TITLE- GUIDELINE FOR MANAGEMENT OF WOMEN WITH SUSPECTED MOLAR PREGNANCY

TARGET AUDIENCE	Maternity and Gynaecology medical, midwifery, nursing and sonography staff.
PATIENT GROUP	Pregnant women with suspected molar pregnancy

Clinical Guidelines Summary

- Molar pregnancy is characterised by proliferations of gestational trophoblastic tissue.
    - Complete molar pregnancy occurs when two sperm fertilise an empty ovum or there is duplication of sperm genetic material with destruction or absence of ovum genetic material. This leads to diploid cells of paternal origin, with no fetal tissue.
    - Partial molar pregnancy occurs when two sperm fertilise an ovum leading to triploid cells with two paternal lines and one maternal line. A fetus is usually present.
- Patients may present with vaginal bleeding, passage of jelly like material per vaginum, with ultrasound features of molar pregnancy or incidentally after miscarriage with pathology of the products. The scan findings should be confirmed by a second operator.
- Surgical management is recommended ideally within 48 hours and certainly by 5 days.
- Urgent pathology of the products should be requested.
- Register the patient at the GTD centre in Ninewells, Dundee. TAY.hmolescotland@nhs.scot
- Follow-up is determined by the GTD centre.
- Anti-D is recommended following surgical management (refer to the anti-D guideline).
- Day 56 bHCG should be taken for all women with suspected molar pregnancy.
- Give advice on contraception.

Guideline Body

Content

Introduction

Complete and partial molar pregnancies belong to a group of conditions known as gestational trophoblastic disease (GTD). They occur in 1:714 live births. They are characterised by abnormal proliferation of gestational trophoblastic tissue. Complete moles are diploid with two paternal haploid lines, with no fetal parts. Partial moles are triploid with two paternal haploid lines and one maternal haploid line, usually with fetal parts present.

Diagnosis

- Patients often present with vaginal bleeding or threatened miscarriage. They may complain of passing jelly-like material per-vaginum. There may be exaggerated symptoms of early pregnancy, including hyperemesis gravidarum.. Occasionally patients may present with thyroid storm, due to the common subunit between bHCG and TSH. Early onset pre-eclampsia, uterine enlargement or abdominal distension due to theca-lutein cysts are also rare presenting features. Women may present with miscarriage and the diagnosis is only confirmed when products are analysed at pathology. Very rarely, women may present with haemoptysis or seizures due to metastatic disease.
- There are particular features of GTD seen on ultrasound:
    - Snowstorm appearance.
    - Polypoidal mass
    - Cystic spaces within gestational trophoblast
    - Absence of fetus (complete) or small for gestational age fetus (partial).
- If the diagnosis is suspected, take blood for bHCG, which is often elevated.
- The scan findings should be confirmed by a second operator.
- Definitive diagnosis is by pathology.

Treatment

- Surgical management by suction curettage of suspected molar pregnancy is recommended. This should be carried out within five days of the decision and ideally within 48 hours.
- Surgical management can be performed in Theatre 11 elective list or if the patient bleeding and it is deemed an emergency, in theatre 12 if available or in CEPOD theatre depending on which route allows safe and timely surgery.
- If expertise is available, ultrasound guidance during curettage can reduce the risk of perforation of the uterus and to ensure maximum removal of tissue as possible. An emergency procedure should not be delayed if there is no ultrasound guidance.
- If the fetal parts of partial molar pregnancy are considered too large for suction curettage, medical management can be considered.
- Pre-operative ripening of the cervix with misoprostol is safe.
- As bleeding should be anticipated, the involvement of a senior clinician is necessary.
- The use of oxytocin prior to the uterus being emptied is not recommended. It can be considered if there is life-threatening haemorrhage.
- Request urgent pathology of the products.
- Inform the woman of the diagnosis and management plan.
- Anti-D prophylaxis should be administered to Rhesus D negative women after surgical management.

