Management of gestational trophoblastic disease

This statement has been developed by the
2 ضَ A list of Women's Health Committee Members
be found in Appendix B.

Declarations of interest have been received from all principal authors and Women's Health Committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: November 2013
Current: March 2017
Review due: March 2020

Objectives: To provide advice on the management of gestational trophoblastic disease.

Target audience: All health practitioners providing maternity care, and patients.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Validation: This statement was compared with RCOG[1] and ACOG[2] guidelines on this topic.

Funding: The development of this statement was funded by RANZCOG.

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PSTT is increasingly thought of as a separate entity, as its behaviour differs from other GTDs. PSTT should be considered in cases of relapse. Treatment for PSTT is usually hysterectomy.

4.1.5 Epithelioid Trophoblast Tumour (ETT)

Epithelioid Tropho į ╔ φ ɒ ő ʻ

4.3 How should GTD be managed?

Suspected molar pregnancy

Early pregnancy

- Ultrasound features
- PV bleeding
- Hyperemesis
- Abnormally high βhCG levels

Mid-trimester

- Large for dates
- Pre-eclampsia, hyperthyroidism, pulmonary

Counselling

Inform both patient and GP:

- Pregnancy is now a reasonable option
- Fertility rate not affected
- 1:70 risk of repeat molar pregnancy, therefore recommend early ultrasound, and βhCG level 6 weeks following the completion of any future pregnancies **(regardless of outcome of that pregnancy)**

5.4 Follow-up

5.5 Technical information

7. References

1. Royal College of Obstetricians and Gynaecologists. The Management of Gestational Trophoblastic Disease: Green-top Guideline No. 38. 2010.
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3. Wells M. The pathology of gestational trophoblastic disease: recent advances. Pathology. 2007;39(1):88-96.
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5. Shen X, Xiang Y, Guo L, Ren T, Feng F, Wan X*, et al.* Analysis of clinicopathologic prognostic factors in 9 patients with epithelioid trophoblastic tumor. Int J Gynecol Cancer. 2011;21(6):1124-30.
6. Nugent D, Hassadia A, Everard J, Hancock BW, Tidy JA. Postpartum choriocarcinoma presentation, management and survival. J Reprod Med. 2006;51(10):819-24.
7. Tidy JA, Rustin GJ, Newlands

8. Further reading

1. Berkowitz RS, Goldstein DP. Current advances in the management of gestational trophoblastic disease. Gynecol Oncol (2013); Jan;128(1):3-5.

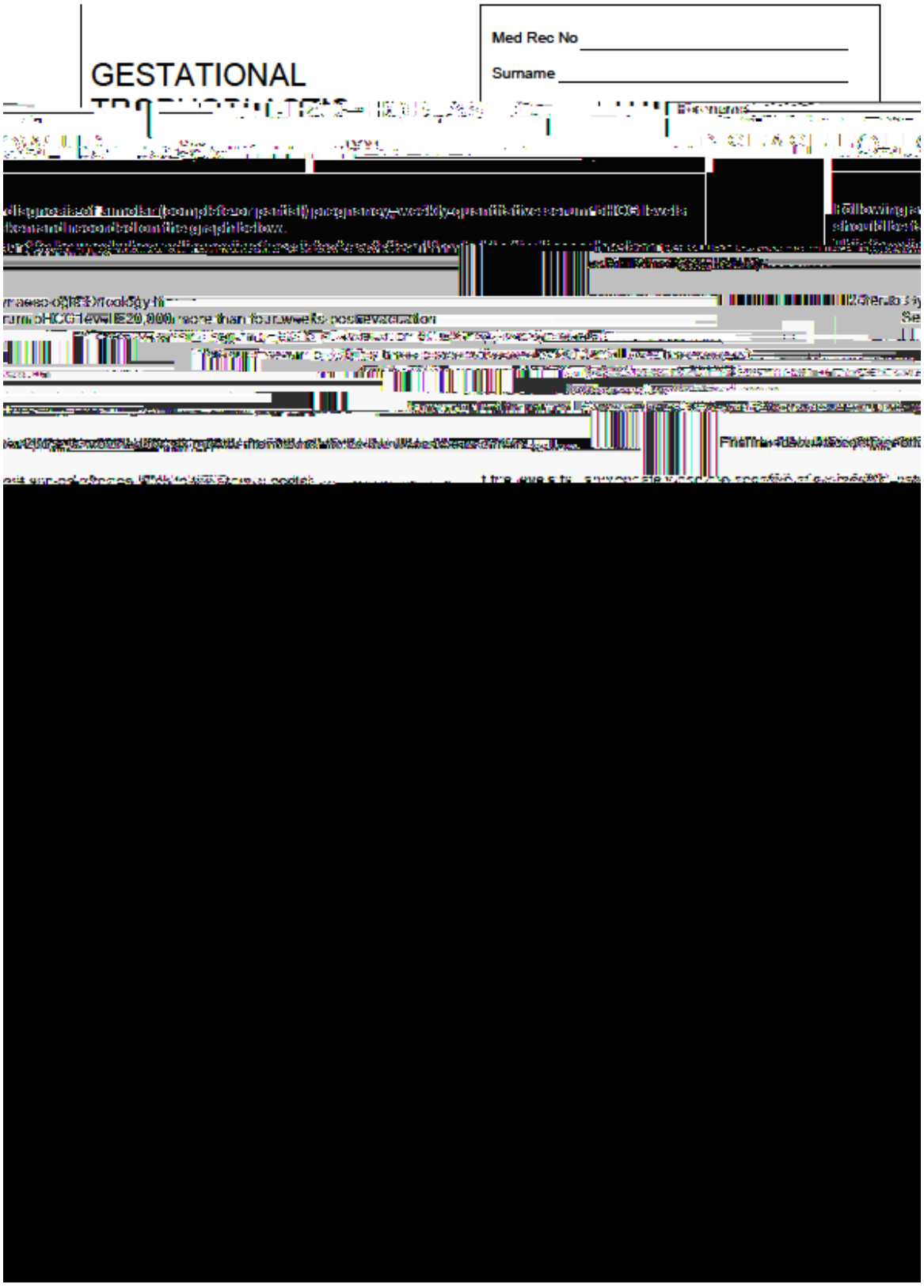
2. Kerkmeijer L *et al.* Guidelines following hydatidiform mole: a reappraisal. Aust NZ J Obstet Gyanecol. 2006 Apr;46(2):112-8.

