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THE EFFICACY OF SECOND CURETTAGE IN THE TREATMENT OF LOW-RISK GESTATIONAL TROPHOBLASTIC NEOPLASIA: A SYSTEMATIC REVIEW AND META-ANALYSIS

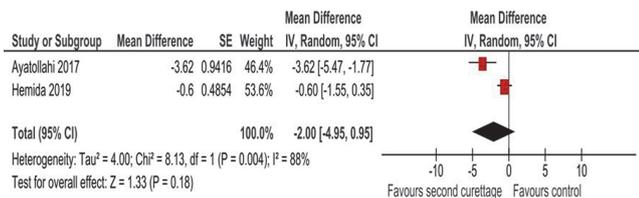
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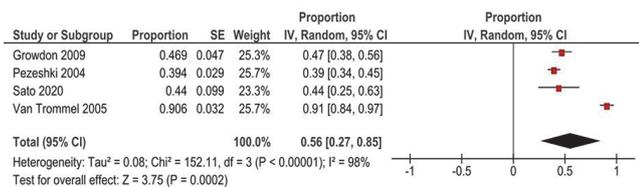
Introduction/Background Patients with low-risk gestational trophoblastic neoplasia (GTN) are almost universally cured with chemotherapy, but second uterine curettage has been explored as an alternative to avoid chemotherapy-related toxicities. We systematically reviewed intervention studies to determine whether second curettage in patients with low-risk GTN affects: 1) the proportion of patients requiring chemotherapy; 2) the number of chemotherapy cycles; and 3) the need for multi-agent chemotherapy.

Methodology A literature search was performed including the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, and Web of Science. Two authors screened titles, abstracts, and full texts and abstracted data. Risk of bias was assessed for each outcome. Data were pooled using a random-effects model and assessed for heterogeneity. Quality of evidence was assigned using GRADE.

Results Six studies met inclusion criteria; 2 randomized studies (RCT) and 4 cohort studies with control arm (CS). Mean difference in number of chemotherapy cycles was 2.04 fewer in patients who underwent second curettage (95% CI -5.00 to 0.91) based on two pooled RCTs (N=138). Those who underwent second curettage had RR=0.60 (95% CI 0.31 to 1.18) for requiring chemotherapy based on 4 pooled CS (N=1105), and RR=1.17 (95% CI 0.76 to 1.80) for multi-agent chemotherapy based on two pooled CS (N=900). The certainty of evidence is very low due to risk of bias for potential confounding, selection bias, missing data, and inconsistency of the results.



Abstract 2022-RA-745-ESGO Figure 1



Abstract 2022-RA-745-ESGO Figure 2

Conclusion In patients with low-risk GTN, second curettage may increase the proportion cured without chemotherapy, with a trend toward decreasing the number of chemotherapy cycles required, without increasing the risk of requiring

alternative chemotherapy. Prospective randomized trials including measurement of safety and fertility data are warranted as the quality of evidence in this review was low.

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GESTATIONAL TROPHOBLASTIC DISEASE IN PORTUGAL: RETROSPECTIVE ANALYSIS OF THE LAST 10 YEARS IN TWO INSTITUTIONS

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Introduction/Background Gestational trophoblastic disease (GTD) was first described by Hippocrates around 400 BCE as ‘dropsy of the uterus’. It is a rare disease that comprises a heterogeneous group of placental lesions arising from abnormal proliferation of the trophoblast. This study aims to evaluate demographic and clinical characteristics and survival outcomes of women diagnosed with GTD.

Methodology This is a cross-sectional retrospective study of patients diagnosed with GTD between January 2011 and December 2021 in two Portuguese institutions. Clinicopathological data, β-hCG levels, treatments and survival data were extracted from medical records.

Results A total of 59 women were diagnosed with GTD, with a median age of 33 years old (range 13–49). Forty patients had a previous pregnancy before diagnosis. 54 patients underwent uterine evacuation and 5 underwent hysterectomy. After histopathological examination, 48 cases were complete molar pregnancy, 9 were partial moles, 1 placental site trophoblastic tumour and 1 choriocarcinoma. 58 patients had FIGO stage I disease and 1 had FIGO stage III. We found 50 patients with a low-risk (FIGO prognostic score ≤4), 7 in the intermediate group (score of 5 or 6) and 2 with high-risk (score ≥7). 17 patients underwent adjuvant weekly intramuscular methotrexate (MTX) with a median of 12 cycles. 7 patients were treated with actinomycin D as second-line therapy due to MTX resistance. The 2 patients with FIGO prognostic score of high-risk underwent first-line chemotherapy with EMA-CO. Both 5-years progression free survival and 5-years overall survival were 97%, with only one death; the choriocarcinoma patient had a fatal pulmonary tumor embolism before starting chemotherapy.

Conclusion GTD is a rare disease, usually curable with chemotherapy, but high-risk disease can be very aggressive with worse prognosis. Despite being a rare disease, physicians’ awareness is critical. Early diagnosis, correct risk stratification and prompt treatment are the main goals for cure.

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TWIN PREGNANCY WITH COMPLETE HYDATIFORM MOLE AND COEXISTENT FETUS

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