Follow-up

- Provide the woman with a patient information leaflet on gestational trophoblastic disease and provide telephone numbers for the EPAS unit for any advice.
- Explain the need for follow-up.
- Register the patient at the GTD centre in Ninewells, Dundee. TAY.hmolescotland@nhs.scot
- Length of follow-up will be determined by the GTD centre. In general, the following is a guide:
    - Complete mole: if bHCG has reverted to normal within 56 days of the event, follow-up will be for 6 months from the date of pregnancy removal. If it has not reverted to normal, it will be from the date the bHCG became normal.
    - Partial mole: follow-up is concluded once bHCG has returned to normal on two samples, at least 4 weeks apart.
    - If the patient has not had chemotherapy, no follow-up is required after subsequent pregnancies.
- All women with suspected molar pregnancy should have bHCG levels checked on day 56.
- If women have ongoing bleeding after the first procedure, advice should be sought from the GTD centre prior to repeating the surgical procedure, unless it is necessary to save life.

Contraception

- Women should be advised not to conceive until their follow-up is complete.
- If chemotherapy is required, pregnancy should be delayed for one year after treatment is complete.
- The combined oral contraceptive pill can be used straight away (if no other contraindications).
- All intrauterine methods of contraception including Mirena IUS are contraindicated until the bHG levels have returned to normal.

References/Evidence

1. Management of Gestational Trophoblastic Disease - 2021 - BJOG: An International Journal of Obstetrics & Gynaecology - Wiley Online Library
2. http://athena/adtc/DTC%20%20Clinical%20Guidelines/ADTC288.pdf
3. Molar pregnancy | Gestational trophoblastic disease (GTD) | Cancer Research UK
4. https://www.miscarriageassociation.org.uk/wp-content/uploads/2017/12/Molar-Pregnancy-Jan-2023.pdf
5. http://www.hmole-chorio.org.uk/
6. http://www.chorio.group.shef.ac.uk/index.html

Contact for Registration

E-mail: TAY.hmolescotland@nhs.scot
Tel: 01382 632748 Monday to Friday 9am-4pm

Hydatidiform Mole Follow Up Scotland
Wards 37/38
Level 6
Ninewells Hospital
Dundee
DD1 9SY

Clinical Director Dr Refaat Youssef
Clinical Coordinator Leigh Jenkins and Elaine Coupar

Appendices

Visual example of the referral form to be completed – link above within the guideline for form and submission.

EMAIL REGISTRATION FORM FOR PATIENTS HAVING HYDATIDIFORM MOLE

Please read the supplementary notes before completing this form. Receipt will be acknowledged. It is advisable to use a secure NHS email account when emailing this form to us.

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Please email the completed form to tay.hmolescotland@nhs.scot

2023

REFERRING CONSULTANT

CONSULTANT	
GMC Number	
HOSPITAL	
ADDRESS	
POSTCODE:	
TEL:	FAX:

PATIENT IDENTITY / AFFIX LABEL

SURNAME			
FIRST NAMES			
CHI No		D.O.B.	
ADDRESS			
POSTCODE			
EMAIL ADDRESS			
TEL:			
ETHNIC ORIGIN			
UNDERSTANDS ENGLISH?	YES/ NO/ LITTLE		
MOTHER TONGUE/1st LANGUAGE?			

OBSTETRIC HISTORY

Number of live births:			
Number of pregnancies including this one:			
Date of evacuation of hydatidiform mole:			
Date of last menstrual period prior to evac:			
Gestational age:		Uterine size:	
Classification of mole (note 4):			
Site of mole:	Uterine	Ectopic	
Repeat D&C?	YES/NO	Date/s	
Comments:			
Family history of H.Mole?	YES / NO		

GP DETAILS

GP NAME	
GP ADDRESS	
POSTCODE	
Telephone:	

EVENTS LEADING TO DIAGNOSIS (Please number the sequence of events)

PV bleeding		Histology report		Missed miscarriage		Foetal abnormality	
Ultrasound		Large for dates		Incomplete miscarriage		Ectopic pregnancy	
Recurrent bleeding-		Small for dates		Termination		Evacuation of uterus	

following abortion, raised hCG		
OTHER (please describe in separate letter if preferred)		

METHOD(S) OF EVACUATION (Tick all that apply)

Spontaneous	☐	Curettage	☐	Hysterotomy	☐	Prostaglandins/Analogue	☐
Suction evacuation	☐	Syntocinon	☐	Hysterectomy	☐	Mifepristone	☐
OTHER (please specify)	☐						

WAS DIAGNOSIS SUSPECTED PRIOR TO EVACUATION?	YES / NO

Please ask the patient to notify us of any change of address. Please confirm the following by ticking the boxes below:

☐ **I confirm that the need for follow-up has been discussed with the patient, that the procedure has been explained to her and that she has consented to her data being held on computer.**

☐ **I confirm that I have read and understood the supplementary notes.**

Signed		Name		Pathologist	
Consultant/Registrar/Midwife		Date		Hospital site	
GMC/NMC Number				Path.Lab.No.	

