DOWNLOAD PDF CANCER COMPLICATING PREGNANCY, AN ISSUE OF OBSTETRICS AND GYNECOLOGY CLINICS

Chapter 1 : Medical Disorders in Pregnancy, An Issue of Obstetrics and Gynecology Clinics eBook - FREE

This issue of the Obstetrics and Gynecology Clinics of North America, prepared by Guest Editor Dr. Kimberly Leslie, deals with cancer complications in racedaydvl.com most common malignancies associated with pregnancy are those of the genital tract, breast, and malignant melanoma.

Pregnancy in Kidney Transplant Patients 1. What every clinician should know Kidney transplantation for end-stage renal disease is now a common procedure worldwide. Many of these women are of reproductive age and become pregnant. They need expert obstetric management since these are high-risk pregnancies with a number of potential complications. Also, virtually all transplant patients have other underlying chronic medical diseases. There are no randomized controlled trials to guide physicians in managing pregnancy in renal allograft recipients. Experience has shown that data from observational studies and voluntary registries can be biased and tend toward more favorable outcomes than actually occur. Important components of care include Pre-pregnancy assessment and counseling Close antepartum and intrapartum monitoring An appreciation for how to prevent and manage complications It is important to understand and anticipate that previous hypertension, underlying chronic medical disorders and immunosuppressant therapy are factors that commonly predispose these women to infections and pregnancy problems such as preeclampsia, fetal growth restriction, preterm birth and cesarean delivery. Diagnosis and differential diagnosis Pre-pregnancy counseling for each kidney transplant patient and her spouse is highly desirable. Transplant patients who are planning a pregnancy should be in good general health with no graft rejection episodes. The couple should be made aware of common pregnancy problems in transplant patients and the possibility and implications of delivering a premature infant. Therefore, a tactful but realistic discussion of ethical issues and family support is also warranted. It may be necessary to recommend against pregnancy if the patient has severe or uncontrolled diseases such as diabetes mellitus, cardiovascular or pulmonary disease, recurrent infections, or major side effects from immunosuppressive drugs. The serum creatinine level is one of the most useful prognostic markers for the course of pregnancy. Patients with a creatinine level less than 1. Serum creatinine levels also have prognostic value regarding the risk of future graft deterioration. It is important that patients who are taking mycophenolate mofetil CellCept, Myfortic are switched to a different immunosuppressive agent before pregnancy because of its teratogenic potential. Currently, azathioprine, cyclosporine and tacrolimus are the immunosuppressive drugs of choice during pregnancy. In fact, all allograft recipients of childbearing potential who are taking mycophenolate mofetil must receive contraceptive counseling and should use two reliable forms of contraception simultaneously. These women should be made aware that this drug reduces blood levels of the hormones in oral contraceptives and could theoretically reduce their effectiveness. They should continue contraceptive use for 6 weeks after stopping mycophenolate mofetil and before attempting pregnancy. Antepartum evaluation An accurate diagnosis of gestational age is important because of decisions that may need to be made about early delivery for pregnancy complications. A careful history to obtain an accurate last menstrual period and a baseline first trimester as well as serial ultrasound examinations are useful to confirm the estimated day of delivery and to detect fetal growth restriction. In addition to routine prenatal laboratory tests complete blood count, blood type, indirect Coombs, rubella, syphilis, cervical cytology, screening for gestational diabetes that are indicated in all pregnant patients, baseline and serial tests to monitor renal function are indicated. These include a urine culture, serum creatinine and hour urine collections for total protein and creatinine clearance. Transplant patients should also be evaluated for a number of acquired viral infections common with suppression of the immune system and that present risks for both the mother and the fetus. The transplanted graft is most commonly a source of CMV for months postoperatively. The primary risk of congenital infection in the fetus in most pregnant women is with a primary CMV infection, but recurrent CMV infection has also caused congenital CMV in immunosuppressed women. It is often difficult to clear condyloma accuminata, and obstetricians should be aware that the risk of cervical, vulvar and skin

