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She's Having A Baby and Cancer

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In October 2011, Megan Harris, a 38-year-old high school teacher from Atlanta, Georgia, found out she was pregnant with a new addition to her happy family of three. But she didn't know until three months later that she'd be planning a funeral rather than a nursery. As she was getting ready for school one January morning, she started bleeding heavily. An hour later, she was lying on the doctor's examination table with her feet propped up in stirrups. The ultrasound showed a healthy baby, but her obstetrician, Kirsten Franklin, wanted to check everything internally. While Franklin examined her cervix, her face paled as white as a ghost. "I'm going to do a biopsy," Harris recalled Franklin saying. "I'm going to rush the results and depending on what they say I'll probably be referring you to an oncologist."

In that moment, devastation overcame Harris. "There are no words. It was like a punch in the gut." After she and her husband left the doctor's office, she broke down sobbing uncontrollably in her husband's arms barely able to breathe. The biopsy results would take a week or two. Harris sluggishly passed the hours waiting for the unknown.

Four days later, as she sat down to dry her hair after showering, the phone shrilly rang. She answered and heard Franklin's voice wavering. "I really hate to tell you this over the phone. You've got cervical cancer," Franklin said. She heard her doctor crying, "There's no way you can have this baby." Franklin was undergoing breast cancer treatment herself, so she understood the heartbreak and turmoil Harris was experiencing.

Women spend a lot of time anticipating what to expect during their pregnancy but the last thing they expect is a cancer diagnosis. Still, one in every 1000 pregnancies is marred by this frightening news. Doctors think the chances of a cancer diagnosis during pregnancy are increasing because more women are starting families later on in life. According to the Centers for Disease Control and Prevention, the number of women who start having children between the ages of 35-39 increased six-fold from 1973 to 2012. Indeed, a 2015 paper published in *JAMA Oncology* noted that breast cancer diagnoses have become more common during pregnancy.

The good news is that doctors are getting better at treating cancer during pregnancy in ways that can keep both mom and baby safe. For decades, women were told to terminate their pregnancies after a cancer diagnosis because doctors worried that the pregnancy would put the mother's life more at risk and that cancer treatments harmed the developing fetus, but most cancer specialists now know that both of these concerns are untrue. In a recent study, Elyce Cardonick, a Maternal Fetal Medicine physician at Cooper University Health Care

in Camden, New Jersey found no evidence that children born to mothers who were treated for cancer during pregnancy had any developmental problems. Research suggests that 80 percent of doctors now recommend treating pregnant women who have cancer while they are still pregnant. The remaining 20 percent are told to terminate for various reasons, including the fact that some cancers are still difficult to treat without harming the fetus. Cardonick said there are no differences in maternal survival rates between mothers who terminate their pregnancy and mothers who continue on with their pregnancy.

After Harris received her fateful news, she met with a gyno-oncologist for an MRI scan, which showed a tumor on her cervix that spanned five and a half centimeters. The doctor diagnosed her with Stage 1 B2 aggressive adenocarcinoma, the deadliest kind of cervical cancer. Due to the serious nature of her diagnosis and the tumor's close vicinity to the fetus, she was advised to terminate. She sought opinions from two other doctors who agreed.

But for Harris, an abortion went against everything she believed in. "I did think about how would I live with myself after making that decision," said Harris. She refused to take no for an answer.

It was 1973 when a Mexican doctor named Agustin Aviles first discovered that pregnant women with cancer could be successfully treated without having to give up their babies. At the time, he was a resident and senior researcher at the Instituto Mexicano del Seguro Social in Mexico City. He had just diagnosed a pregnant woman with a serious blood cancer called acute leukemia. The costs of delaying leukemia treatment for more than a few days pose a dangerous risk for both mother and child. And medical abortions were rarely permitted in Mexico back then.

Despite scarce research on its safety, Aviles' best option was to administer chemotherapy to the mother in hopes of saving both lives. He was shocked to discover that the chemo drugs killing the rapidly growing cancer cells did not harm the fetal cells. The mother survived and delivered a healthy baby girl. This finding changed the course of Aviles' career. After what he had seen, he decided to start studying the safety of chemotherapy given during pregnancy.

Aviles treated 84 pregnant patients who had leukemia, Hodgkin's disease or lymphoma with chemotherapy between 1973 and 2003, which included 58 women who received it during the first trimester, the period when the fetus is believed to be the most vulnerable. The women delivered healthy babies and only 5.8 percent had minor birth defects. In a follow up study conducted in 1991, he again assessed 43 children born to those same mothers, including 19 who were treated during the first trimester. The children ranged from 3 to 19 years old and had all developed normally both physically and mentally. This study suggested fetuses could tolerate chemotherapy in the 2nd and 3rd trimesters and possibly in the first trimester, too. Aviles conducted a final follow up study in 2001

with all 84 children, who at that point ranged in age from 6-29 years old. All were leading healthy lives.

