Melanoma and pregnancy:

ALL THE FACTS

Dr Sumayya Ebrahim states all the current findings and facts regarding melanoma and pregnancy.

The incidence of melanoma has been steadily increasing over the last 40 years. Whilst the peak incidence occurs at 65 years, statistics show that about one third of female patients will be diagnosed with melanoma in their childbearing years.

Pregnancy associated melanoma (PAM) is defined as any melanoma diagnosed during pregnancy or up to one year after delivery.

Impact of pregnancy on melanoma

There is significant debate in medical circles around the effect of pregnancy on melanoma. We still have many unanswered questions. The most important one is: if melanoma is picked up in pregnancy, is the disease more likely to be worse and is spread more likely to be quicker? The data on this is conflicting with some studies saying that melanoma is worse and others not finding the same results. More research in this area is awaited.

Important to note is that pregnancy doesn't increase the risk of melanoma. There are some changes in the body that occur in pregnancy though, that are relevant to, and have been studied in relation to melanoma.

- During pregnancy, oestrogen and progesterone levels are naturally very high; this leads to hyperpigmentation. The appearance of new pigmented lesions is common. Existing lesions can also undergo change. This can be confusing and may lead to either over diagnosis (unnecessary biopsies) or under diagnosis (ignoring suspicious lesions, falsely assuming that these are normal in pregnancy).
- Pregnancy is a time of extreme alteration in the immune system. This has to happen naturally in order for the immune system of the pregnant mother not to attack the growing foetus. It's still unclear from studies done so far, if these changes in immunity can worsen melanoma and its spread. More research is awaited.

Treatment considerations

- In pregnancy, if the stage is early, there should be no impact on the pregnancy. A pregnant woman can still undergo excision biopsy with either local or general anaesthetic. Wide local excision is also acceptable where necessary. Treatment doesn't need to be delayed until after pregnancy. Usually this completes the treatment.
- Pregnant women with advanced disease that has spread, and where chemotherapy or immunotherapy is required, may be advised to either deliver early or perhaps even to terminate the pregnancy. Such situations will need to involve a multi-disciplinary team approach involving both obstetric and oncology input.
- Current understanding is that melanoma in pregnant women doesn't carry a poorer prognosis than for non-pregnant women. Rather, it's the stage of the disease that remains the most important factor to take into account.

Considerations around spread in pregnancy

With advanced disease in the pregnant mother, metastatic spread to the placenta can occur. This is, however, rare. If the melanoma has spread to the placenta, there is a 25% chance that those infants will die from metastatic melanoma.

Considerations about imaging tests for staging and monitoring in pregnancy

- CT imaging should be avoided in pregnancy.
- Ultrasound is the imaging test of first choice in the first trimester of pregnancy.
- Whole body MRI is the imaging method of choice from the second trimester onwards.
- Contrast media (including gadolinium) should be avoided in all stages of pregnancy.

Pregnancy after a melanoma diagnosis

After early-stage disease and treatment, pregnancy is only recommended two to three years after remission. For more advanced disease, pregnancy is only recommended on a case by case basis. There is no evidence that pregnancy increases the risk of melanoma recurrence but having a high-risk or advanced stage of melanoma does.

Meet the expert

Dr Sumayya Ebrahim is a gynaecologist in private practice in Johannesburg. She is also a blogger. Check out her blog Vaginations by Dr E on vaginations.co.za

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