malignancies is increased in these immunosuppressed women. Management Antepartum care It is prudent to see the pregnant kidney transplant patient more often than the normal pregnant patient in order to watch closely for infections, fetal growth restriction, preeclampsia and premature labor. Prenatal visits at least every 2 weeks until 36 weeks, then weekly until delivery allow the obstetrician to closely monitor the progress of pregnancy. Management of most antepartum obstetric complications is no different than with non-transplant patients, but the increased incidence of infection requires a careful and aggressive approach with avoidance of any unnecessary invasive procedures. Asymptomatic bacteriuria should be treated for 2 weeks and follow-up urine cultures obtained. Prophylactic antibiotics to prevent recurrent urinary tract infections may be needed for the rest of pregnancy. The obstetrician should also be prepared for other potentially serious infections associated with immunosuppression such as endometritis, wound and skin infections and pneumonia, often with unusual organisms such as Aspergillus, Pneumocystis, Mycobacterium tuberculosis and Listeria. Immunosuppressive drugs during pregnancy Although rejection of the renal allograft can occur during pregnancy, the risk is no greater than in the nonpregnant state. It is important for the obstetrician to be familiar with the immunosuppressive drugs the patient is taking and their potential side effects. The immunosuppressive drug doses are usually continued as they were before pregnancy, but blood concentrations should be assessed monthly in order to make dosage adjustments if needed. Familiar maternal side effects include glucose intolerance, hirsutism, acne, weight gain, cushingoid features, hypertension, impaired wound healing, osteoporosis and mood changes. Prednisone has been used for many years in patients with a number of diseases with no proven adverse effects in the fetus. Azathioprine Imuran - The most experience in pregnancy over the years has been with this agent, and it is one of the safest despite a Category D classification. The primary maternal hazards are increased risk of infection and neoplasia. Maternal liver toxicity with jaundice and bone marrow depression has occurred but usually resolves when the dose is decreased. Most azathioprine that crosses the placenta is in an inactive form, and no patterns of congenital abnormalities in the infant have been observed. Calineurin Inhibitors - cyclosporine Sandimmune, Neoral, Gengraf and tacrolimus Prograf have been increasingly used because they have decreased rejection episodes and improved survival in transplant recipients. They are often standard components of current immunosuppressive therapy. Cyclosporine predisposes some patients to nephrotoxicity and hypertension; other problems include bone marrow depression, hirsutism, tremor, gingival hyperplasia, hepatotoxicity and a risk of neoplasia such as lymphomas. Tacrolimus side effects include a propensity toward diabetes mellitus, nephrotoxicity, hyperkalemia and a variety of neurotoxicities such as headache, tremor, change in motor function, mental status or sensory function. Neither of these agents is associated with fetal abnormalities. Newer Agents - Much less is known about the newer immunosuppressants during pregnancy. Sirolimus Rapamune , a macrolide antibiotic, has been linked to small-for-gestational-age infants and delayed bone ossification but has not been implicated in specific fetal malformations. Mycophenolate mofetil Cell Cept, Myfortic is a newly available agent currently used in many non-pregnant transplant patients. It is very important for obstetricians to know about this immunosuppressant because of its teratogenic properties, and it should be discontinued before pregnancy. Its use during pregnancy is associated with an increased risk of spontaneous abortion miscarriage and congenital abnormalities. These malformations include bilateral microtia or anotia, sometimes accompanied by atresia of the external auditory canals, cleft lip and cleft palate, and other major structural malformations involving the eye, hands and fingers, cardiac, bowel and skeletal systems. Maternal adverse effects with this drug include progressive multifocal leukoencephalopathy, sometimes fatal, sepsis, neutropenia, pure red cell aplasia and GI symptoms including bleeding. Intrapartum care Preeclampsia, IUGR or other pregnancy complications may require that the infant be delivered preterm. Two doses of betamethasone 12mg 24 hours apart should be given to any patient delivering before 34 weeks of gestation to lessen the chance of respiratory distress syndrome RDS. Chronic hypertension and preeclampsia are the most common complications, but the management is the same as it is with nontransplant patients. There is no contraindication to Induction of labor, and normal uterine contractions usually ensue with

