pregnancies and their sequelae were followed up in medical oncology. The data was collected from out patient & in patient tickets & admission registrars and was analysed by descriptive statistics.

Results Most cases were seen amongst the second gravida 40%, Hindus 53.3%, low socio-economic strata 72%. Predominant Blood group was B 53%. Hemoglobin below 10 mg/dl was seen in 94%. 21.33% of patients had haemoglobin below 6 gm/dl. Most of the patients of Hydatiform Mole (50%) were diagnosed within a period of amenorrhea of 8–12 weeks with 70% of cases diagnosed with amenorrhoea of less than 16 weeks. 18% of patients were diagnosed after a period of amenorrhoea of greater than 20 weeks. The most common presenting symptom in cases of Hydatiform Mole was Bleeding per vagina 74%. Features of Hyperthyroidism & respiratory distress were seen in 5% of patients. The most common signs were pallor 65%, pre-eclampsia were seen in 17.33% of patients.

Suction & Evacuation 58.66% with Oxytocin infusion was the predominant mode of management in cases of Hydatiform Mole. Ligation was done in one patient considering the risk of repeat molar pregnancy in future conception.

Modes of diagnosis were clinical (74%), & USG in 68%.

Persistent Gestational Trophoblastic Disease and Choriocarcinoma were diagnosed during follow up by symptoms of irregular bleeding P/V, elevated beta HCG titre and abnormal USG pelvis and chest X-Ray.

Chemotherapy was the predominant mode of treatment of GTT. hysterectomy was done in 2 patients of Invasive mole.

Single agent chemotherapy with Methotrexate in 20 patients 83.33% i.e low risk GTT. EMA-Co regimen was the preferred multiagent chemotherapy used in 4 patients 18% (upfront) and in 2 patients progressing on methotrexate, surgery in 1 patient not responding to EMACO or EMA-EP.

Toxicity of chemotherapy was predominantly, Nausea & vomiting (38.89%) mucositis (27.78%). Hepatotoxicity and infection was seen in 11.11% of patients. Grade3/Grade4 toxicity was nil.

Conclusion Though the proportion of molar pregnancies & gestational trophoblastic neoplasia is not much in comparison to the heavy attendees in the gynaecology and obstetrics opd but they represent a highly curable one with minimally intense chemotherapy thus avoiding unnecessary hospital stay due to chemotoxicity.

Disclosure I do not have any conflict of interest with any person or organization.

422

NEW CHALLENGES IN THE MANAGEMENT AND FOLLOW-UP OF MOLAR PREGNANCY

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Introduction/Background Hydatidiform mole (HM) is the pre-malignant form of gestational trophoblastic neoplasia. This entity is of clinical and epidemiological interest because of its potential for significant consequences for women's reproductive health.

Methodology This is a retrospective study of all cases of molar pregnancy managed in County Emergency Clinical Hospital of Oradea from 1st January 2019 to 30th August 2020.

The details of maternal characteristics, clinical presentation, tumor type and management were studied.

Results We diagnosed 17 cases of molar pregnancy during this period of 20 months and managed 5364 deliveries. We also recorded 614 miscarriages and histopathological exams performed. The mean age of the patients with HM was 27,17 years old, with the highest incidence in patients between 15–20 years (29,41%). From all the cases of HM, 94,12% were diagnosed in first trimester of pregnancy and we had only one case in second trimester pregnancy. Amenorrhea followed by vaginal bleeding was the common symptom in 14 cases (82,3%). A number of 12 patients were admitted because of exaggerated forms of hyperemesis gravidarum. The ultrasound exam showed the size of the uterus larger than the amenorrhea and ovarian lutein cysts were present in almost half of cases. All the patients have had higher than normal values of HCG. In our department all the cases were managed with dilation, suction and mild curettage when necessary, except one case, finalized with hysterectomy, because of the molar type and the patient's age. Histopathological exam was performed in all cases. In 11 cases (64,7%) partial hydatidiform mole was diagnosed and in 6 cases complete HM (25,3%). A serial determination of HCG until normal values was always recommended, but we could not do the correct monitoring up to 6–12 months in 7 cases, related to the migration of the population in the region.

