

МЕДИЦИНА И СТОМАТОЛОГИЯ

BREAST CANCER AND PREGNANCY - HOW TO SOLVE IT

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Resume

The topic of "breast cancer and pregnancy" is a combination of a number of unsolved problems and questions that we have tried to explain and answer in our work.

Abstract

Every year, more than 1 million new cases of breast cancer are detected in the world, predicting an increase in the number of cases by 2010 to 1.5 million. In Russia, breast cancer (BC) takes 1st place in the frequency of all malignant neoplasms in women: 19.8 % Mortality from breast cancer continues to occupy the first place in the structure of female mortality from cancer and is 17.1% while continuing to grow steadily [8,10]. Despite the last 5 years, indicating the stabilization of the incidence of breast cancer in the age group from 20 to 49 years (51: 100.000), since 2000, there is a global trend towards an increase in the incidence of breast cancer in the group of young women under the age of 35, cancer is "younger" [2, 6]. At the same time, there is a tendency to increase the birth rate among women over 30 years old. Consequently, every year there will be an increase in the number of women in whom breast cancer will be diagnosed during pregnancy or lactation. Today, the incidence of breast cancer is 1 case per 3,000 pregnant women. Mostly women aged between 32 and 38 are affected [4,9].

Key words : Breast cancer , pregnancy and frequency of occurrence

Difficulties in diagnosing the objective (increasing the volume and changing the consistency of the mammary glands, the incidence of complications during lactation) and the subjective nature (psychological "unavailability" for the diagnosis of a malignant tumor in the patient and the doctor) lead to late detection of the tumor in pregnant women, treatment begins at more common stages disease than in the general population of patients.

A set of diagnostic measures for suspected breast cancer during pregnancy is limited. Due to the danger of radiation exposure to the fetus, radionuclide methods are excluded. And the hyperplasia of the breast tissue, its hypervascularization, the changed consistency reduces the information content of the X-ray method of mammography by up to 25%. Thus, the diagnosis, the determination of the stage and the final verification of the diagnosis is based on ultrasound, the study of cytological and biopsy material [1, 6, 8]. Hyperplastic changes in the breast tissue during pregnancy and lactation can potentially lead to false positive or false-negative cytological diagnosis of breast cancer [5]. Traditionally used biochemical and immunohistochemical methods for examining the receptor status of a tumor in this group of patients often give a negative result. This results in a search for more "subtle" methods for assessing the true state of the receptor status. At the moment, there are no clear recommendations in terms of timely and reliable diagnosis of tumor masses during pregnancy.

Therapeutic tactics are also not defined and depend on a number of factors: on the patient's desire to

save the pregnancy, on the timing of gestation, on the stage and prevalence of the disease. Often, a different combination of these options in one patient makes us consider each clinical case individually. Nevertheless, the determination of the sequence of diagnostic and therapeutic measures, taking into account all the accompanying factors, is extremely relevant. In the past, in the few clinical observations of this group of patients, some authors identified them as "inoperable", regardless of the prevalence of the disease at the time of diagnosis. However, in recent years, the point of view of the expediency of radical treatment has become more and more reasonable. There is no consensus on discussing the possibility of performing organ-sparing operations in such cases, there is no unity of views on the feasibility of and modes of radiation and drug therapy in terms of combined and complex treatment, the indications for hormone therapy and the latter are unclear. The prognostic factors that determine the course of the disease in patients of this group remain inadequate. A number of researchers argue that even within the same stages of breast cancer, the prognosis makes pregnancy [3], - others believe that the worst prognosis is only due to the greater prevalence of the disease at the time of diagnosis [7]. The study of such factors as: tumor size, number of affected regional lymph nodes, tumor invasion into surrounding tissues, expression of the Her-2 / neu gene, receptor status, in relation to the prognosis of the disease, will allow defining new approaches to treatment individualization. Thus, summarizing the above data, it can be stated that at present there is no

single concept in the implementation of diagnostic and therapeutic programs in the group of breast cancer patients associated with pregnancy [3].

Cases of diagnosis of breast cancer on the background of pregnancy in patients participating in an in vitro fertilization program require close examination. Such observations suggest the absence of “oncological vigilance” in obstetrician-gynecologists, who observe (sometimes for years) women and conduct the next cycle of extracorporeal fertilization in case of already existing cancer [2].

Pregnancy completed childbirth is considered by many authors as an important preventive measure in relation to the development of breast tumors. It is of scientific interest to study the relationship of the term of a previous pregnancy in a patient and the corresponding effect on the prognosis of the disease. A number of researchers have noted an increase in the relative risk of developing breast cancer and a deterioration in the prognosis of the disease with a decrease in the time interval to a previous pregnancy and childbirth [5].

The question of the possibility of pregnancy after treatment for breast cancer has not yet been resolved. Currently, in the literature, there is almost no information on the increased risk of recurrence and progression of breast cancer associated with a possible subsequent pregnancy. There is no clear definition of the minimum “safe” interval between the end of breast cancer treatment and subsequent pregnancy [8,9].

According to preliminary data obtained on the basis of an analysis of pregnancy after suffering cancer, during the initial stages of the disease and the absence of adverse prognostic factors, the patient may have a pregnancy as early as 2 years after treatment. However, this issue requires further study.

Various combinations of anticancer treatment of breast cancer, including radiation therapy, chemotherapy, directly affect the patient's ovarian function, causing a decrease in oocyte reserves and ovarian reserve. On the one hand, the need to control ovarian function is determined by the general tasks of treating hormone-dependent tumors. On the other hand, the increasing interest of cancer patients to the possible preservation and restoration of reproductive function with subsequent pregnancy is determined.

A number of international conferences under the general title “Cancer and pregnancy”, held in Europe and in America, are devoted to studying the problem of reproduction in cancer patients. In 2006, officially announced the opening of two specialized centers for the study of reproductive capacity in cancer patients (Valencia-Spain, Lyon-France). In Russia, however, in our opinion, insufficient attention is paid to the preservation of reproduction. There are no recommendations on chemotherapy planning, taking into account the possible loss of fertility in patients with breast cancer, and there are no ways to restore reproduction using modern methods of assisted reproductive technology. The possibility of preserving reproductive function, the use of new reproductive technologies that allow one to have a pregnancy after undergoing treatment for cancer, and

conducting prospective studies of preimplantation genetic diagnosis in cancer patients are extremely relevant today [1,2,5,8,9].

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