Cancer in pregnancy: disentangling treatment modalities

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ABSTRACT

Pregnancy-associated cancer constitutes an uncommon and difficult to manage clinical situation. It is defined as the cancer diagnosed from the first day of childbearing to 1 year post partum. Coexistence of cancer with pregnancy adds complexity to treatment recommendations, as both the mother and the fetus may be affected. The optimal therapeutic management of pregnant women with cancer diagnosis should take into account, apart from medical factors, a host of other parameters (ethical, psychological, religious, legal, etc.). Unfortunately, this situation becomes more complex as more women delay childbearing, and consequently the incidence of cancer during pregnancy is constantly increasing. This manuscript summarises the general principles in managing pregnant patients with cancer and gives detailed instructions in the management of pregnant patients with breast cancer, ovarian cancer, melanoma, lymphoma, lung cancer, soft-tissue sarcoma and cervical cancer. Of note, management of pregnant women with cancer diagnosis should be performed in specialised centres with experience and all cases should be discussed in multidisciplinary meetings composed of multiple specialists (medical oncologists, obstetricians, surgeons, radiologists and paediatricians).

INTRODUCTION

Pregnancy-associated cancer constitutes an uncommon and difficult to manage clinical situation. It is defined as the cancer diagnosed from the first day of childbearing to 1 year post partum.1 Unfortunately, coexistence of cancer with pregnancy adds complexity to treatment recommendations, as both the mother and the fetus may be affected. Of note, at this point it should be clearly stated that there are insufficient data for the proper management of pregnant women with cancer; guidelines are mainly based on data coming from small retrospective studies or case series with limited follow-up.1 2 Moreover, the optimal therapeutic management of pregnant women with cancer diagnosis should take into account, apart from medical factors, a host of other parameters, that is, ethical, psychological, religious and even legal considerations. Hence, management of pregnant women with cancer diagnosis should be performed in specialised centres with experience and all cases should be discussed in multidisciplinary meetings composed of multiple specialists (medical oncologists, obstetricians, surgeons and paediatricians).

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STATISTICS

It is estimated that 1 in every 1000 pregnant women is diagnosed with cancer.4 5 Breast cancer, melanoma, cervical cancer, lymphoma and acute leukaemia are the most common diagnosed malignancies during pregnancy.4 5 The incidence of breast cancer is about one case of 3000–10 000 deliveries.6 Most of these cases are diagnosed post partum; of note, <5% of breast cancer is pregnancy associated.4 6 On the other hand, melanoma is probably the most aggressive malignancy during pregnancy and accounts for 0.14–2.8 cases per 1000 pregnancies (8% of all malignancies during pregnancy).5 7–9 Cervical cancer appears in 0.8–1.5 per 10 000 births, with worse survival outcomes when diagnosed post partum.5 8 Of note, up to 5% of cervical intraepithelial neoplasia I–II may progress to invasive cancer during gestation.8 Finally, acute leukaemia and lymphomas are present in 1:75 000–1:100 000 and 1:1000–1:6000 pregnancies, respectively.5 9 Hodgkin’s lymphoma is the more frequent hematological malignancy occurring during pregnancy; approximately 3% of Hodgkin’s lymphomas are pregnancy associated.5 9

GENERAL PRINCIPLES IN MANAGING PREGNANT PATIENTS WITH CANCER

Obstetric care and fetal monitoring

Management of pregnant patients with cancer is a particularly delicate affair as both
the mother and the fetus may be affected. The general golden rule in the management of pregnant women with cancer diagnosis is that treatment should not differ between pregnant and not pregnant women, if this is feasible. The main concerns in the treatment of pregnant patients with cancer are first the prognosis from the malignancy, the proper treatment and the overall survival from the disease. In the meantime, it is of great importance to take into consideration the consequences from the chemotherapeutic drugs on the developing fetus as well as the long-term complications after in utero exposure to anticancer therapy. Pregnancy in coexistence with cancer diagnosis should always be considered as high risk and regular fetal monitoring with morphometric ultrasound and umbilical artery Doppler during gestation is mandatory.1 2