Conclusion Molar pregnancy has remained an important cause of maternal morbidity and mortality. There is need for early diagnosis, for proper treatment and follow-up of this condition. Due to the frequent use of ultrasound scanning, the diagnosis of hydatidiform mole could be made early in pregnancy. If hydatidiform mole is suspected, the quantitative estimation of serum level of HCG should be done. After an appropriate treatment, it is always necessary to follow-up the patient and in present this is a new challenge because the population migration due to new socio-economic conditions and modern life.

Disclosures I have nothing to disclose.

434

METASTATIC POSTMOLAR CHORIOCARCINOMA OF THE SKIN

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Introduction/Background Gestational choriocarcinoma is a malignant tumor arising from trophoblastic cells with the lung and the vagina as its common sites of metastasis. Skin metastasis is known to be extremely unusual.¹ This paper outlines the case of a 45-year-old multigravida who manifested with occasional nonproductive cough; multiple cutaneous lesions in left flank, right triceps area, upper back, and infraumbilical areas associated with neurologic symptoms, two years after undergoing hysterectomy for a molar pregnancy. Skin biopsy of the left flank masses showed metastatic gestational choriocarcinoma; and she had elevated B-hCG (309,245 mIU/mL), and lung, brain, liver, and right adrenal metastases on imaging studies. She achieved remission after treatment with Etoposide Cisplatin induction chemotherapy, high-dose EMACO with concurrent whole brain irradiation, and ten cycles of EMACO.

Abstract 434 Figure 1 Low power view of the skin biopsy of the patient's left flank mass - H&E x 40 (A). High power view showing two cell populations of mononuclear cytotrophoblasts and multinucleated syncytiotrophoblasts in the tumor - H&E x 100 (B). Skin metastasis in the upper back (C) and in the inner, medial portion of the right triceps (D).

Seven months after treatment, she remains alive and well, with ongoing regular follow-ups. The importance of keeping a high index of suspicion in patients with a prior molar pregnancy who only have clinical presentations referable to metastatic sites to avoid delay in the diagnosis and treatment; as well as the curability of widespread disease with aggressive combined treatment modalities, is emphasized herein (figure 1 and 2).

Methodology NA

Results NA

Conclusion Cutaneous metastases in gestational CC is infrequent and one of its diverse atypical clinical manifestations that has the potential to delay diagnosis and affect the clinical outcome. It is also associated with disseminated disease. Nevertheless, remission through aggressive multi-modal therapeutic strategies like Etoposide-Cisplatin induction chemotherapy, high-dose EMACO with concurrent whole brain irradiation, and regular EMACO is still possible for Stage IV multi-metastatic gestational CC patients who have late presentations and already have advanced disease, as documented in the index case. Prompt identification and vigorous treatment as keys to ensure better prognosis in gestational CC is stressed.

