

**Introduction/Background** Twin pregnancy with complete mole is a rare entity, with high risk and non-standardized management. This case allows us to share our experience regarding this entity.

**Methodology** We report the case of a twin pregnancy with complete mole managed in the gynaecology-obstetrics department of the Aziza Othmana hospital in Tunis in April 2022.

**Results** This is a 39 year old patient, chronically hypertensive, who consulted our emergency at 22 weeks of amenorrhea (WA) + 3 days for metrorrhagia. She was a nulliparous woman with a history of early spontaneous miscarriage and fetal death in utero at 6 months in relation with pre-eclampsia. Her 1st trimester ultrasound showed a single fetus with fine nuchal translucency and bilateral uterine artery notch. Her maternal 1st trimester serum markers revealed an elevated trisomy risk of 1/101 and a beta HCG level at 15.35 mom. Ultrasound on admission revealed a 21 (WA) fetus in severe oligohydramnios with a 65\*58 mm heterogeneous honeycomb overlying placenta opposite the internal cervical os suggestive of partial mole. The patient presented with heavy metrorrhagia requiring a transfusion of 3 packed red blood cells and a caesarean section revealing a vesicular overlying placental mass and a fetus of 21 (WA), the end of the operation was uneventful with a blood loss of 500cc. The weekly bhcg levels kinetics were as follows: initial value 11768 mUI/L, at day 7 post operative 242 mUI/L with no image of retention, until it was negated in less than 8 weeks.

**Conclusion** This rare neoplastic pathology cannot be diagnosed by ultrasound or macroscopic examination of the placenta with certainty; only anatomopathological examination provides the diagnosis

#### 2022-RA-1187-ESGO MANAGEMENT AND OUTCOMES IN HIGH RISK GTN – A REGIONAL CANCER CENTER EXPERIENCE

Neha Jain, VR Pallavi, K Shobha, K Rajshekhkar, Tejas Vanakudri. *Department of Gynaecologic Oncology, Kidwai Memorial Institute of Oncology, Bengaluru, India*

10.1136/ijgc-2022-ESGO.908

**Introduction/Background** GTN is a chemosensitive malignancy with an excellent cure rate. Most women having high risk GTN (HRGTN) are treated with EMACO (etoposide, methotrexate, dactinomycin, cyclophosphamide, and vincristine), however, up to 25% of women with HRGTN have refractory disease & require alternate strategies.

**Methodology** 74 women with HRGTN treated at our center from 2006 to 2021 were retrospectively analyzed. Patients were initially started on EMACO & those who developed incomplete response or resistance were treated with salvage therapy which included various drug combinations (employing etoposide and platinum agents) and surgery.

**Results** The mean age of patients was 26.58 ± 6.76 years. Prior pregnancy was molar pregnancy in 33 patients (44.6%), abortion in 32 patients (43.2%), 2 had ectopic pregnancy (2.7%) & 7 had normal delivery (9.45%). Lung metastasis was present in 55 patients (74.32%), 7 had brain metastasis,

4 had vaginal & 3 had liver metastasis. Majority of the patients (66.2%) were in FIGO Stage 3 at the time of diagnosis. All patients received EMACO as the first line chemotherapy, 29 patients (39.2%) developed resistance and received EMA/EP regimen alone in 24 patients and EMA/EP followed by TC in 5 patients. Seventeen patients (23.72%) needed salvage surgery – hysterectomy (12), tumor resection (3) & lung metastectomy (2) and 7 received brain radiotherapy. Complete response to salvage therapy was seen in 82.5% patients. Majority of patients who received salvage therapy had  $\beta$ -hcg >10<sup>6</sup> mIU/mL (p= 0.023) & had FIGO score ≥12 (0.021). The patients were followed-up till May 2022 – 3 deceased during the course of treatment, 3 patients had recurrence and 7 patients conceived successfully and delivered a live baby.

**Conclusion** EMACO as first line chemotherapy and platinum/etoposide-based drug regimens along with surgery as salvage therapy in high risk patients were successful in achieving cure in high-risk GTN patients.

#### 2022-VA-1204-ESGO LOCAL MYOMETRIAL RESECTION FOR CHEMORESISTANT GTN

<sup>1</sup>Reda Hemida, <sup>2</sup>Ahmed Ragab, <sup>3</sup>Hisham Aboutaleb. <sup>1</sup>*Gynecologic Oncology Unit, Obstetrics and Gynecology department., Mansoura University, Mansoura, Egypt;* <sup>2</sup>*Obstetrics and Gynecology department, Mansoura University, Mansoura, Egypt;* <sup>3</sup>*Obstetrics and Gynecology department, Assiut University, Assiut, Egypt*

10.1136/ijgc-2022-ESGO.909

**Introduction/Background** Although gestational trophoblastic neoplasms (GTN) are highly chemosensitive tumors; chemoresistance was reported to occur in 15–25% of cases. As most of patients with GTN are within the reproductive age; Local myometrial resection (LMR) combined with uterine reconstruction might be considered in highly selected patients with non-metastatic GTN who wish to preserve their fertility.

**Methodology** A retrospective report of four cases who had been performed LMR with uterine reconstruction. The data of four cases were collected from computer and paper files of Gestational Trophoblastic clinic, Department of Obstetrics and Gynecology, Mansoura University. All cases were diagnosed initially as low-risk non metastatic GTN then developed resistance to chemotherapy. After re-assessment and counselling; they had been performed LMR as fertility-preserving surgery. The patients were followed up and serum B-hCG was checked weekly after surgery.

**Results** The mean age of the cases was 24.5 years. Three patients were nullipara and one case was primipara. The median operative time was 57.5 minutes and no blood transfusion was needed in all cases. The postoperative course was smooth. The post-operative histopathology revealed choriocarcinoma in two cases, invasive mole in one, and placental site trophoblastic tumor (PSTT) in one. Serum B- hCG reached a non-pregnant level after mean of 3.0 weeks of surgery. The follow up data were uneventful except ‘case 3’ who developed recurrence one month after surgery.

**Conclusion** Chemoresistant, non-metastatic GTN at young age can be managed with local myometrial resection with uterine reconstruction instead of hysterectomy. A multicenter-prospective study is recommended.