HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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MAU Molar Pregnancy Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Protocol

For initial Management and follow up of Molar Pregnancy.

Scope

- All HVDHB Obstetricians , Registrars, Senior House officers and House Surgeons
- All HVDHB Midwives
- All HVDHB Nurses

Definitions

Gestational Trophoblastic Disease (GTD) covers hydatidform mole (including complete and partial moles), invasive mole, gestational choriocarcinoma and Placental site trophoblastic tumour (PSTT)

Gestational trophoblastic neoplasia (GTN) is a term used to describe GTD requiring chemotherapy.

Incidence of GTD is 1:200-1000 pregnancies, with evidence of ethnic variation. Women from Asia have a higher incidence than non-Asian women. Incidence is higher at both ends of the reproductive spectrum ie women younger than 15 and older than 45

Molar Pregnancy can be subdivided into partial and complete:

Partial Mole

Usually does not present with any specific clinical features. It usually presents with signs and symptoms of incomplete or missed miscarriage and the diagnosis is made on histology of products of conception. Partial moles usually have a triploid karyotype, 2 sets paternal and 1 maternal haploid set and most often occur following dispermic fertilisation.

Complete Mole

May be suspected clinically.

The classic clinical features are:

- Vaginal bleeding in the 1st trimester
- Excessive uterine size
- Hyperemesis **and**
- Markedly elevated β hCG titres.

Features which are rarely seen include:

- Pre- eclampsia
- Hyperthyroidism
- Trophoblastic embolization
- Theca lutein

Ultrasound is reliable and sensitive in diagnosis of complete mole but histological confirmation is essential. The characteristic 'bunch of grapes' appearance in complete moles is only seen in the second trimester and as most cases are diagnosed earlier, this is now rarely seen. Complete moles usually have diploid chromosomes of paternal origin are usually diploid, derived from paternal duplication or dispermic fertilisation of an 'empty' ovum (lacking maternal genes).

Twin Molar Pregnancy

One viable fetus with other pregnancy molar

Persistent Gestational Trophoblastic Neoplasia

Persistent elevation of the βhCG titres post evacuation of molar pregnancy with symptoms and signs of local uterine invasion or metastasis.

Higher risk is associated with older age, longer interval from previous pregnancy and higher β hCG levels.

Risks and precautions

Molar pregnancy has following risks:

- Risk of recurrence
- Uterine perforation during evacuation of products of conception
- Haemorrhage at evacuation of products of conception
- Persistent GTN

Procedure

Diagnosis is reached by:

- History
- Clinical examination
- Pelvic ultrasound examination
- Serum βhCG levels.

HISTOPATHOLOGICAL CONFIRMATION IS MANDATORY TO CONFIRM DIAGNOSIS.

Evacuation of Molar Pregnancy:

Suction curettage is the method of choice for evacuation of molar pregnancies (1, 2).
(Medical management using prostaglandins is not recommended for evacuation because of the risk of increased blood loss and malignant sequelae when compared to suction curettage.)

- The on-call consultant is notified by the O & G registrar at the time of booking the patient onto a theatre list.
- Misoprostol can be considered as it helps with cervical ripening.

- The suction curettage is performed by an experienced operator and/ or Consultant.

- The anaesthetist should be informed at the time of booking.
- Pre operative investigations include (only after histologically confirmed diagnosis):
    - FBC
    - Group and Hold
    - Thyroid function tests (TFT)
    - Liver function tests (LFT)
    - Renal function tests (U&Es)
    - Baseline βhCG and
    - Chest X ray [2,3]

- A Syntocinon infusion (0f 40 units in 250 mls Normal Saline) can be commenced once the evacuation is completed and continued over 4 hours.
- An urgent histology report is requested for the:
    - Registrar performing the procedure
    - The on call consultant and
    - The Maternity Assessment Unit

- Rh (D) negative patients should be treated with anti-D Immunoglobulin after evacuation.
- The person who performed the procedure will inform the woman of the histology result, and the likely need for long-term follow up and contraception.
- Follow-up in MAU a week later should be arranged for follow up bloods.
- A discharge summary is sent to the woman's General Practitioner (GP) informing them of diagnosis and follow up plan via MAU.

Post Evacuation Follow Up

- Routine repeat evacuation is not recommended
- Women should be advised NOT to conceive until their follow up is complete Schedule appropriate hCG test (β or t).
- On the day of diagnosis
- Weekly thereafter until normal levels are obtained twice
- Monthly once normal levels are obtained

Duration

- The duration of follow up should be dependent on type of GTD
- Partial mole- stop as soon as hCG negative
- Comple mole: 6 months after normalisation
- any mole with a multiple pregnancy: monthly for 12 month
- If hCG does not settle – Refer to Gynae Oncology after discussion with on call consultant
- A letter with recommendations for a future pregnancy (see below) is sent to the GP at completion of follow up. (Dictated by RMO/ Clinician involved).
- The woman is advised not to conceive until their follow up is complete.

Contraception

- Reliable contraception is strongly recommended during the entire interval of hCG follow up. Barrier methods are the preferred method of contraception.
- Progesterone based contraception can be considered.

- Oral contraceptives may be prescribed after hCG levels are normal. (2). If OCP has been started before diagnosis of GTD, the woman can remain on OCP
- An intrauterine contraceptive device (IUCD) should **not** be inserted until the hCG level is normal because of the potential risk of uterine perforation.
- Women with persistent Trophoblastic activity (ie. no decrease or a persistence and / or a rise in their hCG level) are referred to the gynaecology oncology team for further treatment.

Future Pregnancies

- Risk of further molar pregnancy is low (1 in 55 - 70) (1).
- The development of GTN is significantly increased after a complete mole, but only slightly increased after a partial mole
- The chances of conception after molar pregnancy do not differ from the general population
- In subsequent pregnancies the following steps are recommended
    1. Preconception and first trimester Folic Acid prescription
    2. A early pelvic ultrasound (6-8 weeks) and mid trimester scan looking for molar tissue
    3. Histology of the placenta or products of conception
    4. After all future pregnancy events (including TOP, miscarriage etc.) women should have a hCG blood test 6-8 weeks. A hCG measurement 6 weeks after completion of pregnancy to exclude occult Trophoblastic neoplasia.

Acknowledgements: CCDHB

References

1. Royal College of Obstetricians and Gynaecologists. The Management of Gestational Trophoblastic Neoplasia. Guideline No. 38. Feb 2004.
2. American College of Obstetricians and Gynaecologists. Diagnosis and treatment of Gestational Trophoblastic Disease. ACOG Practice Bulletin 53. June 2004.
3. Society of Obstetricians and Gynaecologists of Canada. Gestational Trophoblastic Disease. SOGC Clinical Practice Guideline NO. 114, May 2002.
4. Berkowitz, RS, & Goldstein, DP. Gestational Trophoblastic Neoplasia. Practical Oncology --- ed. ---yr: 615 – 636.
5. Best Practice and Research Clinical Obstetrics & Gynaecology. Vol 17. Issue 6 (825-985) Dec 2003 - Gestational Trophoblastic Disease.
6. NZGTD Guidelines 15/01/2014

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).