a normal progression of labor. The progress of labor is assessed in the usual manner, but excessive vaginal examinations, artificial rupture of membranes and internal FHR monitoring should be avoided to decrease the risk of infection. Although the transplanted kidney is located low in the pelvis in the iliac fossa, it almost never interferes with vaginal delivery. Acyclovir can be used safely and with all immunosuppressants for prophylaxis and to treat HSV during pregnancy. A high cesarean rate has been common in reported series but the indications for cesarean have often been unclear. Vaginal delivery is safer for the mother. Cesarean should be reserved for bonified obstetric indications. Prophylactic antibiotics, consideration of replacement glucocorticoids, asepsis, and careful surgical technique are necessary with operative delivery. With cesarean, the obstetrician should be aware of the location of the pelvic kidney, implantation of the ureter into the bladder and possible adhesions from previous surgery to avoid inadvertent damage to these vital structures. The infant Hepatitis B immune globulin and HBV vaccine should be given to all of these infants to prevent chronic hepatitis. Most babies have had a relatively uncomplicated course other than complications associated with prematurity. Small amounts of immunosuppressive drugs can be found in breast milk, but the advantages of breast feeding are considered to outweigh any potential risks. Complications Chronic hypertension and preeclampsia are the most common maternal complications, and prematurity is the greatest risk for the infant. Severe preeclampsia, fetal growth restriction, non-reassuring fetal status or other pregnancy complications may require that the infant be delivered preterm Aggressive evaluation and management is warranted should signs of graft rejection, sepsis, worsening of hypertension, onset of preeclampsia or deterioration of fetal status occur. A number of rare and unusual emergencies have been reported that include allograft rejection, overwhelming sepsis, eclampsia, stroke, and rupture of the uterus and renal vessel anastomosis. These are serious complications best managed in a setting where the obstetrician has access to a team of transplant surgeons, nephrologists and other necessary subspecialists. Prognosis and outcome Most transplant patients ultimately have a successful pregnancy with delivery of a healthy infant. Pregnancy does not have a detrimental effect on the renal allograft or health of the mother. These infants usually grow and develop normally throughout childhood, but little is known about their long-term health since most are just now entering adulthood. Therefore, it is important that all offspring exposed in utero to immunosuppressants have long-term follow-up. Further studies on the safety of these drugs on the progeny are also warranted. Management of high risk pregnancy. A systematic review and meta-analysis". Obstet Gynecol Clin North Am. August, P, Vella, J. Outcomes of pregnancy after transplantation". Expert Opin Drug Saf. No sponsor or advertiser has participated in, approved or paid for the content provided by Decision Support in Medicine LLC.

Chapter 2 : Kidney Transplant in pregnancy - Cancer Therapy Advisor

Medical Disorders in Pregnancy, An Issue of Obstetrics and Gynecology Clinics eBook. Medical Disorders in Pregnancy, An Issue of Obstetrics and Gynecology Clinics eBook We are both privileged to have the opportunity to edit this important issue of Obstetrics and Gynecology Clinics of North America on the topic of Medical Disorders in Pregnancy.

Contact us Indexed by: Medical College and Associate Group of P. Hospital, Bikaner Rajasthan, India. Abstract Mucinous cystadenoma is the second most common type of benign epithelial ovarian tumor. It is uncommon during pregnancy. In this case I report a 35 year old fifth gravida with 12 weeks of pregnancy presenting with three month amenorrhea and severe pain in abdomen and vomiting since two days. She had a twisted mucinous cystadenoma of right ovary. Right salpingo- oophorectomy was done. She came in follow up with 18 weeks of healthy viable pregnancy that was confirmed by USG. Although surgical intervention is a well-accepted choice in such an acute condition but abdominal surgery in a pregnant state always carries some risk to mother and unborn fetus, so before management appropriate counsellng of patient should be done as well as risks involved with surgery must be taken into consideration. Most of them are benign, lobulated with smooth wall. The most frequent and serious complication of benign ovarian cysts during pregnancy is adnexal torsion. Torsion is most common in first trimester and then get less frequent as pregnancy advances. Patients undergoing emergency surgery because of torsion or hemorrhage are at the greatest risk of spontaneous abortion or premature delivery compared to elective surgery, which must be delayed till 2nd trimester. Here, I report a rare occurrence of torsion of large mucinous cystadenoma in first trimester of pregnancy. Case Report A 35 year old women gravida 5 para 2 abortus 2 presented to our gynecology emergency with 3 month amenorrhea and pain in abdomen with vomiting for two days. She had 2 alive children delivered vaginally followed by 2 spontaneous abortions at 2 and 2. In this pregnancy she did not took any antenatal treatment. Her past medical and surgical history was insignificant. On examination she had moderate grade of pallor. On per abdominal examination there was moderate distension with generalized tenderness and rigidity. On per vaginal examination cervix was soft, os closed, exact size of uterus was not made out because of distension. Differential diagnosis of ruptured ectopic pregnancy or torsion of ovarian cyst was made. Ultrasonography USG showed a single live intrauterine pregnancy, corresponding to 11 weeks and 3 days maturity. A heteroechoic lesion is noted in pelvis arising from adnexa, measuring Both ovaries were not separately seen. Moderate to gross hemoperitoneum was seen. Decision of emergency laparotomy was taken with proper counseling of the patient and her relatives. During laparotomy moderate hemoperitoeum was found with a large right unilocular cystic mass of 12x10 cm, twisted around its pedicle. Right salpingo-ophorectomy was done followed by peritoneal washing. Her post-operative course was uneventful. She was discharged home after obstetric USG confirmed a viable pregnancy of 12 weeks. The histology report showed a benign mucinous cystadenoma of the ovary. Patient came for follow up, currently having 18 weeks of viable pregnancy. Figure 1 Intraoperative picture showing uterus green arrow with right adnexal mass. Figure 2 Showing macroscopic appearance of the mass. Management depend upon the symptoms, gestational age, size and character of the cysts. If the mass is unilateral unilocular and less than 6 cm in diameter, observation is recommended. If it is larger than 6 cm, solid, bilateral, persists into the second trimester or become symptomatic then a surgical intervention is required. If torsion or rupture of ovarian mass found or any features suggestive of malignancy are present, then emergency surgery is the treatment of choice irrespective of the period of gestation. Though torsion is uncommon in pregnancy it should be kept in mind for making differential diagnosis of acute abdominal pain in pregnancy. Early diagnosis and appropriate intervention are associated with favorable fetomaternal outcome. Adnexal masses in pregnancy. Clinical obstetrics and gynecology. Evaluation and management of adnexal masses during pregnancy. Boulay R, Podczaski E. Ovarian cancer complicating pregnancy. Obstetrics and gynecology clinics of North America. Adnexal masses and pregnancy: American journal of obstetrics and gynecology. Voluminous mucinous cystadenoma of the