But despite Aviles' important findings, doctors have been slow to accept the idea that it's safe to treat pregnant women who have cancer. One problem is that, given the numbers, an obstetrician may only see a pregnant woman with cancer about once every eight years – so he or she may not have much experience or expertise on the subject. Obstetricians, for instance, may not know about Aviles' findings or the literature and assume that the best thing to do in such a situation is to terminate. Or their own personal biases or fears over potential legal ramifications may play a role in their medical advice.

Another reason doctors may be slow to accept the idea of allowing women to carry to term with cancer is that doctors, for decades, actually believed that pregnancy caused cancers to grow more quickly. Certain types of breast cancer cells grow faster in the presence of female hormones like estrogen, and doctors in the 1940s and 1950s theorized that the hormonal shifts that occur during pregnancy could also induce cancer cells to grow. Doctors realized in the 1960s that this logic didn't hold true. The theory was officially debunked in the 1980s when researchers started comparing pregnant women to non-pregnant women to see if pregnancy truly influenced cancer survival. But the notion may linger in some doctors' minds.

A third problem is that researchers have typically been nervous to enroll pregnant women with cancer in scientific studies for fear of exposing them to unnecessary risks. So apart from Aviles's findings, single case reports, and reviewing the literature on past cancer treatments given during pregnancy, there hasn't been much research on the issue for doctors to turn to. Cardonick said it's been tough to get funding to conduct research for her registry because funding agencies are more interested in cancer prevention than cancer treatment.

"If you're a cancer center and you have choice of funding someone whose going to find a prevention of cancer versus something that affects 1 in 1,000 women the dollars are limited," Cardonick said.

And some cancers are legitimately difficult to treat during pregnancy. Harris' was one of them.

Gynecological cancers, such as Harris' cervical cancer, often sit next to the fetus, which means that any treatments end up encroaching on the growing human too, which could pose risks. The standard treatment for cervical cancer is a radical hysterectomy, which removes the uterus and cervix. But that is not a viable option for pregnant woman because the fetus grows inside the uterus.

Other times the patient suffers from recurrent cancer and repeated treatments can be risky. Dr. Dennis Citrin, a medical oncologist at the America Midwestern

Regional Medical Center in Zion, Illinois, part of the Cancer Treatment Centers of America, said he saw a young woman with recurrent breast cancer. He was treating her with a drug called Tamoxifen to keep her in remission until she found out she was pregnant. Tamoxifen is a drug that causes an increased risk of fetal abnormalities. But if she stopped treatment to continue her pregnancy, it was likely that her cancer would return. In the end, her best option was to terminate.

“In some cases termination is what you need to do to save the mom,” Cardonick said. “It just shouldn’t be a knee jerk reaction to every case of cancer.”

In part because she has been frustrated by how some doctors still do have this knee jerk reaction, Cardonick has been collecting data herself in order to prove the point that cancer treatment during pregnancy can be safe, and to help identify the types of treatments that are best for various cancers.

The Cancer and Pregnancy Registry created in 1997 by Cardonick at Cooper University Health Care is a registry that provides women and doctors with data on children ages 1 and up on their health after being exposed to different types of cancer treatments while in the womb. Once a woman shares her story, she is registered into the system. Then the researchers contact the oncologists and pediatricians annually to see how the women and children are doing every year after birth and document it.

The purpose of the database is “to really look at these babies long term and to see that they seem to develop normally because we didn’t have that data, except for Aviles’ one-time study,” Cardonick said.

Dr. Frederic Amant, head of the International Network on ‘Cancer, Infertility and Pregnancy, a research team of the European Society of Gynecological Oncology, and a gynecologic oncology specialist at Antoni Van Leeuwenhoek hospital in Amsterdam, has created a similar European database too. It records the results of developmental tests given to children born to mothers who underwent cancer treatment. His findings have also helped to confirm that treatment during pregnancy is safe. In a study published in September 2015 in the *New England Journal of Medicine*, which was based on his database, Amant and his team compared 129 children born to European women who had cancer during their pregnancies with children born to women without cancer. Some of the women had been treated with chemotherapy, while others had been given radiation or other therapies. When Amant tested the children’s cognitive outcomes and heart function, he found that low birth weight was slightly more common in children exposed to chemotherapy (in part because the babies of moms with cancer were more likely to be induced earlier and born younger), but that otherwise, there were no significant differences between the two groups of kids.

Findings like this, “help women and physicians get the confidence to get treated,” Cardonick said.

Researchers don't yet know exactly why fetuses aren't harmed by powerful cancer treatments such as chemotherapy, which kill cancer cells. "It's kind of remarkable because they are very powerful drugs," Citrin said. And yet the fetus seems to be protected from them." One reason could be because the placenta acts as a protective barrier between mother and baby, which can block some drugs from passing through entirely or only passing through in tiny amounts.

And for women like Harris, for whom chemotherapy is not an option, precision medicine has also made things easier. Research suggests that during the second trimester, surgeries such as trachelectomies, procedures that amputate the cervix, can be performed to safely remove certain tumors during pregnancy.

