Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Molar Pregnancy

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Molar Pregnancy

Patient Information

Gynaecology Department

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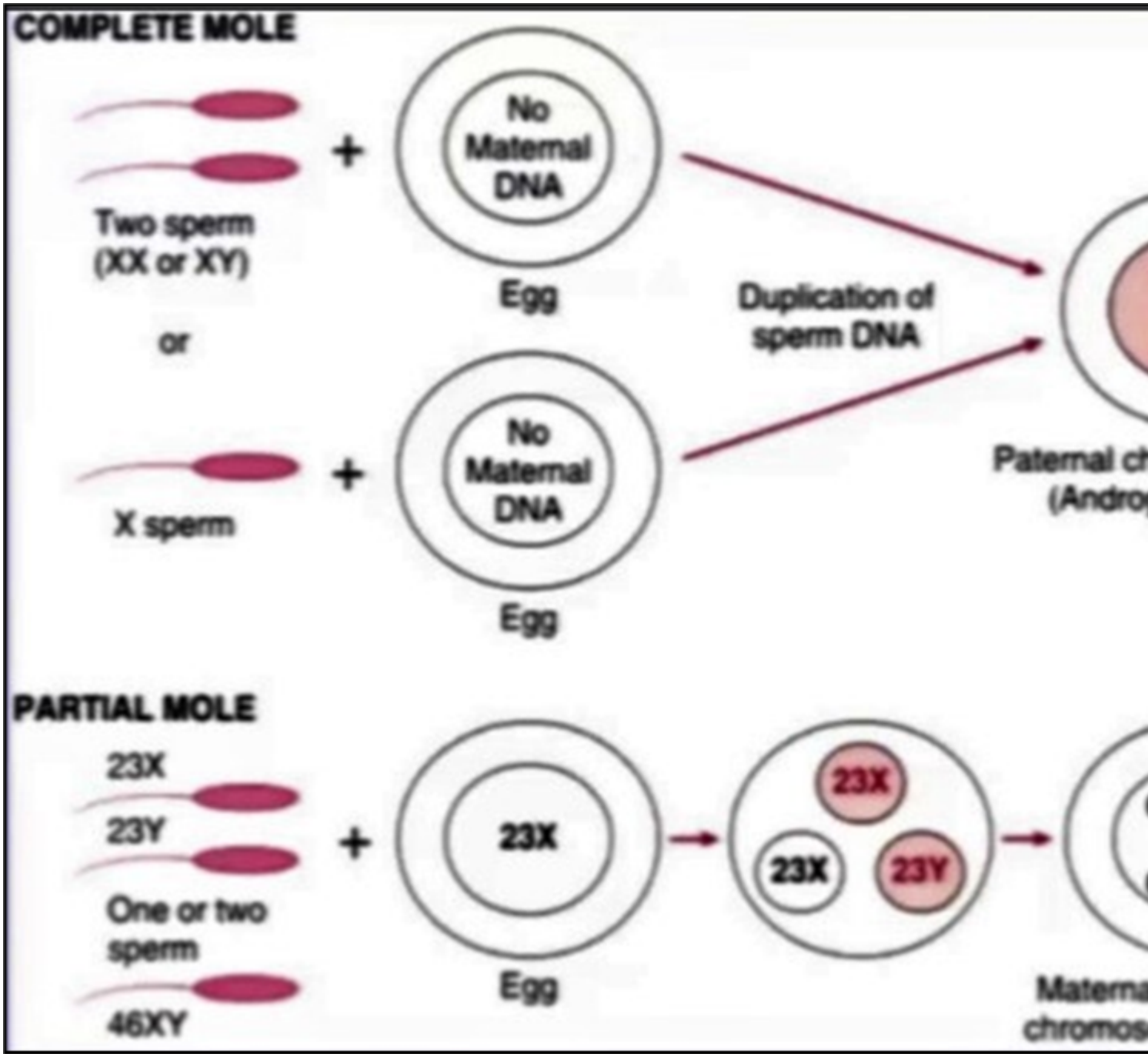
What is molar pregnancy?

A molar pregnancy is a disorder in which there is an overgrowth of the cells which would normally form the placenta (afterbirth) and usually the baby fails to develop. It may also be called ‘trophoblastic disease’ or ‘hydatidiform mole’, affecting 1 pregnancy in 714 live births. In healthy pregnancies, an embryo (baby) develops when a sperm fertilises an egg and the genetic material from each combine 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.

There are two types – complete mole and partial mole.

- Complete moles usually occur when a single sperm fertilises an ‘empty’ egg which has no genetic material inside, and then divides to give the fertilised egg a normal number of chromosomes, all of which have come from the father. Complete moles can also occur when two sperm fertilise an ‘empty’ egg.

- Partial moles occur when two sperm fertilise a normal egg and the developing pregnancy then has three sets of chromosomes or more. In a partial mole, there are usually some early signs of development of a foetus on ultrasound, but it is always abnormal and cannot develop into a baby.



A period of follow up is advised after a molar pregnancy, because there is a small risk of the molar tissue continuing to grow and possibly spreading to other parts of the body, even though you may feel perfectly well in yourself.

