Hodgkin's Disease and Pregnancy

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Ensuing publication of a paper by Daly et al. (Acta haemat. 64:154-156), we received the following letter (Ed.):

To the Editor,

We wish to report our experience in the management of 42 pregnancies, in 32 patients suffering from Hodgkin's disease (HD). 11 were in stage I, 17 in stage II, 3 in stage III and 1 in stage IV. Their ages ranged from 18 to 34 years (mean 24). In 14 cases the patients presented with HD and were found to be pregnant; in 28, pregnancy had occurred in 18 patients who had already received treatment for HD. In our experience the outlook for the two categories of case is different.

6 of the 14 patients who were pregnant when HD was first diagnosed suffered from progression of the disease, 4 in the first 4 months of pregnancy, 2 in the last 3 months; of the 18 other, 7 suffered from progression of the disease: 5 in the 1st month after delivery and 2 within 6 months of delivery. In contrast, 10 patients who became pregnant after having been in remission for more than 2 years did not relapse.

Of the whole series of 32 patients, 2 died 5 and 8 years after the onset of the disease, 28 are still in complete remission, 1 in incomplete remission and 1 died 6 months after delivery after having been in complete remission for 45 months.

34 of the 42 pregnancies ended in the delivery of 35 living infants (one pair of twins). 6 of these were premature births at 8-8V2 months (3 surgically induced) in patients with active HD. There were 8 miscarriages: 2 were spontaneous at 2V2 and 3 months in patients, respectively, in the first stages of HD and after a complete remission for 5 years; 6 were induced in the first 2 months.

1 child died; the 34 surviving children are alive and well, the eldest being 11 years of age. No treatment was given during 26 of the 34 pregnancies. 3 patients diagnosed for the first time during pregnancy were treated by chemotherapy. The first had a premature delivery and one of a pair of twins died of a malformation when 27 days old. The second received infusions of vinblastine at the beginning of pregnancy without any influence on the outcome. The third received MOPP from the 6th month; a normal infant resulted from a premature delivery.

Our conclusion is that pregnancy does not affect the progress of HD if the patient

has been in complete remission for 2 years or longer. On the other hand, when HD is diagnosed for the first time in pregnancy, or when a patient in incomplete or recent remission becomes pregnant, the patient should be watched carefully throughout pregnancy and in the weeks following delivery for signs of progression of the disease so that it can be treated as soon as possible. When HD is diagnosed before the 4th month of pregnancy we recommend termination, then treatment for the HD; after 4 months, the pregnancy should be allowed to proceed as far as the 8th month, the patient being treated in the meanwhile with therapy (hopefully) not harmful to the fetus (e.g., no irradiation). In patients who have enjoyed more than 2 years of remission pregnancy should be allowed to proceed to full-term.

References

Crepin, G.; Gardez, C.; Demaille, A.: L'association maladie de Hodgkin et grossesse. A propos de 9 observations de maladies de Hodgkin associée à révolution de 15 grossesses. *Revue fr. Gynéc. Obstét.* 64: 235-249 (1969).

Thomas, P.; Peckham, H.J.: The investigation and management of Hodgkin's disease in the pregnant patient. *Cancer* 38: 1443-1451 (1976).

Morgan, O.S.; Hall, J.S.; Gibbs, W.N.: Hodgkin's disease in pregnancy; a report of three cases. *West Indian med. J.* 25: 121-124 (1976).

Weisgerber, C.; Goguel, A.; Teillet, F.: Problèmes gynécologiques et obstétricaux au cours de la maladie de Hodgkin. *Actualités Hématologiques*, 8e série (Masson, Paris 1974).

Querleu, D.; Cappelaere, P.; Crepin, G.; Demaille, A.: Cancer et grossesse, pp. 149-177 (Masson, Paris 1978).

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This letter was presented to Dr. McCann and co-workers. Their reply follows:

We would agree with the overall statement that pregnancy does not affect the progress of Hodgkin's disease if the patient is in complete remission and thus these pregnancies should be allowed to proceed to term. We would also agree that Hodgkin's disease diagnosed after the 18th week of pregnancy can be treated aggressively without any adverse outcome.

There are two points, however, where we would differ with Carcassonne et al.: firstly we do not feel that there is clear-cut evidence that pregnancy should be surgically induced at 32 weeks, and secondly there does not appear to be any clear-cut evidence from the literature that treatment within the first trimester of pregnancy is associated with an unfavourable outcome for the fetus, therefore we would not agree with the recommendation of termination of pregnancy within the first trimester should Hodgkin's disease be diagnosed during that time.

We would stress again that due to inadequate data the risk of teratogenicity from chemotherapy in a human is far from clear.