

Supplemental Table 2. Summary of tips for carrying out a uterine manual vacuum aspiration for treatment of hydatidiform mole.

Strategy	Execution
Routine preoperative exams	Request blood type and complete blood cell counts, basic chemistry, hepatic and thyroid panels, urinalysis, serum hCG level (for patients with a uterus larger than 20 cm measured suprapubic–fundus on physical examination, thyroid-stimulating hormone, free thyroxine, electrocardiogram and chest x-ray are also requested)
Blood reserve	We recommend reserving 2 packed red blood cell
Prophylactic antibiotic therapy	We do not recommend
Cervical preparation and uterotonic infusion	We not routinely use cervical preparation with prostaglandin or oxytocin during the procedure to avoid the risk of trophoblastic embolization. We exclusively reserve its use in cases of hemorrhage prior to or during surgery
Anesthetic care	Total intravenous anesthesia with a propofol infusion and fentanyl boluses as needed. Although anesthetic drugs (neuroleptics) or paracervical anesthetic block are allowed, we only recommend general anesthesia in a surgical center for treatment of molar pregnancy using manual vacuum aspiration due to the higher risk of bleeding during the procedure, even in cases of non-enlarged uteri for gestational age
Cervical dilation	We use suction cannulas to promote cervical dilation. Its plastic and flexible structure minimizes the risks of uterine perforation
Intraoperative ultrasonography	Important to confirm the suspicion of molar pregnancy, predict the progression of molar pregnancy into gestational trophoblastic neoplasia evaluating Doppler velocimetry of the uterine arteries and help guides the surgical procedure
Suction cannula	Cervical dilation should begin with a cannula number 4 and proceed to cannula number 7 for uteri smaller than 12 centimeters, leaving cannulas 8 (or exceptionally 10) for uteri enlarger than gestational age. As the uterine volume decreases during the evacuation, we find it prudent to change the cannula to a smaller size in order to access all portions of the uterus
Uterine evacuation	The use of two aspiration syringes makes the procedure more efficient. Once the syringe is filled, it should be removed from the uterus, delivered to the assistant, who returns a new empty vacuum syringe to the surgeon, which will be attached to the cannula for further uterine evacuation. In the meantime, the assistant empties the uterine contents of the syringe and prepares it, with vacuum, for the next evacuation cycle
End of procedure	When the contents collected in the syringe becomes pink and bullous, it is a sign that the uterine cavity is empty
Sharp curettage	After the end of molar evacuation, about 15% of patients may still have molar tissue in the endometrial cavity. We therefore perform a gentle sharp curettage to remove any adherent trophoblastic remnants and avoid the need for a second uterine evacuation
Macroscopic evaluation and preparation for pathology	After the procedure, the surgeon should wash the molar material with saline, taking care to remove blood clots. The tissue should be packed in 10% buffered formaldehyde
Postoperative guide	Use usual analgesics and anti-spasmodics. Assess the need for specific treatment (such as the use of anti-emetics). Use anti-D immunoglobulin in RhD-

	negative patients. Monitor vital signs. Guide effective contraception. Discharge can be given in 12-24h, depending on the clinical conditions
Postmolar follow-up	Do not wait for the histopathology result to refer the patient to the Gestational Trophoblastic Disease Reference Center, if the macroscopy is suggestive of hydatidiform mole