STANDARD OPERATING PROCEDURE

Gestational Trophoblastic Disease

Special Region (1)

Union of Myanmar

Version: (1)

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Approved by: Internal Medicine Unit

Gestational Trophoblastic Disease

Introduction

The term gestational trophoblastic disease describes The pre-malignant disorders of partial and complete hydatidiform mole (PHM and CHM). The malignant diseases of invasive mole, choriocarcinoma. The rare placental site trophoblastic tumour/epithelioid trophoblastic tumour (PSTT/ETT).

Classification

Molar pregnancy (benign)

i) Complete mole ii) Partial mole

Persistent or residual mole

i) Invasive mole ii) Placental mole

Choriocarcinoma

i) Non-metastatic ii) Metastatic

Clinical features

. Amenorrhoea of less than 24 weeks gestation . vaginal bleeding and abdominal pain . The passage of vesicles is rarely observed except when the woman is aborting . Hyperemesis . Pregnancy induced hypertension . The uterus is larger than would be expected from the calculated date of gestation . The uterus feels doughy in consistency . The fetal heart cannot be heard on the Doppler . Pelvic examination-to detect vaginal and sub-urethral nodule, uterine size and theca lutein cysts

Investigation

. Ultrasound examination shows the ‘snow storm’ appearance in the uterus and the absence of fetal shadow in a complete molar pregnancy. . Quantitative Serum β-hCG level

- Very high in a complete mole.
- Is not very much raised in a partial mole.

. X-ray chest is done to rule out lung metastasis. . CT scan is required in liver and brain metastasis.

Treatment

. Blood for grouping and matching, transfuse blood or reserve blood. . Suction curettage is the method of choice for evacuation of molar pregnancies. . Arrange for suction curettage under anaesthesia. . The use of oxytocin infusion prior to completion of the removal is not recommended. . If significant hemorrhage prior to or during removal, surgical removal should be expedited and the need for oxytocin infusion weighed up against the risk of tissue embolization. . Products of conception obtained after evacuation should be histologically examined. . Consider chemotherapy in cases of i. Evidence of metastasis ii. Histological evidence of choriocarcinoma iii. Evidence of GI or intra-peritoneal bleeding iv. Pulmonary, vulval or vaginal metastasis unless hCG falling v. Rising hCG after evacuation vi. Serum hCG>20000 IU/L more than 2 weeks after evacuation vii. Raised hCG 6 months after evacuation, even if still falling . Involve medical oncologist for chemotherapy . Choice of chemo regimen depend on risk scores . Low risk 0-6, high risk> 7 . Give single-agent chemotherapy in low-risk cases i. Methoterxate 50mg IM repeated every 48 hours for a total of 4 doses ii. Courses repeated every 2 weeks . Give combination chemotherapy in high-risk cases(EMACO) Regimen 1 (EMA) Day 1 Etoposide (100mg/m2 IV over 30 mins), Actinomycin D (0.5mg IV bolus), Methotrexate (100mg/m2 IV Bolus) Day 2 Etoposide (100mg/m2 IV over 30 mins), Actinomycin D (0.5mg IV bolus), Folinic acid (15mg IM/PO every 12 hours for 4 doses) Regimen 2 (CO) Day 8 Vincristine (1mg/m2 IV Bolus), Cyclophosphamide (600mg/m2 IV over 30 mins)

Follow up

. All patients with confirmed PHM as well as CHM should undergo hCG follow-up. . If hCG has reverted to normal within 56 days of the pregnancy event then follow-up will be for 6 months from the date of evacuation. . If hCG has not reverted to normal within 56 days of the pregnancy event then follow-up will be for 6 months from normalisation of the hCG level. . Women are advised not to conceive until their follow-up

is complete. . Advise to use barrier methods of contraception until hCG levels revert to normal. . At each visit, explore symptoms of bleeding, pain, and symptoms suggestive of metastasis (cough, hamoptysis, chest pain, headache, jaundice, RHC tenderness).

References

1. Shaw’s Textbook on gynaecology
2. Obstetrics and Gynaecology An evidence-based Text for MRCOG
3. Management of Gestational Trophoblastic Disease Green-top Guideline No.38
4. Obstetrics and Gynaecology Myanmar management guidelines, 2024