Disclosures N/A

Author	Age/ Gravidity	Antecedent Pregnancy	Site of Skin Metastasis	Other metastasis	Biopsy	B-hCG	Medication	Adjuvant surgery	Outcome
Present case (2019)	45 GSP2 (2032)	Mole (2 years ago)	Non-tender, firm, mobile subcutaneous masses with smooth borders and with eschymosis on the upper back (2 x 2 cm), right triceps (1 x 1 cm), and infraumbilical (1 x 1 cm) areas	Lungs, brain, liver, right adrenal gland, skin, bilateral breast tissues	Choriocarcinoma	698,645 mIU/mL	Etoposide-Cisplatin induction chemotherapy High-dose EMACO + WBRT 10 sessions (2,500 cGy) Regular EMACO x 10 cycles	None	Remission
Shahid (2019)	30 G3P3 (2023)	Term (1 1/2 years ago)	Multiple bleeding nodules on the face	None	Choriocarcinoma	31,550 mIU/mL	Not mentioned	None	Lost to follow-up
Li (2015)	68	Term (42 years ago)	Two scalp masses	Lungs, bone, skull, neck, lymph nodes, left flank muscle	Not done	3,171 IU/L	Tegaserod and Actinomycin shifted to Methotrexate + 5-Fluorouracil on the scalp and flank masses (local chemotherapy)	None	Died (6 months after admission)
Choi (2015)	30	Mole (33 months ago)	Solitary reddish, bean-sized firm nodule on the scalp	Lungs	Choriocarcinoma	275,873 mIU/mL	Chemotherapy (not specified)	None	Not mentioned
Brooks (2014)	11 day old infant		Right side of the face	Lungs	Choriocarcinoma	High	BEP	Embolization of facial mass	Remission
Razi (2011)	47 G4P3 (3013)	Abortion (1 year ago)	Raised infiltrated peripheral violaceous and centrally darkened erythematous rubbery hard nodule with ragged surface on the right upper back	Lungs	Choriocarcinoma	Not mentioned	Combination chemotherapy (not specified)	None	Not mentioned
Mendez (2009)	23 G3P2 (2001)	Term (3 years ago)	Nodular lesion in the scalp, ungual lesion in the left third digit	Lungs, brain	Undifferentiated neoplasm	>200,000	EMACO + WBRT x 4 cycles	None	Died (7 months after diagnosis)
Chiriac (2008)	24	Not specified (3 years ago)	Painful raised hemangioma-type lesions in the thorax, scalp, vulva, right nostril, left lower eyelid	Lung	Not done	Not mentioned	EPM Capecitabine x 1 cycle	Autologous BM transplant TAH	Died (3 years after diagnosis)
Afsar (2007)	33 G1P1 (1001)	Mole (8 years ago)	Junction of the hyponychium and the nail bed of the dominant right small finger	Uterus + Brain, lungs	Choriocarcinoma	285,000 mIU/mL	EP-EMA (high dose) + WBRT (3,000 cGy) x 5 cycles shifted after surgery to Leomycin + EP x 3 cycles TP x 3 cycles	TAH	Died (1 year after appearance of cutaneous metastases)
Park (2004)	52	Not mentioned	Two finger-like, raised, rubbery-hard, rapidly growing nodules on the left side of the neck and the upper back	Lungs, liver, left adrenal gland, and left kidney	Choriocarcinoma	100,000 mIU/mL	Combined chemotherapy x 17 cycles For post-operative adjuvant chemotherapy	TAHBSO	Not mentioned
Weiss (2001)	31 G1P2 (0010)	Abortion (2 years ago)	Mobile, nontender mass on the right vulva involving the labia majora, minora, and clitoris	None	Choriocarcinoma	95,000 mIU/mL	Methotrexate x 1 cycle then shifted to Actinomycin x 7 cycles + vulvar radiotherapy (4000 cGy)	Surgical excision of the vulvar mass	Remission
Chama (2002)	40 G3P3 (2003)	Term (15 years ago)	Soft swelling under the right breast and on the right shoulder	Lung, liver	Choriocarcinoma	(+) urine hCG	MAC x 12 cycles	None	Alive
Yuen 1998	31 G3P3 (2003)	Term (4 months ago)	Several noncircular, alopecic patches on the frontal, vertex, and occipital scalp with slight erythema; malle-type telangiectasias on the face, trunk, and limbs	Lungs	PST	158 IU/L	EMACO x 15 cycles EP x 3 cycles	TAH	Remission
Hetzel (1996)	31	Term (2 years ago)	Large lesion on the distal fifth finger of the left hand	Lungs, liver, kidneys	Not done	Not mentioned	EMACO + whole liver radiation therapy (2040 cGy) then shifted to EMA x 8 cycles (3 CC cycles)	BTL	Remission
Ertegun et al (1982)	22 G1P0 (0010)	Abortion (5 months ago)	Solitary soft nodule with small central area of necrosis in the right gluteal area	Lungs	Choriocarcinoma	632,856 mIU/mL	Chemotherapy (not specified)	None	Died (1 month after admission)
	31 G6P5 (0015)	Term (5 years ago)	Solitary, soft, nontender globular mass with small central area of ulceration in the left gluteal region	Lungs, liver, jejunum	Choriocarcinoma	Not mentioned	MAC + liver radiotherapy	None	Not mentioned
Salimi (1977)	35	Mole	Bleeding, elevated, darkish area in the nasal mucosa	Lungs	Choriocarcinoma	Not mentioned	Not mentioned	TAHBSO	Not mentioned
Gosnow (1974)	28	Abortion (3 months ago)	Solitary walnut-sized, violaceous, partially fixed nodule on the crown of the scalp	Brain, lungs, liver, kidney, spleen, jejunum, lymph nodes	Choriocarcinoma	Not mentioned	Extensive chemotherapy (not specified)		Died (3 months after admission)
Park (1950)	123 dying GTD patients autopsied: 4 patients had skin metastases								

Abstract 434 Figure 2 Reported cases of GTN with cutaneous metastases.