ovary in a year-old girl. Journal of pediatric and adolescent gynecology. Giant benign mucinous cystadenoma growing during pregnancy: Journal of ultrasound in medicine: Torsion of ovarian tumors: International journal of gynaecology and obstetrics: Managing ovarian masses during pregnancy. Volume 2 Number

Chapter 3 : PubMed Journals will be shut down | NCBI Insights

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What every clinician should know Clinical features and incidence Cervical cancer is the second most common malignancy in women worldwide. As cervical cancer frequently occurs in young women, it is not surprising that the disease is one of the most common cancers diagnosed during pregnancy. It is now recognized that human papillomavirus HPV is a prerequisite for the development of cervical cancer. As HPV is extremely common in young women, preinvasive cytologic abnormalities are frequently diagnosed in pregnant women. The majority of these changes represent low-grade abnormalities that often are transient and resolve without intervention. A smaller subset of women have high-grade abnormalities that carry a significant risk for persistence and ultimately progression to invasive cervical cancer. Pathophysiology HPV infects the basal keratinocytes of the cervix and can lead to a series of progressive precancerous changes known as cervical intraepithelial neoplasia CIN. While HPV is extremely common, particularly among young sexually active women, the development of cervical cancer is rare. The long preinvasive phase from HPV infection to the development of cervical cancer allows for the detection and eradication of preinvasive changes. Diagnosis and differential diagnosis What is the first step in screening for cervical cancer in pregnancy? Papanicoalou Pap testing can be safely performed during pregnancy and it is recommended that all pregnant women undergo cytologic screening with the Pap test at their initial prenatal visit unless a recent Pap smear has been performed prior to pregnancy. As in non-pregnant women, cervical sampling can be performed safely with sampling of the ectocervix as well as endocervical sampling with a cytobrush or comparable device. What features of the presentation will guide me toward possible causes and next treatment steps? The normal pregnant cervix is typically characterized by ectropion which may be accompanied by inflammation and may be mistaken as an abnormality. Women with a normal Papanicoalou test do not require further evaluation during pregnancy. Abnormal pap results require further assessment. How are abnormal pap smear results interpreted and managed? Atypical squamous cells of undetermined significance ASC-US is an abnormality that is frequently seen in young women. While the lesion is poorly reproducible, the overall risk of cancer is low between approximately 0. Pregnant women over the age of 20 years may either elect to undergo colposcopy or may safely defer colposcopy until 6 weeks or more postpartum. Low-grade squamous intraepithelial lesions LSIL are also common in reproductive age women. For pregnant women over the age of 20 colposcopy is preferred for evaluation although it is acceptable to defer colposcopy until 6 weeks or more postpartum. Pregnant women 20 years of age or younger do not require evaluation and should undergo cytologic follow-up in 1 year. Although atypical glandular cells AGC is a relatively uncommon cytologic diagnosis, these women are at substantial risk for underlying high-grade abnormalities. Pregnant women with AGC should undergo colposcopy with biopsy of any suspicious lesions. What initial studies should you perform to help make the diagnosis? Like non-pregnant women, pregnant women with cytologic abnormalities are typically evaluated with colposcopy. During the procedure acetic acid is applied to the cervix and the cervix and vagina are visualized under low power magnification. An adequate colposcopy should allow visualization of the entire transformation zone. While the ectropion that accompanies pregnancies facilitates visualization of the transformation zone, it may be mistaken for a cervical abnormality. A number of studies have suggested that colposcopy during pregnancy is safe and not associated with adverse fetal outcomes. When do you need more aggressive tests? Although cervical biopsy is safe during pregnancy, the procedure may be associated with more bleeding than typically is seen in non-pregnant women. Many experts recommend performing biopsy only in women with a lesion that is suspicious for high-grade cervical intraepithelial neoplasia. In contrast to cervical biopsy, endocervical curettage ECC is not recommended during pregnancy. While data are lacking that ECC is associated with adverse outcomes, the theoretical

