

Fast Biopsy Is Key in Pregnant Melanoma Patients

BY DOUG BRUNK
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SAN DIEGO — Pregnant women who present with changing nevi should not be treated differently from other patients of similar age, Dina R. Massry, M.D., said at a melanoma update sponsored by the Scripps Clinic.

"Prompt biopsy is key," said Dr. Massry, a dermatologist with the division of dermatology and cutaneous surgery at the Scripps Clinic-Torrey Pines, La Jolla, Calif.

While it is commonly accepted that nevi enlarge and change during pregnancy and that new nevi develop, pregnant women "may get a false sense of security and disregard something that may be potentially worrisome and not get evaluated," she noted. Pregnant women may not be aware that they should be concerned about irregular or changing moles.

Any changing mole—especially one that has become irregular or asymmetric—could be a melanoma. Synchronous and homogeneous darkening of multiple moles "is probably normal but still should be evaluated," she said.

A delayed diagnosis of melanoma in pregnant patients illustrates that physicians should treat changing nevi exactly the same in pregnant and nonpregnant patients, and biopsy the moles promptly, Dr. Massry said.

No study has identified a difference in survival rates between pregnant patients with melanoma and nonpregnant, age-

matched controls, but studies consistently show an increase in median thickness among pregnant patients with melanoma, compared with nonpregnant, age-matched controls. While a delay in melanoma diagnosis is the likely cause for this difference, Dr. Massry said there are no data to confirm or refute the possible role of growth factors that induce thicker and more rapidly growing melanomas.

In her presentation, she also addressed the following questions related to melanoma:

► **How does one approach recurrent melanoma in pregnant patients with stage II-IV disease?** CT and x-ray can be used if the benefits and risks are discussed with the patient. One study supports the use of MRI in the systemic work-up (Semin. Oncol. 2000;27:623-32).

Another analysis (Curr. Opin. Oncol. 1999;11:129-31) reports that the manufacturers and suppliers of interferon have "sparse data" on pregnant patients that suggest babies delivered to mothers receiving interferon therapy have low birth weights, Dr. Massry said.

She added that dacarbazine is considered the best treatment for pregnant patients with advanced disease.

► **What is the risk to the fetus in a pregnancy complicated by melanoma?** Transplacental metastases occur only in patients with hematogenous dissemination of melanoma. The incidence of maternal malignancy during pregnancy is 1 per 1,000, and melanoma accounts for 8% of all cancers during pregnancy.



Melanoma is shown in the arm of a 30-year-old woman.

"About 25% of the cancer that is metastatic to the parts of conception involve the fetus," Dr. Massry said. "Of cases with fetal involvement, 58% or so arise via melanoma." However, transplacental metastases "are very rare."

At birth, she advised, "you want to do a thorough evaluation of the infant, a gross microscopic examination of the placenta, and [an examination of] the cord blood buffy coat for tumor cells."

► **When can a woman safely become pregnant after treatment of melanoma?** The commonly accepted advice for patients is to avoid conception for 2-3 years if their lesions were 1.5 mm or smaller and 5-8 years if their lesions were greater than 1.5 mm.

Part of this recommendation has to do with [when] most recurrences are likely to

occur, Dr. Massry said. "But if you're talking to a 20-year-old woman versus maybe a 40-year-old woman, the recommendations may change, depending on what their sense of urgency is with regard to childbearing."

Some investigators support the notion of individualized recommendations depending on tumor thickness, stage of diagnosis, age of the patient, and the desire of the patient to become pregnant (Cancer 2003;9:2130-3).

► **Is there a link between melanoma and use of oral contraceptives or hormone therapy?** Older studies suggest that high-dose oral contraceptives increase the risk of melanoma, but newer studies that include epidemiologic analysis refute the earlier data.

A controlled study of more than 2,000 women found no relationship between the incidence of melanoma and oral contraceptive use, age at onset of use, number of years used, or proximal relationship to use (Br. J. Cancer 2002;86:1085-92).

Dr. Massry noted that there is "a paucity of information" on hormone therapy and melanoma. Some investigators maintain that there is no reason to withhold hormone therapy from a woman if it is otherwise recommended (Climacteric 2002;5:197-200).

