
Sheffield S10 2SJ
Tel: 0114 226 5205
Fax: +44 (0) 114 226 5511
Website: www.chorio.group.shef.ac.uk/index.html

For complete molar pregnancy - if hCG has reverted to normal within 56 days of pregnancy event then follow up will be for 6 months from date of uterine removal. If hCG

has not reverted to normal within 56 days, then follow up will be for 6 months from date of normalisation of the hCG levels.

Follow up for partial molar pregnancy is concluded once the hCG has returned to normal on 2 samples, at least 4 weeks apart.

5.4 Contraception

Oestrogen and/ or progestogens taken between evacuation of the mole and the return to normality of hCG values appear not to increase the risk of invasive mole or choriocarcinoma developing. Therefore women may use oral contraceptives after molar evacuation, before the hCG returns to normal.

Intrauterine contraceptive devices should not be used until hCG levels are normal to reduce the risk of uterine perforation.

Women should be advised not to conceive until their follow-up is complete.

Women who undergo chemotherapy are advised not to conceive for 1 year after completion of treatment.

5.5 Subsequent pregnancies

Advise women who have had a molar pregnancy to contact the Gynaecology Assessment Unit RDH directly on: 01332 785637 or QHB on 01283 593079 in any future pregnancy in order to arrange an early ultrasound scan.

Women who have not received chemotherapy no longer need to have hCG measured after any subsequent pregnancy event.

5.6. Hormonal Replacement Therapy

Hormone replacement therapy may be used safely once hCG levels have returned to normal.

6. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme

7. References

Royal College of Obstetricians & Gynaecologists Guideline Number 38: The Management of Gestational Trophoblastic Neoplasia. RCOG June 2020.

A guide to management of Gestational Trophoblastic Disease at Sheffield at: www.chorio.group.shef.ac.uk/index.html.

Documentation control

Reference No: UHDB/Gynae/03:24/M3		**Version: UHDB V2**	**Status: Final**
Version	Date	Author	Reason/ amendment
1	27.10.2008	Miss Gill Scothern	New Guideline
2	03.12.2011	Miss Gill Scothern	Review & updated guideline
3	25/11/15	Dr S Chaudhry (St5) Miss S Tahseen - Consultant	Review & Update
4	March 2018	Mr J Allsop – Consultant Gynaecologist	NICE compliance
4.1	Sep 2020	C Meijer Risk Support RM	Replaced Anti D information with link to full guideline that was reviewed and uploaded
UHDB Version 1	March 2021		Adopted by QHB
2	January 2024	Mr J Allsop – Consultant Gynaecologist, Miss A Tirlapur - O&G Consultant	Triannual review

To be read in conjunction with Associated local guidelines:

- Fetal Tissue/Disposal **(F4) /** Early Pregnancy Losses **(M1)**
- Anti D Administration **(A2)**

Consultation with:	Gynaecologists
Business Unit sign off:	04/03/2024: Gynaecology Guidelines Group - Miss B Purwar, Chair 15/03/2024: Gynaecology Governance Group - Mr V Asher - Chair (Exceptional ratification)
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