

---

# Protocol for the Management of Molar Pregnancy

---

**Author:** Dr Tabitha Oosterhouse and Ms Charity Knight  
**Date Approved:** 10/11/20  
**Approved by:** Gynaecology forum  
**Date for Review:** November 2023.

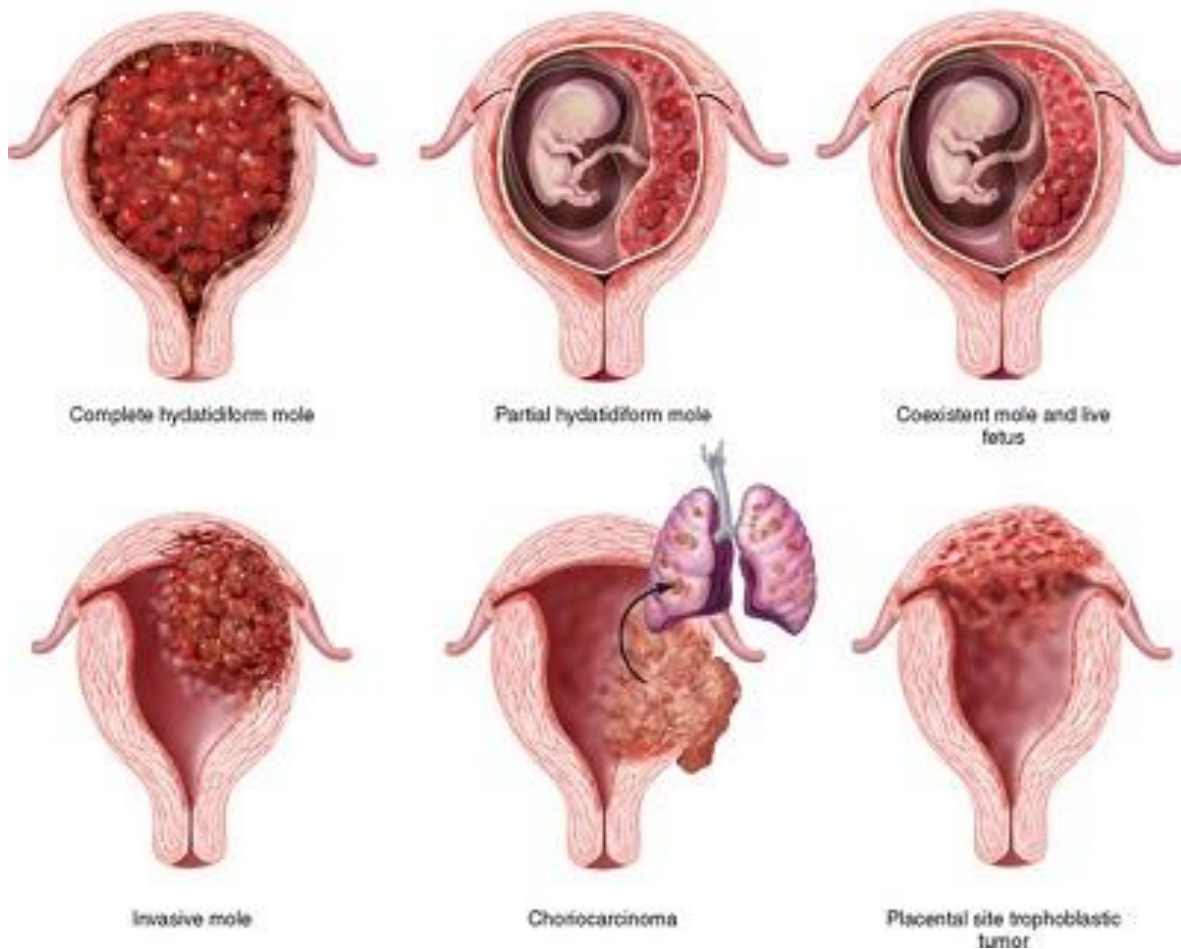
## Contents

1. Background
2. Suspected Molar Pregnancy
3. Surgical Management
4. Molar Pregnancy Confirmed
5. EPAU Follow Up
6. Follow Up through Charing Cross

