Gestational Trophoblastic Disease

**Hydatidiform Mole**

Suction curettage is the preferred method of evacuation of the hydatidiform mole. Post-operative surveillance with serum hCG assays is essential.

- Following tests should be done prior to evacuation of hydatidiform:
  - CBC
  - Clotting function tests
  - Renal function and liver enzyme studies
  - Blood type with antibody screen
  - Determination of hCG level
  - Preevacuation chest x-ray

- Serum levels should be obtained within 48 hours of evacuation, every 1-2 weeks while elevated, and then at 1-2 month intervals for an additional 6-12 months

- Indications for therapy:
  - An abnormal hCG regression pattern (a 10% or greater rise in hCG levels or a plateauing hCG of three stable values over two weeks)
  - An hCG rebound
  - Histological diagnosis of choriocarcinoma or placental site trophoblastic tumour
  - The presence of metastases
  - High hCG levels (greater than 20 000mIU/mL more than four weeks post-evacuation)
  - Persistently elevated hCG levels six months post-evacuation

**Gestational Trophoblastic Tumours**

Low-risk patients (WHO Score: 4 or less):

- In selected women with nonmetastatic disease and not wishing to preserve fertility, hysterectomy may be used as primary therapy.
- Both nonmetastatic and metastatic disease should be treated with single-agent chemotherapy, either methotrexate or dactinomycin
- In-house protocol: Methotrexate IV day 1,3,5,7 1mg/m2 with Leucovorin rescue day 2,4,6,8 0.1mg/m2 Q2 weeks

Medium-risk patients (WHO Score: 5-7):

- Should usually be treated with multi-agent chemotherapy, either MAC or EMA but single-agent may also be used.
High-risk patients (WHO Score: 8 or greater):

- Should be treated with multi-agent chemotherapy EMA/CO, with selective use of surgery and radiotherapy.
- Salvage chemotherapy with EP/EMA and surgery should be applied in resistant disease.

Placental site trophoblastic tumour that is nonmetastatic should be treated with hysterectomy and metastatic disease should be treated with multi-agent chemotherapy.

Women should be advised to avoid pregnancy until hCG levels have been normal for six months following evacuation of a molar pregnancy and for one year following chemotherapy for gestational trophoblastic tumour.

The combined oral contraceptive pill is safe for use by women with GTT.

Surveillance following completion of chemotherapy for GTD with serial serum hCG levels should be every 2 weeks for the first 3 months of remission and then once per month until monitoring has shown 1 year of normal hCG levels.

**When to refer:**

Patients for whom initial therapy for nonmetastatic disease fails and those with metastatic disease should be referred to specialists with experience treating this disease.

**Relevant Clinical Trials:**

NCIC GT.1: Methotrexate vs. dactinomycin in patients with gestational trophoblastic disease.

**Reference:**


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