concern that the procedure could lead to pregnancy-related complications precludes routine performance of ECC. Cervical excisional procedures, including cold knife conization, large loop excision of the transformation zone LLETZ , and loop electrosurgical excision procedure LEEP are usually only performed during pregnancy to rule out a microinvasive cancer How are the colposcopy results interpreted? The understanding of cervical intraepithelial neoplasia CIN is rapidly involving. Management of young women with CIN must carefully balance the risks of progression to cancer against the adverse effects of treatment with conization. The diagnosis of CIN 1 is poorly reproducible. Pregnant women with CIN 1 do not require any further evaluation. Cervical intraepithelial neoplasia 2 and 3 CIN 2 and CIN 3 represent moderate to severe cervical intraepithelial neoplasia. The distinction between CIN 2 and 3 is poorly reproducible and as such, these lesions are classified similarly. The underlying risk of progression to invasive cancer is substantial. Pregnant women with a diagnosis of CIN 2 or CIN 3 may either be followed during pregnancy with repeat colposcopy or defer repeat colposcopy until at least 6 weeks postpartum. For those women who undergo repeat colposcopy during pregnancy the procedure should not be performed more frequently than every 12 weeks. Repeat biopsy is unnecessary unless the appearance of the lesion worsens. An excisional procedure should not be performed unless invasive cancer is suspected. What signs and symptoms should make you concerned for invasive disease? Women with microscopic tumors are usually asymptomatic. Among women with clinically visible lesions vaginal bleeding is the most common symptom. Classically, vaginal bleeding is postcoital. Abdominopelvic pain and vaginal discharge may also occur. Women with advanced-stage tumors may have back pain, hydronephrosis or sciatica. Management If a diagnosis of cervical cancer is made, how is a pregnant patient treated? The management of cervical cancer during pregnancy depends primarily on the stage of the cancer and the gestational age of the mother at the time of diagnosis. Cervical cancer is staged using the International Federation of Gynecology and Obstetrics staging system. The staging of women with cervical cancer relies on clinical examination. What imaging studies if any will be helpful? Both CT and MRI are anatomic imaging modalities that have been used to evaluate tumor size, parametrial spread and nodal dissemination. A prospective study by the Gynecologic Oncology Group suggested that both tests were only moderately accurate in disease assessment. Computed tomography of the pelvis results in fetal radiation exposure and should be used with caution. In contrast, MRI does not expose the fetus to ionizing radiation and may be safely used during pregnancy. More recently, PET imaging has been widely utilized in women with newly diagnosed cervical cancer. However, as the effects of the radioisotope on the fetus are unknown, PET is contraindicated during pregnancy. How is treatment of cervical cancer made specific to pregnant women? Treatment planning for women with invasive cervical cancer must take into account both maternal and fetal considerations. Treatment is predominately guided by the stage of disease and the gestational age of the fetus. As randomized trials are lacking, most recommendations for the treatment of cervical cancer during pregnancy are based on observational studies and expert opinion. In general, women diagnosed prior to weeks of gestation are encouraged to receive immediate therapy, while those women diagnosed after weeks may delay treatment until delivery which is typically planned at weeks depending on the clinical scenario. What are the various treatments available based on stage? For Stage IA1 cervical cancer, women who have tumors with a depth of invasion of less than 3 mm and less than 7 mm of lateral spread have an excellent prognosis. Given the increased blood flow to the gravid uterus, cervical excisional procedures such as conization performed during pregnancy can result in substantial blood loss. Conization is typically reserved for women at less than weeks of gestation to confirm the diagnosis of a microinvasive cervical cancer and exclude a more extensive tumor or when invasion is suspected on a cervical biopsy but the results are inconclusive. In general, patients with stage IA1 cervical cancer can defer treatment until delivery. Treatment of pregnant women with stage IA2, IB1, and small IB2 and IIA cervical cancer at less than weeks of gestation may elect to undergo immediate radical hysterectomy, which can be performed either after elective termination or with the fetus in situ. Patients diagnosed after weeks of gestation generally defer treatment until the time of delivery. For these patients the timing of delivery should be coordinated with a multidisciplinary team including maternal-fetal