# 1. Background

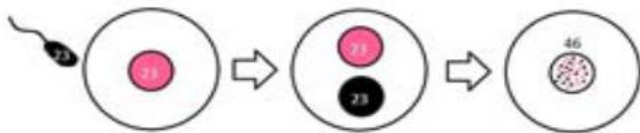
Gestational trophoblastic disease includes complete and partial molar pregnancies as well as the rare malignant conditions of invasive mole, choriocarcinoma and placental site trophoblastic tumour. Sometimes a molar pregnancy can co-exist with a normal foetus in a twin pregnancy. Gestational trophoblastic disease occurs in approximately 1 in 600 pregnancies in the UK and is more common in women of Asian origin, teenagers and women over the age of 40.

SPECTRUM OF GESTATIONAL TROPHOBLASTIC NEOPLASIA



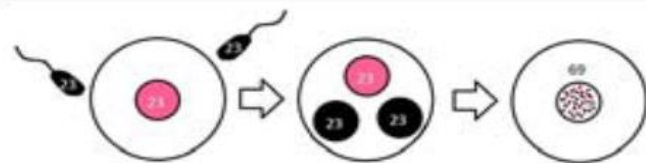
Complete mole usually forms when one sperm (rarely two sperm) fertilizes an empty egg and duplicates. No fetal tissue develops in this condition.

Partial mole forms when two sperm fertilize one egg. A non-viable fetus or some fetal tissue can develop.



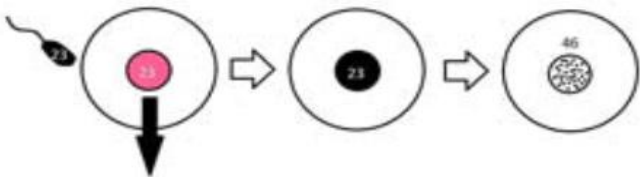
### Normal Pregnancy

One sperm and one egg join to form an embryo with 46 chromosomes



### Partial Mole

Two sperm and one egg join to form an embryo with 69 chromosomes



### Complete Mole

One sperm enters an egg which has lost its chromosomes. The sperm duplicates its own chromosomes therefore the pregnancy has only paternal (father) chromosomes and no maternal (mother) chromosomes

**Presentation:**

The classic feature of molar pregnancy is irregular vaginal bleeding, though less commonly patients may present with hyperemesis, excessive uterine enlargement, hyperthyroidism, early onset pre-eclampsia or abdominal distension due to theca lutein cysts.

Very rarely, women may present with respiratory symptoms such as haemoptysis/acute respiratory failure or neurological symptoms such as seizures, resulting from metastatic disease of the lungs or brain.

**Diagnosis:**

Molar pregnancy can only be definitively diagnosed by histological examination of pregnancy tissue. The diagnosis may be unexpected, though recent studies report ultrasound diagnosis in between 56-86% of cases. Many histologically proven complete moles are originally diagnosed as a silent miscarriage or anembryonic pregnancy. Hence products of conception (POC) should be sent for histological examination, following surgical or medical management of miscarriage. Diagnosing a partial mole is more complex but cystic spaces, abnormal shaped gestational sac and elevated hCG level (which is double the normal) is suggestive.

## 2. Suspected Molar Pregnancy

- Discuss the condition with the patient and give the molar pregnancy – information for patients leaflet.
- Book the patient for surgical evacuation
  - Ensure you document suspected molar pregnancy in the notes and ward book then inform the on call gynaecology registrar and EPAU.
- CEPOD booking – inform the anaesthetist of the increased risk of bleeding and the importance of trying to avoid oxytocin use.
- If booking within the next 3 days, take a group and save and check rhesus status. Take a baseline FBC.
- Discuss with patient disposal of products after histological examination and sign the form with them.
- Discuss need for contraception until histological results are known.
- Discuss follow up and fertility implications if molar is diagnosed to the level that the patient wishes to know now.
- Where there is a suspected ectopic molar pregnancy, manage as any other ectopic pregnancy case.

