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CLINICAL MANAGEMENT OF CIN AND INVASIVE CERVICAL CARCINOMA DURING PREGNANCY

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Today the therapy of CIN and invasive squamous cell carcinoma of the cervix is standardized. However the clinical procedure during pregnancy is discussed controversively. (1,2,4). The incidence of cervical neoplasia during pregnancy is 3 o/oo. In our clinic we observed 6.807 pregnancies over a period of ten years with only 17 cases of neoplastic alterations of the cervix. All neoplasias were diagnosed by routine cytology. During pregnancy, the interpretation of cytology and colposcopy can be very difficult (3). As a result we diagnosed in some cases cytologically a beginning infiltration which was not verified in the following histologic examination. Therefore cytologic examination should be carried out in the first eight weeks when those alterations caused by pregnancy are still absent. Since there exist no studies that prove that CIN is biologically more aggressive in pregnancy we carried out only follow-up controls every 6 weeks. We obstained from conisation to avoid complications. By this management an invasive cervical carcinoma never developed or escaped our notice. The invasive cervical carcinoma needs an individual procedure. This depends on the size of the tumour and the age of pregnancy at the time of diagnosis. Before the 20th week we induced abortion followed by radical hysterectomy and pelvic lymph node extirpation. In the second half we tried to carry on the pregnancy until the 34th week of gestation. Then a caesarean section with simultaneous Wertheim-Meigs operation was performed. All decisions ask for our intensive communication with the parents.

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CERVICAL PREINVASIVE AND INVASIVE NEOPLASIA DURING PREGNANCY.

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The influence of pregnancy on the development of preinvasive and invasive cervical neoplasia was evaluated on the basis of the cytological, colposcopic and biopsy findings at the Department of Obstetrics and Gynecology, University of Tübingen from 1970 until 1984.
During this time 128 pregnant patients with cytological findings Papanicolaou grade III/III D. 37 pregnant patients with Pap IV a/Pap IV b and 2 pregnant patients with Pap. V were treated. 100 pregnancies were delivered at term. 56 were terminated by legal abortion and 12 pregnancies ended as spontaneous abortion. The results can be summarized as follows:

1. Marked increase of cervical intraepithelial neoplasia (CIN) in pregnancy.
2. Recognizable age shift towards younger patients during the period of study in patients with preinvasive and invasive cervical lesions.The mean age of the patients was 27,6 years. The mean parity was 0.9, 40.8% of the women were nulliparous.
3. 80% of the patients had their first Pap-smear at the time of prenatal care
4. The careful evaluation of the abnormal findings resulted in 8 cases with light or moderate dysplasia (CIN I/II), 3 cases with severe dysplasia (CIN III). 18 cases with carcinoma in situ, 6 cases with microinvasive carcinoma and 4 cases with invasive carcinoma.
5. Pregnancy seems not to promote progression of CIN lesions into invasive carcinoma. There was no difference between full-term pregnancies and abortions.
6. In suspicious cases invasion should be excluded by conisation.
7. The rates of remission and progression are similar as in non-pregnant patients. Long-term follow-up post partum resulted in the detection of one case of carcinoma in situ and one case of invasive carcinoma in this group of patients.
8. It is concluded, that findings of CIN in pregnancy have the same importance as in the non-pregnant state. Prenatal care should include a cytologic investigation in order to improve screening programs in young women. Patients with cytological remission after birth shouldbe followed on a long-term basis.

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DIAGNOSIS OF THE CERVICAL INTRAEPITHELIAL ATYPIA IN THE PREGNANCY: ECTOCERVICAL SCRAPING AND ENDOCERVICAL CURETTAGE - T. Weyerstahl

In the period between 1979 and 1985 routine preventive Pap smears were taken from 7.962 pregnant women. 186 Pap smears were diagnosed as suspect.2 cases occured in Group III,140 in Group III D,42 in Group IVa, 0 in Group IV b and 2 in Group V (Munich classification/. - Our procedures in these cases in the last six years are as following 1. By cytological suspicion of CIN I to II (Group III D) we repeated the Pap smear after one month;if the results were unchanged we did nothing.- 2. If CIN III (Group IV a) was suspected we routinely carried out, also with pregnant women up to the 32. week of pregnancy, an ectocervical scraping and endocervical curettage for a histological examination. - 3. If suspicion of invasive carcinoma arose by a clinical and/or cytological examination (Group V), we diagnosed by a histological examination independent of the length of pregnancy. - Duo to our selection criteria (Group IV a - V) we performed an ectocervical scraping and endocervical curettage on 41 women (3 women refused the diagnosis). Hereby we determined in 9 cases only CIN I or II, by 32 patients the cytological suspicion and the histological result agreed:in 30 cases we verified a carcinoma in situ and in 2 cases we found an invasive squamous-cell carcinoma of the cervix uteri. Only by the last 2 patients was continuing therapy by a WERTHEIM's hysterectomy operation necessary. By the 30 patients with definite carcinoma in situ (CIN III) the therapeutical conization was executed directly after the pregnancy. - Complications related to ectocervical scraping and endocervical curettage arose by one pregnant patient which resulted in a premature amniorrhexis and respectively a miscarriage. We think that the ectocervical scraping and endocervical curettage as diagnostic procedure by pregnant patients is more accurately representative than the heavily prefered biopsy and has fewer complications than the alternatively recommended diagnostic conization.

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HUMAN MAMMARY CANCER UNDER INFLUENCE OF PREGNANCY AND PUERPERIUM

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Several problems of mammary cancer (MC) related to pregnancy (PG) and puerperium (PP) are controversially discussed, raising the following questions: Which is the adequate therapy? Should the PG be terminated? Which prognosis can be expected? Should those patients be recommended to another PG? To answer these questions the data of patients suffering from MC correlated to PG or PP of the last ten years were evaluated. An incidence of 6 patients per 10.000 deliveries was observed. The mean age was 34.0 (range 25-45 years). In 2/3 of the patients MC was confirmed during the last trimester of PG or during the PP.The delay between the first symptoms and the confirmation of MC was in average 4.2. months. In a relatively high number of patients a T2- or T3-stage of MC was confirmed. In only one case an early cancer was diagnosed. 6 of 14 patients had positive lymph nodes and half of them demonstrated a positive steroid receptor level (estrogen- or progesterone-receptor). In about 2/3 of all cases the PG could be maintained in spite of the malignant disease until termination of PG by caesarean section. The prognosis of such patients was not worse than that of other comparable non-pregnant women. The prognosis was also independent from a continuation of the PG prior to the adequate therapy. Conclusions: The MC during PG or PP is a rare, but very dangerous complication. The patients are relatively young. The tumor size and the lymph node status are infavourable due to the delay of diagnosis. This delay is responsible for the relatively bad prognosis. Termination of the PG does not improve the prognosis. The kind of therapy is therefore identical in pregnant and non-pregnant women. The improvement of the results can only be achieved by realizing that each swelling or inflammation of the breast tissue during PG might be a carcinoma.

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