medicine experts. For pregnant women with stage IIB-IVA cervical cancer as well as those women with larger stage IB2-IIA lesions, many experts recommend initiation of treatment immediately in women at less than weeks of gestation and delay of therapy until after delivery in women at later gestational ages. While chemoradiation is now the standard of care for non-pregnant patients with advanced-stage cervical cancer, data specifically evaluating combination therapy during pregnancy are largely lacking. Are alternative treatments available? Neoadjuvant chemotherapy is a potential therapeutic consideration for patients with cervical cancer who wish to delay treatment. Neoadjuvant treatment has been shown to decrease the size of local tumors and facilitate surgical management. Unfortunately, large studies to describe the effects of chemotherapy in pregnancy are lacking. Some reports have suggested that women treated with chemotherapy are at increased risk for preterm delivery and adverse neonatal outcomes. Treatment early in gestation, particularly with 5-fluorouracil and cyclophosphamide, has been associated with fetal anomalies. What novel therapeutics are emerging? Over the course of the last decade there has been an increasing interest in more conservative surgical procedures for cervical cancer. A number of case reports of radical trachelectomy for pregnant women with localized cervical cancer have now been reported. While the application of radical trachelectomy to pregnancy is evolving, in non-pregnant women the procedure is usually reserved for women with tumors less than 2 cm in greatest diameter. In addition to the abdominal approach, radical vaginal trachelectomy has also been performed during pregnancy. What mode of delivery is recommended for pregnant patients with cervical cancer? Cesarean delivery is recommended for most women with bulky cervical tumors to decrease the risk of bleeding at the time of delivery. Other reports have suggested that vaginal delivery is safe, particularly for women with microinvasive or small tumors in which the risk of bleeding is less. A potential concern for women who deliver vaginally is local recurrence. How do you counsel the patient and family on prognosis of cervical cancer in pregnancy? While it is difficult to directly compare the outcome of pregnant and non-pregnant women with cervical cancer, it appears that pregnancy does not worsen outcomes. Stage appears to be the most important prognostic factor. The effect of delaying treatment on outcome has long been debated.

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Extra info for Cancer Complicating Pregnancy, An Issue of Obstetrics and Gynecology Clinics (The Clinics: Internal Medicine) Example text Increased thickness of pregnancy-associated melanoma.