Third-Trimester Nausea May Point To Acute Fatty Liver of Pregnancy

BY MARY ANN MOON
Contributing Writer

WASHINGTON — Acute fatty liver of pregnancy must be ruled out in any woman who presents in the third trimester with nausea, vomiting, epigastric pain, or malaise, Michael F. Fesenmeier, M.D., said at the annual meeting of the Central Association of Obstetricians and Gynecologists.

The disorder is rare, estimated to affect only 1 in 7,000-16,000 pregnancies. But it is deadly. Maternal and neonatal mortality rates of 75% have been reported in some studies.

"Physicians must be diligent in diagnosing acute fatty liver of pregnancy, and be prepared for its high morbidity and mortality," said Dr. Fesenmeier of the University of Cincinnati Medical Center.

He and his associates assessed the clinical presentations and outcomes of all 16 women treated for acute fatty liver of pregnancy (AFLP) at three tertiary-care centers in Ohio and Kentucky between 1993 and 2003. The average gestational age at diagnosis was 35.2 weeks (range, 30.0-37.2 weeks). There were 13 singleton and 3 twin pregnancies.

Nausea and vomiting were the most common presenting symptoms, affecting 12 patients (75%). The average duration of nausea and vomiting before the women

presented for emergency care was 3-4 days, but some women went undiagnosed for much longer, including one who was undiagnosed for 3 weeks. That patient died within a month of delivery.

Other symptoms included epigastric pain in seven patients (43%), jaundice in six (38%), malaise in five (31%), and loss of consciousness in one (6%), he said in a poster presentation at the meeting.

There were two maternal deaths from multiorgan failure (12.5% maternal mortality) and three fetal deaths (15% infant mortality). Ten women (62%) developed acute tubular necrosis, seven (43%) developed pulmonary edema, seven (43%) developed disseminated intravascular coagulation, and six (38%) developed pancreatitis.

The average length of stay was 15 days, with a range of 5-58 days. Three were referred for liver transplantation at discharge.

Clinical and laboratory findings of AFLP often overlap with those of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelet count), and pancreatitis. "We recommend that patients who present with nausea, vomiting, epigastric pain, or malaise in the third trimester should receive evaluation of liver enzymes, renal function, and a complete blood count to rule out the diagnosis of AFLP," Dr. Fesenmeier said. ■

IBD Relapse Not Triggered by Pregnancy, Treatment Appears Safe

BY SHARON WORCESTER
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ORLANDO, FLA. — Pregnancy does not cause relapse in patients with inflammatory bowel disease, and standard IBD treatments during pregnancy do not increase the risk of adverse fetal outcomes, a prospective case-control study suggests.

The findings of the 20-year study may give some peace of mind to the many women with IBD who are concerned about the effects of treatment on their fetus, and about the effects of pregnancy on the course of their disease. Until now, these women have had little to go on; the data regarding treatment effects and pregnancy outcomes in IBD have been scant and based only on cohort studies and registry data, Flavio M. Habal, M.D., said at the annual meeting of the American College of Gastroenterology.

He compared outcomes in 138 women with IBD who gave birth to a total of 174 infants over the course of the study, 83 case-matched nonpregnant controls with IBD, and 100 healthy pregnant controls. IBD relapses occurred in 18% of the case patients, compared with 23% of the control pa-

tients with IBD. The difference was not statistically significant, said Dr. Habal of the University of Toronto.

Furthermore, the relapse rate was significantly higher in the 50 case patients who were not on IBD maintenance therapy, compared with those who were on maintenance therapy (34% vs. 10%). Treatments used by case patients were oral 5-aminosalicylic acid (5-ASA) used by 58 patients, rectal 5-ASA (10 patients), prednisone (47 patients), and azathioprine (9 patients), he noted.

As for fetal outcomes, the mean birth weight of babies in the case patient group (3,210 g) was similar to the mean birth weight of babies in the healthy control patients (3,215 g), and the mean birth weight among babies of treated case patients (3,328 g) was significantly greater than the mean birth weight among babies of the untreated case patients (3,020 g).

Congenital anomalies occurred in fewer than 2% of the 174 babies in the case patient group, and in a comparable 4% of the 100 babies in the healthy pregnant controls.

Of note is that there were no relapses or congenital anomalies among the nine case patients treated with azathioprine, Dr. Habal said. ■