Northern Care Alliance
NHS Group

Molar Pregnancy (Gestational Trophoblastic Disease - GTD)

An information guide

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Molar Pregnancy (Gestational Trophoblastic Disease - GTD)

Introduction

Molar pregnancy is one of a number of different conditions that are called gestational trophoblastic disease (GTD). These are rare conditions and occur when the pregnancy does not develop normally from the very beginning. For every 714 pregnancy which result in a live baby, there will be one pregnancy that develop into a GTD.

What is a molar pregnancy?

In healthy pregnancies, an embryo (baby) develops when a sperm fertilises an egg and the genetic material from each combines to produce a baby which has half of its genes from each parent. A molar pregnancy is abnormal from the very moment of conception as a result of an imbalance in the number of chromosomes supplied from the mother and the father.

In a molar pregnancy, an abnormal fertilised egg implants in the uterus (womb). The cells that should become the placenta grow far too quickly and take over the space where the embryo would normally develop. Those cells are called trophoblasts. That's why molar pregnancy is sometimes called 'trophoblastic disease'.

About one in 600 pregnancies is a molar pregnancy. That means it is quite rare, especially compared with miscarriage, which affects around one in four pregnancies.

A hydatidiform mole may be either partial or complete, depending on the genetic make-up of the fertilised egg. The easiest way to explain this is to look first at what happens in a normal conception.

Normal conception

Each of our cells contains 23 pairs of chromosomes, where one of each pair is from the mother and the other from the father. In a normal conception, a single sperm with 23 chromosomes fertilises an egg with 23 chromosomes, making 46 in all.

There are **two** types – complete mole and partial mole.

- **Partial mole** - In this situation, two sperm fertilise the egg instead of one, creating 69 instead of 46 chromosomes. There is too much genetic material and the pregnancy develops abnormally, with the placenta outgrowing the baby. There may be evidence of a fetus but it will be abnormal and cannot survive.
- **Complete mole** - A complete mole is when one (or even two) sperm fertilises an egg cell which has no genetic material inside. Even if the father's chromosomes double up to make 46 in all, the balance of chromosomes from the mother and father is wrong. Usually the fertilised egg dies at that point but in rare cases it goes on to implant in the uterus. When it does, no embryo grows, only the trophoblast (the cells that will become the placenta) and that grows to fill the uterus with the molar.

When might a molar pregnancy be suspected?

If you have a molar pregnancy you may have irregular or heavy bleeding from the vagina, or excessive morning sickness (hyperemesis). Your uterus (womb) may feel larger than your midwife or doctor would expect in early pregnancy. Less commonly, you may develop raised blood pressure, symptoms of an overactive thyroid gland or abdominal pain because of large ovarian cysts.

If your doctor suspects that you may have a molar pregnancy, you will be referred to an early pregnancy clinic for an ultrasound scan. If you have a complete mole, there will be no baby present inside the pregnancy sac and there may be other signs that suggest the presence of a molar pregnancy. Ultrasound may also help in diagnosing partial moles, but it is not as reliable as in cases of complete moles.

A blood test which measures the amount of the pregnancy hormone human chorionic gonadotrophin (HCG) may also raise the suspicion that you have a molar pregnancy. Usually, the levels of this hormone are much higher than would be expected in a healthy pregnancy.

Sometimes a molar pregnancy is only diagnosed after the pregnancy tissue is looked at in the lab after a miscarriage. Examining pregnancy tissue in the lab is the only way to confirm the diagnosis of a molar pregnancy.

Can a molar pregnancy survive?

Sadly, as there is no baby present in a complete mole, these pregnancies cannot survive and cannot lead to the birth of a baby. In a partial mole, there may be a fetus visible on scan, but it is not developing properly and also cannot survive.

What happens if a molar pregnancy is suspected?

The preferred treatment for complete molar pregnancy is an operation to take away the pregnancy tissue from your uterus (womb). You might hear this procedure referred to as an ERPC (Evacuation of Retained Products of Conception) or an "evac". Medication may be used to soften the cervix (neck of the womb) prior to your operation.

You will usually need a general anaesthetic for this type of operation. During the operation, the cervix is stretched slightly and a suction device is used to remove all of the abnormally formed tissue from inside your uterus.

A sample of the tissue that is removed is sent to the laboratory and tested to see if it is normal pregnancy tissue. (This process is called histology and you may be asked to give your permission). This examination can identify molar tissue and thus a molar pregnancy.

There may be a delay between when you have the surgery and when you are told that you have (or might have) a molar pregnancy. It may be some days or a few weeks after your miscarriage when you are contacted by letter or telephone. You may be asked to return to see the doctor before you are told any more.

An operation is also the preferred method to treat pregnancies where a partial mole is present.

Will I need anti-D?

If you have a rhesus negative blood group you should be given medication known as anti-D to prevent your blood system from developing antibodies which may affect the blood cells of any future babies.

What follow-up will I have?

In the UK all women who have had a molar pregnancy are asked if their details can be registered with a specialist centre so that treatment can be coordinated and provided by doctors who are experts in this field. These centres are in hospitals in London, Sheffield and Dundee.