Full-term pregnancy (ie, ≥37 weeks) should be always the goal, according to all current treatment guidelines, since prematurity influences the emotional and cognitive development of babies.10 11 The last chemotherapy dose should be administered 3 weeks before the planned date of delivery, in order to avoid haematological toxicity in both the mother and the baby and in order to prevent fetal drug elimination.1 11 The mode of delivery should be based exclusively on the obstetrician’s recommendations, except for cases of gynaecological cancer.1 11 However, sometimes a caesarean section is the preferred method of delivery by physicians, since it is possible to determine the exact date of delivery.11 Of note, the placenta should always be carefully evaluated for micrometastases, especially in patients with melanoma, which is the most common neoplasm involving the fetus and the placenta.7 12

Surgery during pregnancy
Surgery can relatively safely be performed during pregnancy; of note, there is a slightly elevated risk of miscarriage during the first trimester, whereas very close monitoring, especially after the 25th week of gestation, should be performed.1 11 Of note, increased morbidity and higher rates of complications may happen in major pelvic and abdominal surgery; in these cases, a multidisciplinary team approach and detailed discussion with the patient are mandatory.1 11 Nonetheless, surgery should never be delayed during pregnancy.

Chemotherapy during pregnancy
Systemic chemotherapy should not be administered in the first trimester, due to the higher risk of miscarriage and congenital malformations, as the first trimester is the period of organogenesis of the fetus.16 17 Of note, the risk of malformations varies from 10% to 20% in the first trimester of pregnancy and it drops to 1.3% in the third trimester.18 Hence, pregnancy termination should be considered in pregnant patients with cancer who need chemotherapy administration in the first trimester.1 13 On the basis of multiple studies, it seems that it is relatively safe to give chemotherapy after the first trimester; however, there is a relatively higher risk of premature rupture of membranes, intrauterine growth restriction and premature labour.16–18 Moreover, according to available data, it seems that there are not significant long-term complications in fetuses exposed to chemotherapy during the second and third trimesters of pregnancy.16–18

Obviously, chemotherapy agents that cross the placenta at increased levels should be postponed after delivery. Weekly chemotherapeutic schedules are generally preferred, as close monitoring of adverse events is more feasible.1 11 As far as the dosage of chemotherapeutic drugs is concerned, there are few pharmacokinetic and pharmacodynamic data available during pregnancy; hence, despite the fact that pregnancy may alter the pharmacokinetics of these agents, doses should not vary from those used outside pregnancy.19

Radiotherapy during pregnancy
Radiotherapy should be avoided during pregnancy due to its teratogenic effects on the fetuses; hence, it is strongly suggested to delay irradiation post partum, apart from the cases with an urgent clinical need and provided that the radiation field is adequately far from the uterus.1 2 11 In all cases, adequate shielding should be used. Radiotherapy may cause detrimental effects to the fetus, that is, intrauterine growth restriction, congenital malformations, mental retardation, carcinogenesis, etc.20 21 Of note, there is an increased risk of congenital malformations and mental retardation with radiation doses >100–200 mGy; however, lower doses may cause the development of cancer or leukaemia in childhood and sterility.20 21 Table 1 summarises the
radiation dosages along with the effect on the fetus and in relation to the gestational age.

**Supportive care during pregnancy**
Vomiting and nausea are often symptoms during pregnancy; metoclopramide is the first choice for these symptoms, whereas ondansetron can safely be given. These drugs belong in category C for use during pregnancy and its sequelae.

