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 anemia globuling 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 amenorrhea of less than 16 weeks. 18% of patients were diagnosed after a period of amenorrhea 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. Grade 3/Grade 4 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.

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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**

**Results**

**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

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**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).

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