3. Kohorn EI. Negotiating a staging and risk factor scoring system for gestational trophoblastic neoplasia. A progress report. J Reprod Med. 2002;47(6):445.

4. International Federation of Obstetrics and Gynecology Oncology Committee. FIGO staging for gestational trophoblastic neoplasia 2000. Int J Gynecol Obstet 2002;77:285–7.

Appendices

Appendix A GTD Follow-up form (Source: Western Australian Gyneacologic Cancer Service)



Appendix B How should GTN be managed?

GTN

Persistent GTD
PSTT, ETT
Choriocarcinoma

Metastatic workup

Request MDT review

Organise FBE, UE, LFT, Group and hold, quantitative serum βhCG, TFT

Organise metastatic screen (CT head, thorax, abdomen and pelvis. (Additional MRI head if choriocarcinoma, pulmonary metastases or neurological symptoms)

WHO Risk score

Age
Antecedent pregnancy
Interval months from index pregnancy
Pre-treatment βhCG level
Largest tumour size (cm)
Site of metastases
Number of metastases
Previous failed chemotherapy

WHO Score <7

Low risk protocol

Low risk protocol

Methotrexate/Folinic acid OR Actinomycin D

Example protocol MTX

Methotrexate 1mg/kg IMI on Day 1,3,5,7 and Folinic Acid 0.1mg/kg IMI (or 15mg oral) on Day 2,4,6,8 repeated every 2 weeks

Example protocol Actinomycin D

Actinomycin 1.25mg/m^2 (max 2mg) IV every 2

βhCG normalises

Chemotherapy until normal βhCG level, then further three cycles

Monthly βhCG for 12 months, advise not to conceive during that time

Inform both patient and GP:

Patient cleared to get pregnant
Fertility rate not affected
1:70 risk of repeat molar pregnancy, therefore recommend early ultrasound, and βhCG level 6 weeks following the completion of any future pregnancies **(regardless of outcome of that pregnancy)**

WHO Score 7 or more

High risk protocol

High risk protocol

EMACO – example protocol

Appendix C Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Professor Susan Walker	Member
Associate Professor Ian Pettigrew	Member
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Dr Lisa Hui	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the A&TSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Appendix D Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was developed during 2013 and most recently reviewed in March 2017. The principle authors carried out the following steps in developing this statement:

Declarations of interest were received from all principal authors and Women's Health Committee members prior to reviewing this statement.

Structured clinical questions were developed and agreed upon.

A literature search to answer the clinical questions was undertaken and a draft was

appropriate) based on the body of evidence and clinical expertise of Women's Health Committee.

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.[18] Where no robust evidence was available but there was sufficient consensus within the writing group, consensus-based recommendations were developed and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations

Good Practice Note	Practical advice and information based on clinical opinion and expertise

Appendix E Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.