### 3. Surgical Management

- Suction curettage is the preferred method for management of all suspected molar pregnancies.
  - In partial mole where fetal parts are too large to allow surgical management then medical management may be used. (Medical management is generally avoided because of the concern that uterotonics could disseminate trophoblastic tissue.)
  - Ultrasound guidance during the procedure maybe of use to reduce the chance of uterine perforation and ensure as much tissue is removed as possible.)
- Anti D
  - Anti-D should be given to all Rhesus negative women with suspected molar pregnancy who undergo surgical management.
- It is safe to prepare the cervix with misoprostol immediately prior to surgery.
- Surgeon experience
  - Because of the increased bleeding risk, a senior surgeon supervising the surgical evacuation is advised.
- Send histology as suspected molar pregnancy, as USC and with the consultant listed as Paul Flynn/ Charity Knight.
- Do not biopsy suspected secondary deposits due to the significant risk of haemorrhage.
- Repeat surgical procedure
  - Where there is heavy or persistent vaginal bleeding causing acute haemodynamic compromise, (especially where retained tissue has been confirmed on ultrasonography) then urgent surgical management should be undertaken.

## 4. Molar Pregnancy Confirmed

The patient will be informed of the histology results by the Early Pregnancy Unit and their referral sent to Charing Cross by Mr Paul Flynn or Ms Charity Knight (or on call team in their absence.)

Charing Cross registration forms can be found on their website:  
<http://www.hmole-chorio.org.uk>

The following diagnosis should be registered:

1. Complete molar pregnancy/ partial molar pregnancy.
2. Twin pregnancy with complete or partial molar pregnancy.
3. Limited macroscopic or microscopic molar change suggesting possible early complete or partial molar/ choriocarcinoma
4. Placental-site trophoblastic tumour (PSTT) or epithelioid trophoblastic tumour (ETT.)
5. Atypical placental site nodules (PSN.)

### Contraception

Contraception is needed as it is important to avoid pregnancy until Charing Cross follow up is complete – this may help prevent progression to cancer and improve treatment success.

Barrier or hormonal contraception is recommended with avoidance of intrauterine devices.

### Follow up

The Charing Cross registration and treatment programme is very effective, with a cure rate of 98-100%. Approximately 13-16% of patients after complete mole and 0.5-1% after partial mole will need further treatment. It is important for patients to understand and comply with the program, whose goal is to detect any progression to gestational trophoblastic neoplasia (choriocarcinoma, invasive mole, placental site trophoblastic tumour) early and ensure prompt and complete treatment.



Reassure women that their chance of further molar pregnancy is 1% and they will have no increased obstetric risks for further normal pregnancies.

## **5. EPAU Follow Up**

EPAU will take and send the blood samples required for Charing Cross using their provided kit. Patients should use EPAU as their first contact in case of any symptoms. Generally this would be regarding abnormal vaginal bleeding and may require additional ultrasound. Patients should also be advised to report any shortness of breath.

## **6. Charing Cross Follow up**

### **Complete Molar Pregnancy:**

If hCG levels have returned to normal within 56 days (around 8 weeks) from surgical evacuation then follow up will be for 6 months from surgery date. If the hCG takes longer to normalize then follow up will be 6 months from normalization.

### **Partial Molar Pregnancy:**

Follow up is concluded once the hCG levels have returned to normal on two samples, at least 4 weeks apart.

### **Future Pregnancies:**

Only women who have received chemotherapy treatment need to have hCG measured after any subsequent pregnancy. The screening centre should be notified at the end of any future pregnancy whether miscarriage, termination or delivery, so that hCG levels can be tested 6-8 weeks after the end of the pregnancy to exclude disease recurrence.

### **Future issues:**

If patients have persistent high hCG levels, abnormal bleeding etc, discuss with Charing cross prior to arranging further surgical treatment or investigation. Charing Cross will contact the unit if further surgical management or chemotherapy is required. We prescribe and provide the chemotherapy regime as advised by Charing Cross.

## References:

1. RCOG Green Top Guideline: 38. The Management of Gestational Trophoblastic Disease. (September 2020.)
2. Charing Cross Gestational Trophoblast Disease Service  
[www.hmole-chorio.org.uk/info-for-clinicians](http://www.hmole-chorio.org.uk/info-for-clinicians)
3. Faculty of Sexual and Reproductive Health Executive Summary: Contraception after Pregnancy (January 2017.)