***** PLEASE ATTACH A COPY OF THE HISTOLOGY REPORT OR FAX TO 01382 496255 *****

SUPPLEMENTARY NOTES RELATING TO THE REGISTRATION OF

PATIENTS HAVING HYDATIDIFORM MOLE

1 It has been agreed by the Health Departments and the Royal College of Obstetricians and Gynaecologists that it is desirable to have a form of Registration for patients who have hydatidiform mole (h.mole).

2 The need for careful follow-up of patients after hydatidiform mole is generally accepted but it has been found that follow-up may break down for a variety of reasons and when this happens an ensuing Choriocarcinoma may prove fatal. There is evidence that fatalities are avoidable if follow-up arrangements are sustained and use made of radioimmunoassays for human chorionic gonadotrophin (hCG) measurements.

3 The purpose of registration of hydatidiform mole is:

(i) To facilitate regular hCG follow-up.

(ii) To collect information relating to abnormal trophoblastic proliferation following h.mole.

4 Registration applies to:

(a) Complete hydatidiform mole (classical type, androgenetic, no other foetal tissue).

(b) Partial hydatidiform mole (usually triploid, other foetal tissues present).

(c) Twin pregnancy with Complete or Partial hydatidiform mole.

(d) Limited macroscopic or microscopic molar change judged to require follow-up.

5 **The referring consultant retains full responsibility for the patient and her follow-up care**. If the consultant does not wish the laboratory to request samples directly from the patient this should be clearly stated, otherwise the following arrangements will apply. In addition to the consultant's own clinical follow-up, one of the designated laboratories will supply the patient with instructions and requisites for providing the samples on a regular basis. The laboratory will provide the gynaecologist and the general practitioner with the results of the hCG assays and an interpretation of their significance. The laboratory will also inform the patient of when samples are due and will send reminders if she defaults. Assays are usually done every 2 weeks until normal then four-weekly until follow-up is complete (depending on which centre the patient is registered at). (See note 6).

6 Follow-up of cases may not need to be of long duration. For **complete hydatidiform moles** if hCG levels reach normal within 56 days of evacuation follow-up will be limited to 6 months from the date of evacuation. For women who have not fallen to normal within 56 days of evacuation follow-up will continue until 6 months of normal tests have been seen. **Partial hydatidiform moles**, confirmed on pathology review at the centre will have follow-up until hCG has reached normal level plus one confirmatory test 4 weeks later. There is no evidence that taking oestrogens or progestogens before hCG values have become normal increases the risk of requiring chemotherapy.

7 Blood samples for hCG should be 2-3ml serum. Please quote the patient's h.mole Registration Number. If the patient has not been registered please enclose a completed form with the sample, or enclose a letter giving:

(a) the patient's name and address.

(b) the patient's age or date of birth.
(c) the date of evacuation of the mole.
The Scottish Follow-up Centre normally requests urine samples, but details will be sent to the patient directly.

8 It is suggested that in addition to routine follow-up, a patient who has had a hydatidiform mole should have further hCG assays after any subsequent pregnancy, or unexplained haemorrhage.

9 A new pregnancy should be delayed until follow-up is complete.

1. Governance information for Guidance document

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Endorsing Body:	
Version Number:	V1
Approval date	**05/11/2024**
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Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	
Consultation Process / Stakeholders:	Maternity Clinical Effectiveness Group UHW Early Pregnancy Assessment Service Multi-Disciplinary Team Women and Neonatal Services DMT UHW HMT

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Distribution	Maternity Clinical Effectiveness Group UHW Early Pregnancy Assessment Service Multi-Disciplinary Team Women and Neonatal Services DMT Consultant Obstetricians/Gynaecologists. Senior midwifery team.

CHANGE RECORD

Date	Lead Author	Change	Version No.
05/11/2024	E Ferguson	Version 1	1
5/12/2024	E Ferguson	Modifications following CEG meeting	2
22/04/2025	E Ferguson	Target audience clarified and note that the form in the appendix is a visual example.	3
		.	4
			5

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance

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Lead Author	**Evelyn Ferguson**	**Date approved**	**05/12/2024**
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