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 foetus visible on

scan, but it is not developing properly and cannot survive.

What causes it?

No definite cause has been identified, but the following may increase the risk of having a molar pregnancy:

- Age over 40 years and under 15 years
- Previous history of molar pregnancy (1 in 80)
- Possible ovulatory disorders
- History of miscarriage
- Living in certain geographic locations e.g. Eastern Asia, Northern Brazil
- A diet low in carotene (a form of vitamin A)

What are the symptoms of molar pregnancy?

Symptoms usually appear in the second or third month of pregnancy. Some women may have no symptoms. Most molar pregnancies are now detected early before the onset of symptoms. When symptoms occur, these include:

Common	• Vaginal bleeding • Severe nausea and vomiting • Tummy pain or cramps
Less Common	• High blood pressure • Coughing (sometimes with blood) • High levels of thyroid hormone •

How is it diagnosed?

You may experience bleeding in early pregnancy and an ultrasound examination may result in the diagnosis being suspected. The diagnosis is confirmed after a miscarriage or evacuation of the uterus, when tissue from the womb is sent to the laboratory for examination under a microscope.

How is it dealt with?

You will usually have at least one minor operation (evacuation of the uterus sometimes known as a D and C) to ensure that all molar pregnancy has been removed from the womb. This tissue is sent to the laboratory for examination.

Because it is a very rare condition, there are only three national centres which monitor women who have had a molar pregnancy. One centre is in London, one in Dundee and one in Sheffield. In most cases, ladies from Wrightington, Wigan and Leigh NHS Foundation Trust are followed up by the Sheffield Centre, although you do not actually need to go to Sheffield. Your urine and blood samples are sent there by post (see below).

In 6% or 1 in 15 cases, drug treatment is required to eliminate any remaining disease. This treatment is organised by and commenced in Sheffield, but some of the medication can be given in Wigan.

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.

How will I be followed up?

Follow-up involves measuring the levels of the pregnancy hormone called Human Chorionic Gonadotrophin (HCG), in urine samples and occasionally in the blood. Pre-paid boxes are provided for you to post your samples to the screening centre, also full instructions on how to collect the urine samples. At first you will be asked to send a sample of urine every week. From time to time, the interval will be increased and every so often you will be asked for a blood test which will be taken at your local hospital.

If the HCG levels fall quickly, you will need to be followed up for only six months from the end of the pregnancy, otherwise it may be for longer and will continue for six months from the date of your first normal results.

When can I try for another baby?

You will be advised **not** to become pregnant during follow-up, as it makes it difficult for the screening centre to monitor your progress properly. The coil (IUD) is not recommended as it may cause perforation in the uterus if it is inserted too soon after treatment for a molar pregnancy. A barrier method of contraception (sheath or cap) is advisable. Oestrogen and/or progestogens, taken between evacuation of the mole and the return to normality of HCG values, appear not to increase the risk of invasive mole or choriocarcinoma developing. Therefore, women may use oral contraceptives after molar evacuation, before the HCG returns to normal.

Avoid a new pregnancy for six months from the date of the end of the molar pregnancy if results have returned to normal within 56 days. If the result returns to normal more than 56 days from the end of the molar pregnancy, avoid a new pregnancy until six months of normal results having been achieved.

What happens if I become pregnant during follow-up?

If you become pregnant during follow-up, the pregnancy will need to be confirmed by ultrasound scan. The centre in Sheffield will be informed by your Consultant (or you can inform them yourself if you wish) and the follow-up will be temporarily suspended.

The detection rate for recurrent molar pregnancy on routine post-pregnancy screening of women previously diagnosed with one molar pregnancy is extremely low. Therefore, the national gestational screening service has deemed it safe to no longer require HCG monitoring for women post-pregnancy who have had one previous molar pregnancy that has not required chemotherapy.

For women previously treated with molar pregnancy-related cancer, post-pregnancy monitoring should still be continued.

Am I likely to have another molar pregnancy?

It is possible, but very unlikely. Your chance of a normal pregnancy after a molar pregnancy is more than 98%, even if you have had chemotherapy. As a precaution you will need follow up tests after every pregnancy, whether normal or a miscarriage.

What is Gestational Trophoblastic Neoplasia?

If you have had molar pregnancy, it does not mean you have cancer. One in five patients who have had a hydatidiform mole have tissue not completely eliminated by D&C. This happens when molar pregnancy cells keep growing into the wall of uterus and they may spread to other parts of body through the blood stream. If this happens, it is called ‘gestational trophoblastic neoplasia’ or ‘persistent trophoblastic tumour’. Trophoblastic disease may develop into cancer, but it is very treatable with chemotherapy. It has a 99.9% cure rate when treated early with chemotherapy.

Further information

Information can be obtained from the web site of the International Society for the Study of Trophoblastic Diseases: **https://isstd.org/patient-info.html**

General information

If you have any questions or concerns, please feel free to discuss them with any member of staff.

Ward 2 Leigh Infirmary	Swinley Ward
Monday to Friday	Royal Albert Edward Infirmary
7:30am until 8:30pm	(Outside these hours)
Telephone: 01942 264857 or 01942 264252	Telephone: 01942 822568



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