Once your diagnosis has been made you will be registered with the GTD centre which specialises in monitoring women after molar pregnancy. To monitor your HCG levels they will need a sample of urine once every two weeks. The sample must be taken the first time you pass urine in the morning. They will send you urine sample bottles in the post, along with a stamped, addressed box so you can return them.

The urine tests are important for you because it means they can tell how your disease is progressing without having to call you for frequent examinations.

If your level of HCG is falling, then the number of abnormal cells in the uterus is also falling and no further treatment is needed. You will be advised not to get pregnant while you are still in follow-up.

How long does monitoring last?

How long you receive follow-up will depend on your individual circumstances and what type of molar pregnancy you have. Partial molar pregnancies are followed up until your HCG level is normal on two samples taken 4 weeks apart. Complete molar pregnancies are followed up for at least 6 months, or longer if your HCG levels are falling slowly.

If you needed to receive chemotherapy as part of your treatment, then your HCG level will need to be monitored after subsequent pregnancies. If you did not receive chemotherapy, then you no longer need to have this measured after future pregnancies.

Continuing with this specialist follow-up is important as it is very successful in treating GTD (98 to 100% cure rate) and there are very low rates of progression to more serious forms of GTD.

The specialist centre will be able to put you in touch with support groups.

How do I get the results of my urine tests?

The centre will inform you by letter once your test result has returned to normal. On average it takes 8 weeks to return to normal following a pregnancy but it can take longer.

When can I get pregnant again?

The progress of molar disease is monitored by measuring hCG, a hormone that is only produced during pregnancy. If you become pregnant the level of hCG in your body will automatically rise.

If this happens while you are being monitored for your molar pregnancy this can cause some confusion and make it difficult to monitor your molar disease.

Pregnancy following too soon after trophoblastic disease may also increase the risk of recurrence or re-activation of the mole. For all these reasons you are advised to avoid pregnancy until your follow-up programme is complete.

If you have had chemotherapy for GTN, you are advised not to get pregnant for 12 months after your treatment is complete.

What method of contraception should I use?

Most contraception methods are safe to use after treatment of molar pregnancy or GTD. You can start using contraception immediately after the pregnancy tissue has been removed. The advice is to avoid using intrauterine contraception devices until your HCG levels return to normal as there is a risk of uterine perforation if the devise is fitted too soon after treatment.

You can discuss your contraception options with you doctor who should be able to answer all your questions.

What is GTN?

A molar pregnancy is best thought of as a pre-cancerous illness which can occasionally progress to a cancerous form of GTD known as gestational trophoblastic neoplasia (GTN).

GTN is regarded as a rare form of cancer and includes invasive mole, choriocarcinoma, placental site trophoblastic tumour and epithelioid trophoblastic tumour. It has a cure rate of over 99% if it develops after a molar pregnancy.

GTN occurs when some of the molar pregnancy tissue persists in the uterus. It is usually diagnosed if your HCG levels do not return to normal.

What happens if I have GTN?

If you are diagnosed with GTN, you will usually need to have further treatment. This will be organised by the specialist centre that you have been registered with.

If your HCG level is lower than 5000, you may need to have a second operation to empty your uterus (womb). However, further treatment usually involves drugs (chemotherapy). One in seven (15%) women who have a complete mole and 1 in 200 (0.5%) women who have a partial mole will need chemotherapy.

The most frequently used chemotherapy (methotrexate) does not cause sickness or hair loss. The side-effects that can occur with methotrexate chemotherapy are generally quite mild producing sore eyes, sore mouth, chest and abdominal discomfort.

Treatment is continued until 6 weeks after your HCG level has returned to normal.

Surgery, such as hysterectomy (removal of your uterus), may be recommended if you have one of the much less common types of GTN.

Will I have another molar pregnancy?

The risk of a molar pregnancy happening again is 1 in 80. This means that for more than 98 out of 100 women (98%); their next pregnancy will not be a molar pregnancy.

GTD can sometimes recur after a subsequent healthy pregnancy, so you should contact the specialist centre 6 to 8 weeks after all future pregnancies, whatever the outcome, and arrange for a further hCG blood or urine test.

Contacts and further information:

Trophoblastic Screening and Treatment Centre:
Weston Park Hospital,
Sheffield,
S10 2SJ
Telephone: 0114 226 5205
Website: www.chorio.group.shef.ac.uk/index.html

Gynaecology Assessment Unit:

Oldham – open all hours
Telephone: 0161 627 8855

North Manchester – open daily (0730-2100hrs)
Telephone: 0161 720 2010

Women and Children's Counselling Service:

Telephone: 0161 720 2969

Miscarriage Association at www.miscarriageassociation.org.uk

Mariposa Trust:
www.mariposatrust.org

Molar pregnancy information and support:
http://molarpregnancy.co.uk/

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For general enquiries please contact the Patient Advice and Liaison Service (PALS) on 0161 604 5897

For enquiries regarding clinic appointments, clinical care and treatment please contact 0161 624 0420 and the Switchboard Operator will put you through to the correct department / service

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