Updated management of Gestational Trophoblastic Neoplasia using a State Registry

Hodge T, McNally O
Royal Women's Hospital, VIC
Taylor.Hodge@thewomens.org.au

the women's
the royal women's hospital
victoria australia

Introduction

A Victorian statewide registry is used to monitor gestational trophoblastic disease, including gestational trophoblastic neoplasia (GTN). From mid-2016 management of GTN was updated, with ward-based care for low-risk disease, and referral of high-risk disease to the new Peter McCallum Cancer Centre. Our aim was to evaluate protocol compliance and outcomes for women in Victorian with GTN.

Methods

All women treated for GTN between July 2016 – July 2017 were included (n=20) and following registration with the Victorian Molar Registry, data was entered prospectively into electronic databases (HyMol and GEMMA). Clinical notes were also consulted.

Results

The majority of patients were multiparous (65%) and <39 years old (75%), with complete hydatiform moles (85%) diagnosed on histopathology following surgical evacuations (90%). Staging imaging (chest, pelvic, and cerebral when indicated) was consistent. All patients commenced chemotherapy <4 months following diagnosis: 90% low risk patients on single agent therapy, 5% high risk regimen and 5% resistant disease upgraded from low to high risk therapy. The median serum beta-human chorionic gonadotropin (bHCG) at diagnosis was 12,257 but lack of power prevented correlation between diagnosis bHCG and number of chemotherapy cycles required. Of the patients who finished receiving chemotherapy (60%), 83% completed treatment including recommended consolidation cycles, but the remaining disengaged secondary to treatment burden (including side effects). Patients rarely consented to adjunctive surgical management except in cases of persistent bleeding. 83% are compliant with regular post-chemotherapy surveillance.

Table 1: Chemotherapy treatment and compliance for GTN management in Victoria

Chemotherapy regime	Total number	Completed treatment	Surveillance compliance	Surgical adjunct	Side effects
Low risk *Methotrexate (MTX) or Actinomycin-D*	18 (90%) *All chose MTX 1st line, 1x MTX resistant received Act-D 2nd line*	9/11* (82%) *1x disengaged during active MTX, 1x during consolidation MTX*	9/11 (82%) *1x disengaged completely, 1x pregnant during surveillance*	2/18 (11%) repeat evacuation 1/18 (6%) hysterectomy *(persistent bleeding)*	4/18 (22%) mucositis 1/18 (6%) liver derangement *(all managed conservatively)*
Low risk converted to high risk	1 (5%) *MTX/Act-D, then EMACO and now TE/TP for repeat recurrences*	Ongoing treatment	N/A	0/1 (0%)	0/1 (0%)
High risk *(EMACO or TE/TP)*	1 (5%) *Choriocarcinoma EMACO*	1/1 (100%)	1/1 (100%)	0/1 (0%)	1/1 (100%) Peripheral neuropathy *(partial dose reduction)*

**7 still actively receiving MTX at audit conclusion*

Conclusion

The majority of Victorian patients with GTN had low risk disease following complete hydatiform moles, and responded to single agent therapy with minor side effects only. This audit revealed adequate treatment completion and surveillance compliance rates.