What every clinician should know A. Clinical features and incidence Varicella zoster virus VZV , a double-stranded DNA herpes virus, causes clinical infection with the development of primary infection, chicken pox, or reactivation, herpes zoster shingles. Although the morbidity of infection is significantly greater within the adult population, most of the primary infections occur during childhood. Over the past two decades, a dramatic decline in disease incidence - with concomitant increase in immunity - has been seen with the implementation of routine childhood varicella vaccinations. Herpes zoster arises as a reactivation of dormant virus particles within the dorsal root ganglia following prior exposure. More than , cases of zoster occur annually in the United States, but mostly in elderly and immunocompromised patients; pregnancy is not recognized as an antecedent event. No evidence supports pregnancy worsening severity or frequency of herpes zoster in the healthy, pregnant patient population. Varicella-zoster virus primary infection, chicken pox, can present at any stage of the disease process, with many patients presenting later in the course of disease with a "rash. The characteristic pruritic vesicular lesions initially appear along the head and trunk, then spread sporadically to the lower abdomen and extremities. These lesions begin as papules and rapidly progress to superficial clear vesicles surrounded by a halo of erythema. The lesions typically are at all stages at any one time during the disease. As a clinical marker, once all the lesions have crusted, the patient is no longer considered infectious. Reactivation of VZV, shingles, is typically localized to sensory nerve dermatomes, with systemic disease extremely rare Figure 1. The lesions develop as erythematous papules which develop into vesicles that coalesce, rupture and crust over. Pruritic vesicular lesions consistent with Varicella reactivation presenting postpartum along the unilateral posterior flank lumbar dermatomal distribution. Image courtesy of Dr. Fetal and neonatal clinical disease presentation is related to the timing of infection. Congenital varicella syndrome is typically identified following maternal infection between weeks gestation. Congenital varicella syndrome features include limb abnormalities, chorioretinitis, microphthalmia, cerebral cortical atrophy, microcephaly, growth restriction, hydronephrosis, seizures and mental retardation. Specific limb abnormalities include cutaneous scarring, limb hypoplasia and muscle atrophy. Fortunately, the risk of congenital varicella syndrome is relatively low, with an expected rate of 0. Additionally, no reports of congenital varicella infection have been reported in the setting of maternal zoster infection at any point in gestation. Diagnosis and differential diagnosis Establishing the diagnosis When a clinical suspicion of VZV arises, important historical elements should be sought to elucidate the etiology of the disease process. If the patient denies prior exposure to VZV or previous immunization, then a presumptive diagnosis of primary VZV must be applied. VZV infection, primary or reactivation, is typically diagnosed based on clinical exam with identification of the characteristic lesions. If the diagnosis is uncertain or a possible chicken pox or zoster exposure has occurred, laboratory testing can confirm maternal infection status. The varicella virus can be isolated from a scraping of the base of an active lesion during the acute phase of infection with subsequent Tzank smear, tissue culture or direct fluorescent antibody testing DFA testing. Nucleic acid amplification tests are available with increasing sensitivity and specificity. Seroconversion can be identified with the use of an antibody assay identifying acute and convalescent sera. If maternal VZV infection is confirmed, fetal infection can be assessed using DNA amplification techniques on amniotic fluid. In addition to invasive testing, limited reports of antenatal diagnosis have been described using ultrasound to identify limb abnormalities. Differential diagnosis Several other dermatologic disorders in pregnancy may present with a clinical picture similar to chicken pox. Dermatology consultation may be useful if laboratory testing excludes VZV. HSV culture or nucleic acid amplification testing will help differentiate between these two herpesviridae infections. Shingles is also usually limited to one dermatome while HSV may cross dermatomes. Management Prevention strategies are

