



# Molar Pregnancy

**Tena koutou katoa, Kia orana, Talofa lava, Malo e lelei, Fakaa-  
lofa lahi atu, Taloha Ni, Ni Sa Bula Vinaka,**

**Greetings and Welcome to National Women's**

## Introduction

This booklet provides general information for women who have been diagnosed with a **molar pregnancy**, also called a **hydatidiform mole**. As a booklet, it provides basic information about a molar pregnancy and the required follow-up. It does not contain all the information you will need to know about a molar pregnancy. It is important that you discuss any issues or concerns with the doctor or nurse involved with your follow-up care.

## What is a Molar pregnancy?

Molar pregnancy is part of the spectrum of diseases known as trophoblastic disease. It is an uncommon complication of pregnancy. A normal pregnancy consists of two parts. Firstly, the fetus or developing baby, and secondly, the placenta or after-birth, which is made of millions of cells called trophoblasts.

In trophoblastic disease there is an abnormal overgrowth of all or part of the placenta, causing what is called a molar pregnancy or hydatidiform mole.

A hydatidiform mole is usually harmless, however it can keep growing and, if left untreated, can bury itself into the organs around it, including the uterus (womb) and even spread via the blood to other distant organs including the lungs, liver or brain.

Once it has reached this stage, it can have serious effects and is referred to as persistent gestational trophoblastic disease.

Although a hydatidiform mole is not cancer and rarely becomes cancerous, it can behave in similar ways. Most of the treatment is aimed at stopping the disease process long before any of these things happen.

Different types/stages of moles:

- Partial mole
- Complete mole
- Persistent gestational trophoblastic disease Choriocarcinoma

### **Hydatidiform mole**

The commonest kind of trophoblastic disease is where the overgrowth is benign but may spread to other parts of the body if not treated. This is further subdivided into:

- Partial Mole

Where part of an apparently normal placenta overgrows (proliferates) and another part develops normally. There may be a developing fetus present, but unfortunately it is genetically abnormal and cannot survive outside the womb.

- Complete Mole

Where the whole placenta is abnormal and usually grows very rapidly. There is no developing fetus in these pregnancies.

### **Persistent Gestational Trophoblastic Disease**

This is where some of the mole remains in any part of the body despite initial treatment by the gynaecologist. Even a tiny amount anywhere in the body can grow quickly and cause problems, so active treatment of this condition is very important.

### **Choriocarcinoma**

Very rarely the abnormal placental tissue can form a cancerous growth. This can arise from a molar pregnancy or an otherwise normal pregnancy or miscarriage. Choriocarcinoma can also spread throughout the body, usually to organs like the lungs,

liver and brain.

This is very rare and generally curable.

## **Diagnosis**

The diagnosis of a molar pregnancy is usually established by the pathologist when he/she looks at the placenta under a microscope. This is done routinely after any miscarriage, or ectopic pregnancy.

A molar pregnancy may be suspected for several reasons in an ongoing pregnancy, for example, if the womb is larger or smaller than it should be for the stage of the pregnancy, or if you are being sick more than expected in a normal pregnancy.

Complete hydatidiform moles also have a characteristic appearance on an ultrasound scan. The placental tissue has a grape-like appearance so this, and the fact that no developing fetus is seen when you have a scan at the antenatal clinic, can allow the diagnosis to be made.

You will probably undergo a dilatation and curettage (D&C,) to remove as much of the placenta from your womb as possible. This is a minor operation which is carried out under a general anaesthetic.

In most cases, one or occasionally two of these minor operations will be enough to remove the abnormal tissue permanently.

## **Follow up care after surgery**

Molar pregnancies are not cancer but can persist. Persistent molar pregnancy can turn into cancer (choriocarcinoma) or behave like a cancer. However, provided you are carefully monitored, persistent or cancerous molar pregnancy will be diagnosed early and chances of cure are excellent.

