Pre 05

MALIGNANT MELANOMA AND PREGNANCY
E.W.Breitbart and Th.Nasemann

Confusion exists concerning the influence of pregnancy on survival in patients with malignant melanoma. The reason is, that the effects of pregnancy or hormonal manipulation on the pathogenesis and metastatic spread of malignant melanoma is unclear. On one side the presence of steroid receptors (SR) (E.T. Creagan et al., Cancer Treatment Reports 64, 199, 1980), estradiol receptors (ER) and progesterone receptors (PgR) (M.Ferris et al., Anticancer Research 4, 179, 1984) in melanoma has been reported. On the other side there is no correlation between the detected receptorproteins and the hormonal influence on the melanoma growth phase. In literature there is conformity that there is no change in the 5 year survival rate in comparison to non-pregnant females, if the melanoma is diagnosed during pregnancy. An improvement of the 5 year survival rate is described for females with multiple pregnancies before developing a melanoma. A decrease of the 5 year survival rate is found for pregnant females in stage II, and again there occurs no change in prognosis in case of pregnancy after melanoma excision. All this makes the medical advice for pregnant females difficult. According to the most important prognostic factor, the tumorthickness, it is possible to justify the following procedure:

classification	treatment	interruption	contraception
stage I tumorthickness < 1,5 mm	excision (3 cm)	no interruption	for 3 years without hormones
stage I tumorthickness ≤ 1,5 mm	excision incl. lymphnode-dissection	interruption (individual decision)	for 5 years without hormones
stage II-III	operation	interruption	sterilisation

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Pre 06

PREGNANCY OUTCOME FOLLOWING CANCER THERAPY
M. Rister

Intensive chemo- and radiotherapy cures in many cases malignant diseases. This leads to an increasing number of former cancer patients, who wish to start a family. In a retrospective study we performed a survey among 58 paediatric and 26 obstetric-gynecologic centers as well as a review of the literature to investigate the pregnancy outcome after successful treatment for cancer. Following chemotherapy 507 children from 445 former cancer patients have been documented. Only 36 (7%) newborns exhibited abnormalities. In 23 of 120 (19%) children have been observed abnormalities, who descended from 92 patients who had received a combined radio- and chemotherapy. Malformations were seen in four of 28 (14%) newborns from parents who were treated for cancer before the onset of puberty. Abnormalities were observed in eight of 84 (9%) children, who descended from parents treated for cancer after the onset of puberty. We observed no special malformation pattern induced by cytostatic drugs or following radiotherapy. The main abnormality documented was prematurity. Since the observed incidence of abnormalities following cancer therapy corresponds to the frequency in a normal population, this study demonstrates no effects of intensive tumor therapy on subsequent newborns.

Thus, at present one year after the cessation of cancer treatment a too pessimistic attitude towards conception does not appear justified from a medical viewpoint.

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Pre 07

ASPECTS OF CONTRACEPTION IN FEMALE CANCER PATIENTS

W. Sauerwein, R. Callies, M. Nohlen, P.F.Tauber
Pregnancies of women with cancer are usually unwanted and may represent a medical, eugenic or psychological problem. Frequently, contraceptive counseling has been insufficient. Within the last year, 5 unwanted pregnancies were observed in women following completed treatment of either Hodgkin's disease or breast cancer. Among an annual 150 female outpatients with various malignant tumors and at risk of pregnancy, the above 5 women represent a clinical incidence of 3.3% of unwanted pregnancies. One case was due to OC failure and 4 cases occurred for incompetent counseling. Reasons given to the patients for abstaining from contraception were assumed negative influences of hormones upon the malignant condition. Four pregnancies went to term and healthy babies were delivered. One was terminated for psychosocial grounds. Pregnancies of cancer patients after treatment are relatively safe with regard to malformation, although they should not occur unwantedly for psychological reasons. For these patients, safe contraception is desired, but in contrast is absolutely necessary during cancer treatment. Among the contraceptive methods available, the intrauterine device seems to meet all needs. Barrier contraception with adequate counseling for its use may also be recommended. Oral contraceptives however, might not be suitable in suspected hormone dependent tumors and 2. when occasional vomiting is expected. Sterilization may be advised in women over 35 years of age. Further studies into this clinical problem should be of value.

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Pre 08

PREGNANCY FOLLOWING RADIO-ONCOLOGICAL THERAPY: ASPECTS OF GENETIC COUNSELING

W. Sauerwein and E. Passarge
Successful radio-oncological therapy allows an increasing number of patients to lead a normal life and become parents. Anxiety results from fear of possible mutagenic or teratogenic effects of the previous therapy. On the basis of theoretically possible risks patients are not infrequently advised by physicians to avoid or to terminate pregnancy following cancer therapy. Between 1978 and 1985 we re-assessed 30 tumor patients who sought genetic counseling. They had received radiotherapy (17), chemotherapy (2) or a combination of both (11). 19 couples came prior to pregnancy, 11 during pregnancy, of the latter, 5 explicitly came to confirm that termination of pregnancy was necessary. Two women had previously terminated a pregnancy for fear of a mutagenic risk to their offspring. In the prior-to-conception situations we counseled that cancer therapy would not constitute a recognizable individual mutagenic risk. Thus, a pregnancy could well be considered. We recommended an interval of about 6-12 months following therapy. Once a pregnancy had occurred, we recommended that it could be continued. In no instance was a child born with congenital developmental defects. In spite of the theoretically expected mutagenic risk of radio-oncological therapy, empirical observations do not indicate that such risk exists. For counseling purposes it appears to be important to distinguish a theoretically possible risk, the demand for formal exclusion of such a risk, and the actual lack of evidence for an increased risk.
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