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Follow up of a gestational trophoblastic disease management: Need for information education and communication (IEC) module

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Abstract
Objective: Clear standards for diagnosis, treatment, and follow-up are necessary for the management of gestational trophoblastic disease (GTD). Poor care, inconsistent surveillance, therapy and drop-out are all very prevalent especially in environment with lack of resources and can cause morbidities and problems that are potentially fatal. In order to deal with these issues, this type of patient should be monitored with the help of anganwadi workers, healthcare professionals who keep in touch with these patients for routine follow-up, and chemotherapy at tertiary care hospitals. Utilizing telemedicine is another option for keeping track of these patients.
Conclusion: This approach was implemented and carefully monitored, which improved patient care by preventing dropouts and delays in identifying and managing issues.

Keywords: Workers, healthcare professionals, managing issues

Introduction

The phrase "gestational trophoblastic illness" refers to the diverse collection of linked lesions that result from the aberrant proliferation of placental trophoblasts. Malignant lesions include invasive moles, placental site trophoblastic tumours (PSTT), epithelioid trophoblastic tumours (ETT), and choriocarcinoma. Benign lesions include hydatidiform moles, both complete and partial [1].

The term "gestational trophoblastic neoplasia" refers to a subset of malignant lesions with varied propensities for local invasion and metastasis (GTN). Even when they have global distribution, certain rare human cancers, such as GTNs, can be treated [2].

A detailed pathologic review revealed that the prevalence of whole and partial hydatidiform moles was 1:945 and 1:695, respectively. The rate of molar pregnancy is influenced by maternal age and reproductive history. A full mole is 2- to 10-fold more likely to occur in women over 40. A full mole might develop seven times more frequently in adolescents. According to these results, eggs from older and teenage women may be more susceptible to aberrant fertilisation, which would result in fully developed hydatidiform mole [3].

Over the past three decades, numerous studies on GTD patients, therapeutic outcomes, and quality of care have drawn attention to the frequent absence of clear guidelines and protocols for diagnosis and treatment in many healthcare settings, which can result in inadequate risk classification, inaccurate treatment, insufficient post therapeutic surveillance, or even drop-out. Evaluations have revealed a definite improvement in the care of patients and the prognosis of their diseases as a result of the establishment of GTD reference centers and observatories to address these deficiencies [4].

One such instance of choriocarcinoma was diagnosed at RPGMC Tanda and was routinely monitored personally by telephone and with the aid of telemedicine throughout the COVID period for her chemotherapy cycles. Patients have been encouraged to implement the GTD management programme in order to improve their care due to the lack of standardized practices in diagnosis, treatment, and patient surveillance among practitioners, patients limited understanding of their condition due to inadequate explanations, irregular follow-up, and frequent dropout. Follow-up with the aid of telemedicine and with the assistance of anganwadi workers and healthcare workers has also helped to motivate patients.

Case report

A married P0A2 age 23 arrived in the delivery room with a history of 4 days of vaginal bleeding and 4 days of lower abdominal pain as well as significant anaemia (Hb 4.5 g/dl) and molar pregnancy. It was accompanied by weariness and dizziness, and there was no prior history of palpitations, heart palpitations, oedema, fever, vomiting, or loss of consciousness.

The patient has a history of a two-molar pregnancy and has been married for two years. In her first pregnancy, which she experienced spontaneously after three months of marriage, she underwent suction and evacuation in Chamba after receiving a diagnosis of molar pregnancy at about 12 to 14 weeks. After an earlier spontaneous pregnancy that lasted 1.5 years, the patient became pregnant again. She was identified with a molar pregnancy at about 22 weeks and had suction and evacuation at DR RPGMC Tanda. Patient did not receive follow-up care and reported 3 months later with current Per Vaginum haemorrhage symptoms.

Patient showed tachycardia and pallor+++ upon assessment. On Per Abdomen, the patient felt a mass in the right fornix that was roughly 10x10 cm in size, firm too hard in consistency, and constrained in movement. On Per Vaginum, the uterus looks separate from the mass in the fornix. Another medium-consistency nodular mass, measuring 5x5 cm, was also felt via the anterior fornix and up to the urethral sulcus when the uterus was not present. A second mass that was hard and fixed at the lateral pelvic wall slid away from the left fornix. USG abdomen and Pelvis were uterus 99x54x64 mm with ET 7.2 mm with dilated endometrial cavity with fluid within cystic lesions involving myometrium. Bilateral ovaries were enlarged in size showing multiple cysts.