The granulocyte colony-stimulating factor (G-CSF) can cross the human placenta at least in the second and third trimesters. According to the limited available data, the use of G-CSF during pregnancy does not seem to cause any significant sequelae on either the mother or the newborn. However, G-CSF is considered as agent belonging in category C for use during pregnancy and its use should be based on clinical necessity. There are no published safety data regarding the use of human erythropoietin in pregnant patients with cancer; however, according to published data on pregnant women exposed to bisphosphonates, no published safety data regarding the use of human erythropoietin in pregnant patients with cancer; however, in the outline of the therapeutic plan, it is mandatory to take into account the gestational age at diagnosis and the estimated date of delivery. Anthracycline-based regimens (ie, Adriamycin, Cyclophosphamide (AC); Epirubicin, Cyclophosphamide (EC); Fluorouracil, Adriamycin, Cyclophosphamide (FAC); or Fluorouracil, Epirubicin, Cyclophosphamide (FEC)) represent the first choice of treatment, as the majority of safety data are available with the use of anthracyclines; of note, no increased risk of cardiotoxicity of the neonates due to in utero exposure of anthracyclines has been documented. As far as taxanes are concerned, data from animal models have shown minimal transplacental transfer of both agents, probably due to the high expression of P-glycoprotein in the placenta. In a systematic review on 50 pregnant patients with breast cancer, who had received taxanes during pregnancy, a completely healthy neonate was born in 76.7% of cases, whereas 90% of children were completely healthy with a median follow-up of 16 months. Consistent with these results are the data from the American-based and European-based registries. Hence, on the basis of these data and according to the European Society for Medical Oncology (ESMO) guidelines, taxanes may be used in selected cases during pregnancy (ie, selected cases of triple-negative or HER2-positive breast cancer) or in cases where anthracyclines are contraindicated. Of note, more data are available with the use of paclitaxel than of docetaxel during pregnancy; consequently, weekly paclitaxel schedule is the preferred treatment option in selected cases of patients with breast cancer during pregnancy.

According to current treatment guidelines, trastuzumab is contraindicated during pregnancy, due to its apparent risk of oligohydramnios and/or anhydramnios as well as to the unknown long-term effects on the fetus. However, studies in cynomolgus monkeys have not found placental transfer of the antibody in monkeys and have failed to identify any harm to the fetus. According to a recently published meta-analysis, trastuzumab administration seems to be relatively safe during the first trimester, whereas there is a high incidence of oligohydramnios and/or anhydramnios when the monoclonal antibody is used beyond the first trimester. An interesting finding of this meta-analysis is that all children exposed to trastuzumab exclusively during the first trimester were completely healthy, without evidence of adverse effects on the fetus.
malformations. Of note, oligohydramnios/anhydramnios was recorded in pregnancies exposed to trastuzumab in the second and/or third trimester. Interestingly enough, Pentsuk and van der Laan found that the exposure of the fetus to trastuzumab is really limited in the first trimester, increases from the second trimester of pregnancy and reaches at birth a drug concentration comparable to that of the mother.

For women becoming accidentally pregnant while on trastuzumab administration, they can preserve their pregnancy, based on the data of HERA trial; in these cases, trastuzumab should be discontinued and the patient should be informed that this recommendation is based on data from a limited number of cases.

Perutzumab is contraindicated during pregnancy, as there are limited data for its toxicity. Despite one published case report with laptatinib exposure resulting in uncomplicated delivery of a healthy neonate, the agent should not be recommended during pregnancy; its pharmacological characteristics (ie, massive transplacental transfer), along with the insufficient data on its use during pregnancy, strongly suggest against its use.

Endocrine treatment (ie, tamoxifen, luteinizing hormone-releasing hormone analogues) is contraindicated during pregnancy due to the high risk of birth defects, up to 20% of exposures. Hence, tamoxifen use should be delayed after delivery. Moreover, for patients becoming accidentally pregnant while on tamoxifen use, termination of pregnancy should be advised due to the high risk of congenital malformations.

Lymphomas
For patients diagnosed with advanced Hodgkin’s lymphoma in the first trimester, pregnancy termination should be considered; on the other hand, for patients diagnosed with early-stage Hodgkin’s lymphoma in the first trimester, close monitoring and initiation of chemotherapy in the second trimester can be advised. The combination of adriamycin, bleomycin, vinblastine and dacarbazine (ABVD) is the recommended therapy after the first trimester of gestation, without significant fetal complications been reported. Of note, no safety data exist for other chemotherapeutic combinations during gestation (ie, Stanford V or BEACOPP); hence their use cannot be recommended during pregnancy.

For patients with aggressive non-Hodgkin’s lymphoma (NHL), immediate treatment is mandatory; hence, for patients diagnosed in the first trimester of gestation pregnancy, termination should be considered, whereas for patients diagnosed in the second and third trimester, Cytoxan, Hydroxyrubicin (Adriamycin), Oncovin (Vincristine), Prednisone (CHOP) is the standard chemotherapy regimen, without significant increased fetal morbidity. Regarding rituximab, on the basis of the data of a retrospective analysis that evaluated the outcomes of 253 pregnancies with exposure to rituximab during pregnancy, it seems that rituximab administration in the second and third trimesters of pregnancy seems to be relatively safe, without significant increased risk of fetal adverse effects; however, a relatively increased risk of neonatal infection and transient B cell depletion without related infection in the neonates has been documented. Moreover, rituximab does not cross the placenta early in gestation; consequently, patients becoming accidentally pregnant during rituximab administration can preserve their pregnancy, provided that treatment is stopped during pregnancy.