For these reasons follow-up care is very important and usually continues for between 2 and 12 months. Very occasionally the follow-up period will be longer. **This will be organised via the Early Pregnancy Assessment Unit**

In a normal pregnancy the placenta makes many hormones to support itself, the baby and the mother. One of these hormones is called human chorionic gonadotrophin (HCG), and in a molar pregnancy (where there is overgrowth of the placenta) there is a large amount of this hormone produced. HCG can be readily measured in the laboratory from blood or urine samples.

A sub-unit of HCG, called bHCG, is used to diagnose pregnancy and is available in all laboratories. It is most helpful in molar pregnancies to measure the whole HCG molecule.

HCG levels reflect the amount of active placental or molar tissue in the body and allow us to accurately track the progress of the disease.

Once diagnosis of a molar pregnancy has been confirmed, the test results will be reviewed by a consultant or registrar.

At your first appointment, the doctor will discuss your diagnosis and the recommended follow-up arrangements. This will involve having regular blood tests. You will need to have a chest X-ray. Occasionally, an ultrasound scan is also performed.

If a molar pregnancy is suspected or confirmed you will begin having weekly blood tests to monitor the fall of the HCG. As mentioned earlier, this is done using a more sensitive hormone level called a tumour HCG (THCG). Once the hormone level has reached a non detectable level the doctor or nurse involved in your follow-up then will explain how often to repeat the test.

If the THCG levels plateau or begin to rise, this would require further investigations to find out if you have a persistent molar pregnancy. If you develop persistent molar disease then it is

most likely you would need to receive a course of chemotherapy to treat the problem.

You should not try to get pregnant again while you are in the follow up period. Contraception will be discussed with you at your initial appointment.

### **When to contact the Molar Pregnancy Follow-up Nurse**

- If you experience any abnormal bleeding, for example, between your periods or your periods have not returned and you are not pregnant.
- If you cough up any blood.
- If you have any unusual headaches.
- If you have any concerns relating to your treatment or follow-up arrangements.

### **Future Pregnancies**

Future pregnancies do not necessarily need to be cared for by a specialist / obstetrician, but some medical input by an obstetrician is advised. This is because of the possibility of reoccurrence.

It is strongly recommended that you do not become pregnant during the follow-up period. This is because both normal and molar pregnancies produce BHCG. If you are pregnant it is not possible to detect the presence and monitor the progress of persistent or recurrent molar tissue and this may delay diagnosis if the molar tissue becomes cancerous. This delay may mean it is more difficult to cure.

If you are planning a pregnancy it is extremely important that you discuss this with the doctor so your blood tests can be assessed and personalised advice given. If you become pregnant during your follow-up period, please contact the Early Pregnancy Clinic nurse as soon as possible.

Having a previous molar pregnancy will mean your chance of having another will increase to 1-in-70 pregnancies. It is therefore recommended that you have an early ultrasound scan in future pregnancies and have BHCG blood tests at six weeks and three months after any future pregnancy event.

### **Contraception**

You may use the contraceptive pill once your hormone levels have returned to normal range or you have had your first normal period. We recommend that you use barrier contraceptive methods such as condoms until this happens.

The insertion of IUCDs (intra-uterine contraceptive devices) should only be carried out in a hospital because insertion may be associated with a slightly greater chance of bleeding.

### **Counselling and Support**

You may feel shocked and anxious by the unexpected diagnosis of a molar pregnancy in addition to grieving for your lost pregnancy. It is therefore not surprising that many women who have a molar pregnancy feel overwhelmed at first.

Please do not hesitate to access the support available for you. Please feel free to contact the clinic nurse who follows up women with molar pregnancies.

The telephone number is 3074949 extension 27230

The Women's Health social worker is also available to assist you to work through the complex feelings you may experience. She may be contacted via telephone number 3670000 ask for the Women's Health Social Worker or mobile 021863152

**Further Information**

If you have any questions about your condition, treatment or about the information in this booklet, please ask the doctor or nurse involved with your care.

**Contact details:**

Early Pregnancy Assessment Clinic

ph: 3074949 ext 27230

Building 4, Level 6

Greenlane Clinical Centre

ADHB Gynaecology Service  
Women's Health  
August 2015