A trachelectomy was ultimately what saved Harris' life – and her baby's. After searching far and wide for a doctor who wouldn't recommend termination, Harris eventually ended up at MD Anderson Cancer Center in Texas. There, she and her husband met with Dr. Pedro Ramirez, professor and Director of Minimally Invasive Surgical Research and Education in the Department of Gynecologic Oncology. At first, he too recommended that she terminate so that she could have a hysterectomy. Harris shook her head. "I wouldn't be in Texas if that's what I wanted to do," she told him.

After more thinking, Dr. Ramirez realized that he could modify her treatment and recommend a simple trachelectomy instead, which could remove her tumor without having to remove the entire uterus.

This wasn't to say that Harris had nothing to worry about: Dr. Ramirez had only performed six trachelectomies on pregnant women during his medical career, so he didn't have a long track record of success. And with a surgery, there is a high risk of bleeding, which would cause a fetus to abort during or after the procedure. But the six women that Ramirez had treated all recovered, so Harris stepped forward to become his seventh patient.

One week later and sixteen weeks pregnant, Harris flew back to Houston to undergo her trachelectomy. While she was signing her surgery papers, Dr. Ramirez prepared her for the worse case scenario. He said if her tumor ended up being worse than they thought, he might have to perform a hysterectomy and take the baby at 16 weeks.

After four and a half hours under the knife, the pathologist said there were no cancer cells on the tissues removed from her cervix. Harris was cured of her cancer, and her baby was still healthy.

“We had to be very proactive for both of our health. But it was still very scary,” Harris said. “I was very happy with the decision we had made because we had done the best thing for the baby and I.”

On July 22, 2012, Baby Harris delivered full term through a cesarean at 40 weeks and 6 days at 9 pounds and 1 ounce. Harris named him Houston David after the city that saved him and David, a Biblical name from the Old Testament that means “remember.” “Every time we hear his name, it is a reminder of the miracle God gave us,” Harris said. Eight weeks later, Harris had a hysterectomy. Today, mother and son are happy and healthy.

“We want to make sure that women know they do have options. It doesn’t always have to end badly,” said Harris.

SIDE BAR:

For pregnant women, a cancer diagnosis can be a very scary thing. Here are what our experts say you should do if you find yourself in this situation.

First, find a team of physicians who have experience with and are comfortable treating pregnant women.

Don’t just rely on a general obstetrician. “Their local obstetrician and local doctors may not be appropriate for that because it does take some experience and team effort and finesse to manage both the pregnancy and the tumor,” Stan Lipkowitz, Chief Physician for the Women’s Malignancies Branch at the National Cancer Institute and attending physician for the Breast Cancer clinic at the Walter Reed National Military Medical Center in Bethesda Maryland, said.

Women should look for reputable cancer centers like MD Anderson in Texas, Sloan Kettering in New York City, or the Cancer Treatment Centers of America who have experience in this area. Google the words “cancer treatment center” and “pregnancy” to find more options.

You can also go onto the Hope for Two website (hopefortwo.org) which connects women to nearby doctors who have experience treating pregnant women with cancer. You can also look at the Pregnancy with Cancer registry to see how other doctors have treated women in similar situations.

“We have a network of physicians who are comfortable and we can find who is based in their area,” Elyce Cardonick, a Maternal Fetal Medicine physician at Cooper University Health Care in Camden, New Jersey, said.

If you still have trouble finding an experienced doctor, talk to an oncologist.

Weigh your options and engage in open conversation with doctors.

Ask your doctor to explain the reasons behind his or her treatment plan. Discuss

what the options are for non-pregnant women and how those treatment plans could be modified for you during the pregnancy. Weigh pros and cons of each option so you can understand how each treatment affects your prognosis and your baby's health.

Ask your doctor questions like:

What will happen if I decline treatment?

What's the risk that I might need to induce early to continue treatment?

What's the longest I can delay my treatment without changing my prognosis?

Are you giving me the same doses of chemotherapy I would get if I wasn't pregnant?

How will chemotherapy affect my child?

What are the risks to my survival and my baby's survival for each option?

Always seek a second opinion.

Pregnancy with cancer is a complex and rare occurrence so it's good to seek opinions from at least two highly-trained specialists so you know you're making the best decision for you and your baby.

"This is not a common situation," Dennis Citrin, a medical oncologist at the America Midwestern Regional Medical Center in Zion, Illinois, part of the Cancer Treatment Centers of America, said. "It's a complex situation because you're treating in a sense two people at once."

Find a support group.

As rare as getting diagnosed with cancer while pregnant is, there is emotional support out there to help get you through this difficult time.

Hope for Two, an online support group, pairs women with other women who have gone through similar experiences to provide support and hope for each other. This gives women the opportunity to ask other women how they were treated, where they were treated, and how comfortable they were with their doctor.