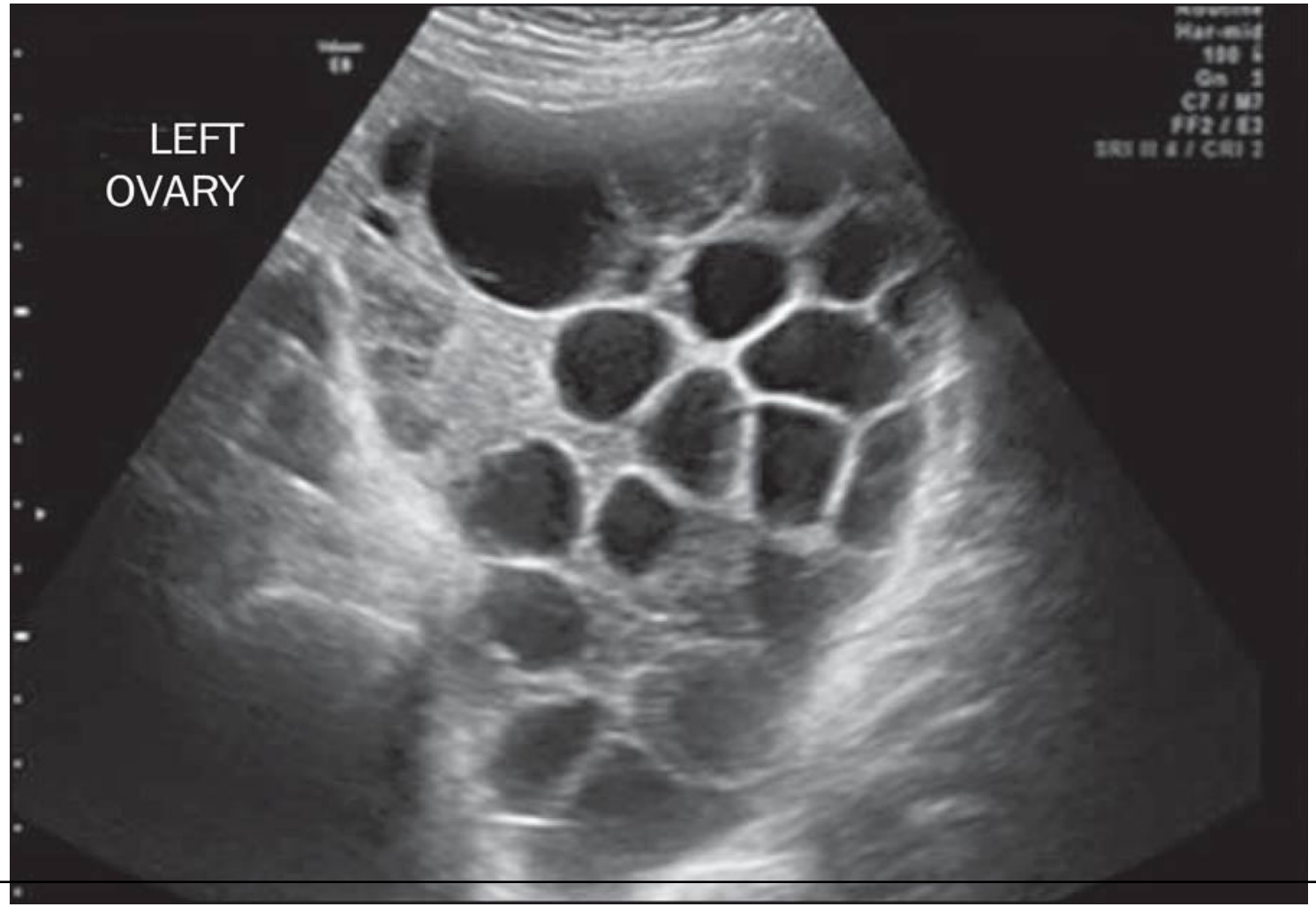
INVESTIGATIONS

ULTRASOUND

- Diagnostic.
- “”SNOW STORM””appearance
- Theca lutein cysts in ovaries
- if partial mole – FETAL SHADOW
- focal cystic spaces in the placenta
- placenta with scattered cysts
- Absence of fetal shadow helps confirm a complete mole

Thecalutein cyst.