paramount in the management of this disease. Within the clinic setting, all healthcare workers in contact with pregnant patients should be screened and vaccinated, or identified as susceptible, to permit redeployment to nonpatient areas. Once maternal varicella infection is suspected, the affected individual should be isolated from other pregnant women due to the highly contagious virus and severity of disease associated with pregnancy. A detailed history and physical exam should be performed to delineate the current disease status as to either primary or reactivation see above. Meticulous hygiene and skin care should be stressed in the prevention of secondary skin infection. Pruritus can be decreased with topical dressings, tepid water baths and wet compresses, or by administering antipruritic drugs. Uncomplicated maternal infection is typically self-limited and does not require treatment. Evidence of maternal compromise with dehydration, pulmonary involvement with pneumonia, or extracutaneous involvement with neurologic, hepatic or ocular disease may require hospitalization and medical therapy. Acyclovir, a synthetic nucleoside analogue of guanine which is highly specific for cells infected with VZV, is the drug of choice. Once ingested, acyclovir is converted to acyclovir di- and tri-phosphate by other cellular enzymes. Acyclovir triphosphate inhibits DNA synthesis and viral replication by competing with deoxyguanosine triphosphate for viral DNA polymerase and being incorporated into viral DNA. Exposure of a susceptible pregnant woman to a contact with VZV should prompt maternal lgG testing as soon as possible. The investigational VariZIG is made from plasma containing high levels of anti-varicella antibodies immunoglobulin class G [lgG]. Although previously recommended to be administered within 96 hours after exposure, in May the Food and Drug Administration FDA approved administration of VariZIG for up to 10 days following exposure. Despite this expanded window of treatment, VariZIG is expected to provide maximum benefit when administered as soon as possible after exposure. Prevention of congenital varicella syndrome with the use of VariZIG is unknown, but unlikely to be tested due to ethical issues. Two live, attenuated varicella zoster virus-containing vaccines are available in the United States for prevention of varicella: These live, attenuated vaccines are not recommended in pregnancy, and pregnancy should be delayed for 1 month following the last dose because there is a small chance of mild varicella infection after vaccination with the live, attenuated vaccine. Consequently, the CDC currently recommends that unintentional vaccination of varicella in pregnancy does not imply a need for termination. Postpartum breast feeding should not be disrupted as these vaccines are not excreted into breast milk if vaccination is administered postpartum. Complications Maternal systemic complications in pregnancy are similar to those seen in the non-pregnant population. The most common infectious complication is secondary bacterial superinfection of the skin and soft tissues from excoriation of the lesions with resultant infection with common skin flora, such as Staphylococcus aureus. Extracutaneous involvement of the infection can also include the central nervous system, myocarditis, corneal lesions, nephritis, arthritis, bleeding diatheses, acute glomerulonephritis, pneumonia and hepatitis. Varicella pneumonia is the most severe complication associated with VZV infection. According to Harger et al. Risk of disease is further increased in adulthood and more so in pregnancy. As the gestation advances, the risk of pneumonia is increased, possibly due to displacement of the diaphragm by the enlarging gravid uterus. Additional risk factors include current tobacco use and greater than chicken pox skin lesions, indirectly indicating more severe, disseminated infection. Symptoms develop days following the onset of the rash with cough, dyspnea and tachypnea. As respiratory symptoms can be mild, a chest x-ray with fetal radiographic shielding is recommended for all pregnant patients presenting with varicella. Radiographic findings include nodular infiltrates similar to those seen with other viral pneumonias. Fortunately, mortality rates associated with pneumonia have drastically improved to less than 2 percent with improvement of supportive care and aggressive medical therapy with antiviral medication. Resolution of pulmonary issues typically follows the time course of skin lesions, however, compromised pulmonary function could persist up to several weeks. Acyclovir is recommended for the treatment of complicated VZV infection. The Acyclovir Pregnancy Registry, designed to assess pregnancy outcomes in women exposed to the antiviral medication, was closed in The advisory committee concluded that there was no increase in the number of birth defects in exposed patients when compared to the general unexposed population. Prognosis

and outcome Pregnant women diagnosed with uncomplicated VZV primary or reactivation disease have a self-limited course that usually resolves without maternal sequelae. Complications such as Varicella pneumonia are uncommon but potentially fatal if unrecognized, as discussed above. Shingles is unusual in the reproductive age group. The most common complication of shingles is postherpetic neuralgia - the patient experiences severe pain in the area of the shingles outbreak, even when the shingles rash itself has resolved. This is usually seen in patients 60 years of age and is rare in pregnancy. No sponsor or advertiser has participated in, approved or paid for the content provided by Decision Support in Medicine LLC.

Chapter 5 : K. Leslie's Cancer Complicating Pregnancy, An Issue of Obstetrics and PDF - WOW POP E-bo

This issue of the Obstetrics and Gynecology Clinics of North America, prepared by Guest Editor Dr. Kimberly Leslie, deals with cancer complications in pregnancy. The most common malignancies associated with pregnancy are those of the genital tract, breast, and malignant melanoma.

Chapter 6 : Cervical cancer in pregnancy - Cancer Therapy Advisor

*Cancer Complicating Pregnancy, An Issue of Obstetrics and Gynecology Clinics (The Clinics: Internal Medicine) [K. Leslie] on racedaydvl.com *FREE* shipping on qualifying offers. [The Obstetrics and Gynecology Clinics of North America, Volume 32, Number 4> Univ. of New Mexico.*

Chapter 7 : Varicella-Zoster virus during pregnancy - Cancer Therapy Advisor

TY - JOUR. T1 - Invasive cervical cancer complicating pregnancy. T2 - Obstetrics and Gynecology Clinics of North America. AU - Sood,A. K. AU - Sorosky,J. I.

Chapter 8 : Obstetrics and Gynecology Clinics of North America - Journal - Elsevier

Lung cancer during pregnancy is rare. Herein we describe a case of metastatic cancer of the lung in a year-old pregnant patient whose initial complaint was pain in the left thigh. Management of this neoplasm during pregnancy depends on the gestational age of the fetus and the potential operability of the tumor.