CECT abdomen with thorax showed that the uterus had been replaced by a heterogeneously enhancing mass lesion that was 15.6x10.6x8.6 cm in size and displayed areas of low attenuation foci surrounding by significantly increased areas, closely This lesion is seen to encase the bilateral iliac vessals and is adjacent to the anterior abdominal wall, showing loss of fat planes, the urinary bladder anteriorly and the rectum posteriorly, and surrounding gut loops. It also has opened venous collaterals and multiple metastatic nodules in the bilateral lung fields. Finding suggestive of Choriocarcinoma with metastases

Management

The radiotherapy department identified the patient as having high risk GTN and started them on the EMACO regimen, which consists of Actinomycin D, Etoposide, and Methotrexate.

At a nearby hospital, the patient was assessed by serum beta-HCG levels and ultrasonography during telephonic follow-up through telemedicine. Moreover, the patient's menstrual cycle condition was enquired about. The patient successfully finished her cycles of EMACO chemotherapy.

Discussion

After removal of the whole mole, roughly 15% of individuals develop locally invasive GTN, and other gestations rarely. Following total mole removal, metastatic GTN develops in roughly 4% of individuals, but it is more common when GTN develops after nonpolar pregnancies. Because of its propensity for early vascular invasion with broad dispersion, GTN typically metastasizes as choriocarcinoma. Due to patients' ignorance and lack of awareness, it has been challenging to follow up with these patients in rural locations where tertiary care facilities are far away. As in this instance, the patient entered with choriocarcinoma and was in poor condition at the time of admission. She also had recurrent H Mole and consistently lost in follow-up.

The majority of cases of metastatic GTN are choriocarcinomas that result from full molar gestations [5]. Following evacuation, treatment is recommended anytime choriocarcinoma is histologically determined to exist in four to five percent of entire moles [5]. Metastatic GTN is very vascular and prone to significant bleeding, either spontaneously or during biopsy, despite the fact that many patients are mostly asymptomatic. Lungs (80%), vagina (30%), pelvic (20%), liver (10%), and brain (10%) are the most frequent metastasis locations [6].

These patients can be followed up with the help of anganwadi staff, healthcare professionals who keep in touch with these patients for routine follow-up, and chemotherapy at tertiary hospitals. With the use of telemedicine, these patients can also be followed up on in these COVID moments.

These patient should be followed up on a regular basis by telephone, and the patient and patient attendant are being reminded of the importance of using contraception and that the management plan should be addressed with the IEC Module. Design of an Information, Education, and Communication (IEC) module, including (a) in-depth explanations of the characteristics of GTD in an understandable manner, (b) messages to raise awareness of the value and advantages of routine surveillance and the risks of irregular monitoring or drop-outs, and (c) systematic contraceptive counselling, in collaboration with the Department of Family Planning of the Center. Due to the high degree of curability of GTN, the goal of treatment should be to reduce medication toxicity, but not at the expense of treatment effectiveness [7].

Establishment of standardised GTD clinical files to uniformly record patient histories, treatment plans, and surveillance results. hCG values should be recorded in each file along with a semi logarithmic graph that will help to track patients' progress. Development of a local GTD Excel Electronic Registry that would house all patient data and should be updated each week by the practitioner in charge [7].

Conflict of Interest

Not available

Financial Support

Not available

References

1. Cunningham, Leveno, Bloom. Williams Obstetrics. 25th ed. Tata McGraw Hill; c2018.
2. AlJulaih GH, Muzio MR. Gestational Trophoblastic Neoplasia. In: StatPearls. StatPearls Publishing; c2023. Accessed August 5, 2023. http://www.ncbi.nlm.nih.gov/books/NBK562225/
3. Martin BH, Kim JH. Changes in gestational trophoblastic tumors over four decades. A Korean experience. J Reprod Med. 1998;43(1):60-68.
4. Lybol C, Centen DW, Thomas CMG. Fatal cases of gestational trophoblastic neoplasia over four decades in the Netherlands: A retrospective cohort study. BJOG. 2012;119(12):1465-1472. doi:10.1111/j.1471-0528.2012.03480.x
5. Seckl MJ, Sebire NJ, Berkowitz RS. Gestational trophoblastic disease. Lancet. 2010;376(9742):717-729. doi:10.1016/S0140-6736(10)60280-2
6. Thomakos N, Rodolakis A, Belitsos P. Gestational trophoblastic neoplasia with retroperitoneal metastases: A

fatal complication. World J Surg Oncol. 2010;8:114. doi:10.1186/1477-7819-8-114
7. Sekharan PK, Sreedevi NS, Radhadevi VP, Beegam R, Raghavan J, Guhan B. Management of postmolar gestational trophoblastic disease with methotrexate and folinic acid: 15 years of experience. J Reprod Med. 2006;51(10):835-840.

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