Snowstorm appearance

Partial mole

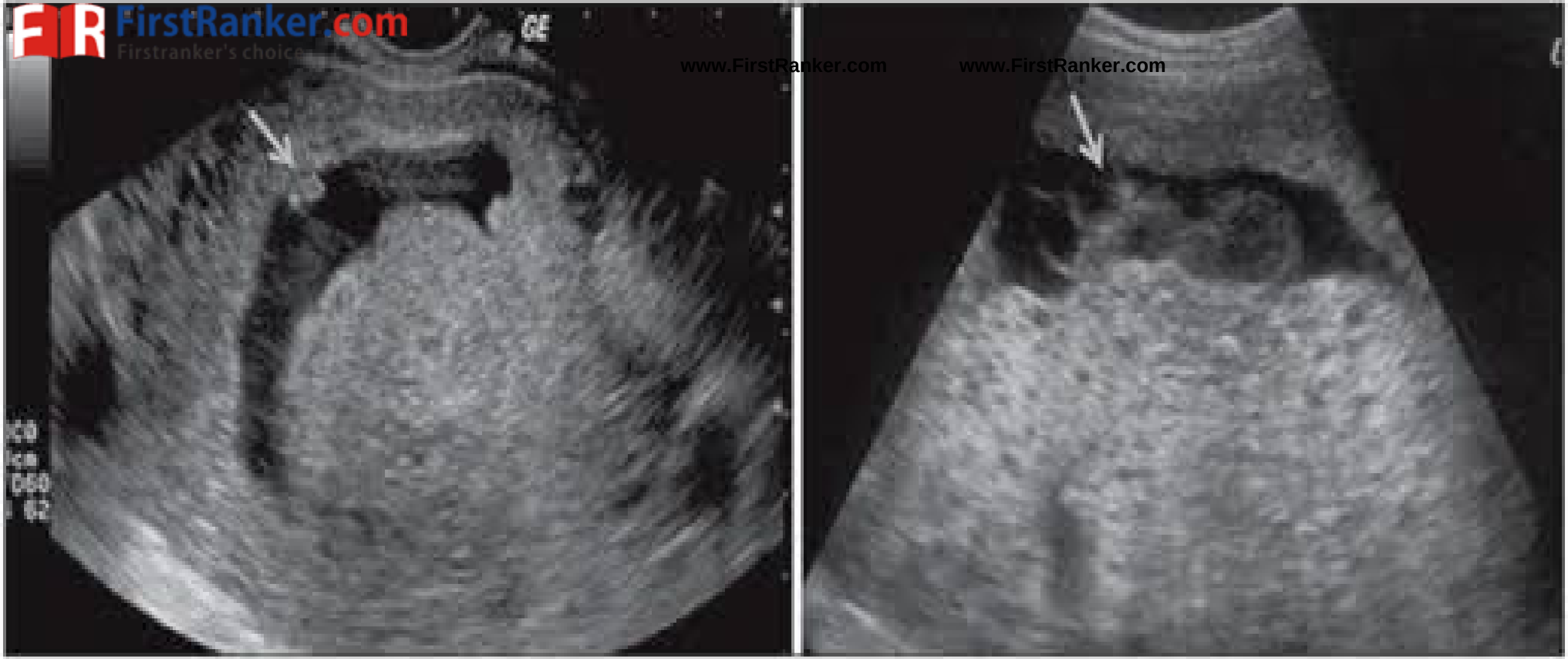


Figure 10. Sonographic signs of partial hydatidiform mole. Focal thickening of the placental bed with predominance of cystic areas and irregularity. Embryo or embryonic remains (arrows) can be visualized.

PARTIAL MOLE

- **Doppler** – Absence of Fetal heart sound
- **Serum B-hCG**
  - High >40,000 mIU/ml
  - Role now limited to Post molar and post chemo followup
- **X ray chest** – to rule out embolization and pulmonary metastasis
- **CT chest,abdomen and brain**

LIMITATIONS

- Early gestations- beta HCG not highly elevated.
- False negative usg where chorionic villi have not attained characteristic vescicular pattern - early gestations
- Only 20-30% of partial moles have sonographic evidence
- Diagnosis made from the histological view of abortal specimen

- In unclear cases with live fetus & desired pregnancy, **fetal karyotyping** is done for the triploidy.

