Initial Management of Complete Hydatidiform Mole (CHM)

This is a guide to the initial management of a Complete Mole up to the time of registration with our GTD service at CUMH.

Complete Hydatidiform Mole (CHM) complicates approximately 1 in 600 pregnancies and is usually suspected on ultrasound prior to ERPC in over 90% cases and therefore the patient can be counselled regarding the likely diagnosis and follow up prior to and after the ERPC before discharge.

When the diagnosis is suspected on an ultrasound the probable cause of the CHM can be discussed with the patient (genetic material absent from "mother's ovum" and duplication of the "fathers" genetic material predisposing to abnormal growth of the placenta which often presents with bleeding in early pregnancy or as an unsuspected finding on a routine early pregnancy ultrasound scan). As the placenta is growing abnormally and there is no foetus present the management of choice is ERPC to help to prevent further growth of this molar tissue.

In approximately 85% of cases the ERPC will be curative but 15% women will need further treatment to cure any remaining molar cells. Therefore, all patients should have a baseline hCG prior to ERPC and should start weekly hCG follow up from the time of ERPC without waiting for the official Histopathology report. The histopathology report will usually be available within 2 weeks of ERPC and the ERPC path request form should be marked "URGENT". After the ERPC the patients should be counselled about the need for immediate contraception and they should be seen in the clinic regarding confirmation of the diagnosis by the responsible team and then advised that it is important that she should register with the National Gestational Trophoblastic Disease Registry, Monitoring and Advisory Centre as soon as the diagnosis is confirmed by histopathology. The patients can be told that after registration they will be contacted by the GTD team who can further explain the diagnosis and follow-up program. The registration forms will be available in OPD and on the website

of the National Gestational Trophoblastic Disease Registry, Monitoring and Advisory Centre and they should be filled in, including the patients' consent, at the post-ERPC visit.

Very few of the suspected CHM patients will have the diagnosis changed following histopathology analysis so it is usually easier to have the patients counselled appropriately. Follow up should commence immediately rather than starting from the time of histopathology confirmation as a few weeks of follow up will have already been lost and the disease may have progressed in that short time.

Please note that the National Guidelines for the diagnosis, staging and Treatment of GTD are available at https://www.hse.ie/eng/services/list/5/cancer/profinfo/guidelines/gtd/national-clinical-guideline-gtd-2022-.pdf

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