Melanoma
Surgical resection in pregnant patients with melanoma is the mainstay of treatment; SLNB procedure using Technetium-99, rather vital blue is recommended, despite the limited published data. For patients with metastatic disease, interferon-α may be used, due to the lack of safety data of ipilimumab, vemurafenib, dabrafenib, trametinib and cobimetinib during gestation.

Cervical cancer
Management of pregnant patients with cervical cancer differs from the standard treatment of patients with cervical cancer outside the pregnancy setting, due to the fact that radical surgery and pelvic radiation, the mainstay of cervical cancer treatment, would cause fetal death and pregnancy termination. Of note, this difference may have an impact on the survival data of pregnant patients. For pregnant patients with early-stage cervical cancer who want to preserve the pregnancy, therapy may be delayed until after delivery; of note, close monitoring in these cases is of great importance. For pregnant patients with stage IB1, IB2 or IIA, lymphadenectomy is the mainstay of treatment; lymphadenectomy can safely be performed during pregnancy, despite a slightly increased risk of bleeding and other complications. Notably, radical surgery can be performed concurrently with the caesarean section. According to current guidelines, platinum-based chemotherapy (cisplatin 75 mg/m² q 3 weeks or carboplatin), with or without paclitaxel, may be used, especially in patients with locally advanced disease or with high-risk tumour. Of note, local response rates reported in pregnant patients with cervical cancer are similar to those recorded outside the pregnancy setting.

Epithelial ovarian cancer
For patients with epithelial ovarian cancer, the combination of carboplatin (5 or 6 AUC) with weekly paclitaxel (60–80 mg/m²) is recommended after the first trimester and seems to be relatively safe. According to a recently published systematic review, conducted on 11 pregnancies (12 newborns), a completely healthy child was born in 92.3% of cases with a median follow-up of 20 months.

Germ cell ovarian tumours
According to ESMO guidelines, the combination of cisplatin (75 mg/m²) and weekly paclitaxel (80 mg/m²) is
highly recommended for patients with germ cell ovarian tumours, after the first trimester; this combination is based on the safety data during pregnancy and on the efficacy data coming from non-pregnant patients with relapsed germ cell tumours. Of note, the etoposide-platinum based combination (BEP or EP), typically used for the treatment of germ cell tumours, is not proposed due to the relatively increased risk of fetal intrauterine growth restriction and neonatal complications that have been reported.  

Non-small cell lung cancer

For patients with non-small lung cancer, the combination of carboplatin (5 or 6 AUC) with weekly paclitaxel (60–80 mg/m²) is recommended after the first trimester and seems to be relatively safe. The use of gemcitabine and pemetrexed should be discouraged due to the lack of data. Moreover, epidermal growth factor receptor inhibitors are not favoured during pregnancy.

Soft tissue sarcomas

For pregnant patients with metastatic soft tissue sarcomas, single-agent doxorubicin is highly recommended, after the first trimester, extrapolating the safety data of the use of anthracyclines in pregnant patients with malignancy. The combination of doxorubicin with ifosfamide has been evaluated in nine patients during pregnancy; however, this combination is not recommended for pregnant patients with metastatic soft tissue sarcoma due to the limited safety profile of ifosfamide along with the increased toxicity and the lack of survival benefit of the combination versus monotherapy.  

Conclusion

Treatment of patients with malignancy during pregnancy is a particularly delicate issue as both the mother and the fetus may be affected; treatment should be personalised and performed in specialised centres with great experience. Unfortunately, the optimal therapeutic management of pregnant women with cancer coexistence is mainly based on small retrospective studies; hence, improved collaboration between cancer centres and registries is more than necessary in an effort to record survival data of patients and the long-term effects of the drugs on the developing children. This registration is more than mandatory taking into consideration that the coexistence of cancer and pregnancy would be encountered more and more often in the forthcoming years, as women tend to postpone childbearing.

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