Histopathology

- Need to differentiate from **hydropic abortuses**
- Failed pregnancies from union of haploid egg & halpoid sperm.
- Show hydropic degeneration.

- **Complete moles-**
- a)Trophoblastic proliferation
- b) hydropic villi

Partial moles

1. Two populations of villi
2. Enlarged dysmorphic villi with trophoblastic inclusions.
3. Enlarged cavitated villi
4. Syncitiotrophoblastic hyperplasia

ANCILLARY TECHNIQUES

- Immunostaining of p57KIP2
- expressed only in tissues containing maternal allele.
- So absent in complete moles
- Molecular genotyping determines whether
- Diploid diandric
- Triploid diandric monogynic
- Biparental diploidy

MANAGEMENT

2 PHASES

- IMMEDIATE EVACUATION.
- SUBSEQUENT FOLLOW UP.

EVACUATION

- **SUCTION EVACUATION** is the treatment of choice irrespective of size of the uterus
- Cervical ripening agents like misoprostol- to dilate the cervix to facilitate evacuation,if needed
- Not given in nulliparous, as it increases uterine contractions & risk of embolisation to pulmonary vasculature

PRE-OPERATIVE

- History and clinical evaluation.
- Laboratory tests:
  - Hemogram
  - Serum beta –Hcg
  - Creatinine
  - Hepatic amino transferase
  - TSH, free T4 levels
  - Blood grouping, screening and crossmatch

- Chest radiograph
- Ultrasound pelvis to exclude pregnancy
- Adequate cross matched blood has to be arranged
- Iv infusion started (chance of heavy bleeding)
- CT or MRI of head for brain metastasis.

INTRAOPERATIVE

- Large bore IV catheters
- Done in local anaesthsia. Regional and general used if needed.
- Karman cannula –size 6 or 8
- Consider sonography machine.
- If significant haemorrhage prior to evacuation, surgical evacuation should be done, The need for oxytocin infusion weighed up against the risk of tumour embolisation.

- Symptomatic **Theca leutin cysts** usually regress after evacuation.
- In extreme cases, aspiration is done.
- If torsion lead to extensive infarct, oophrectomy is suggested.

POST EVALUATION.

- Once evacuation is complete a gentle but thorough curettage is done to remove any remnants
- Intra or post evacuation ultrasound is done to ascertain the completeness of evacuation
- If necessary, a check curettage can be done.
- **All products of conception must be sent for HPE** – to confirm,to rule out neoplasia, presence of fetal parts
- **Anti-D prophylaxis** to mother if Rh-ve

Complications during evacuation

- Haemorrhage
- Perforation (as uterus is very soft) – emergency laparotomy needed
- massive DIC / massive pulmonary embolization by molar tissue.

  Sudden unexplained collapse during evacuation from acute pulmonary HTN and cardiac failure

ROLE OF HYSTERECTOMY

- NOT indicated except as prophylaxis for preventing choriocarcinoma in patients in perimenopausal age & who have completed family ;
- But even with hysterectomy,chance of metastasis is always present

FOLLOW UP

- CRUCIAL part of management
- Helps in early detection of any malignant change and prompt institution of chemotherapy

- Weekly follow up with BhCG till levels become normal (usually within 8 weeks)
- Thereafter monthly testing for 6 months (risk of developing GTN is greatest in the first 6 months)
- If not normal within 8 weeks, follow up till 6 months after the B hcg becomes normal.
- Contraceptive measures are adopted to prevent pregnancy.
- Advised not to conceive till follow up is complete.

- Each visit : **relevant symptoms** – irregular bleeding,persistent cough ,hemoptysis , dyspnea

- **Clinical examination** – uterine size

  ovarian cysts

  vulval & vaginal metastasis

  distant metastasis

- **Ultrasound** if necessary – residual/locally invasive tumor, subinvolution of uterus ,ovarian cysts

Risk of GTN

- **Complete moles** - 20% progress to GTN

Risk factors for postmolar GTN:

- Advanced maternal age
- High preevacuation BhCG levels >1lakh mIU/mL
- Uterus large for dates
- Bilateral theca lutein cysts
- Respiratory distress after evacuation
- Eclampsia or Hyperthyroidism
- Uterine subinvolution with post-evacuation bleeding