Surgical Treatment of a Gastric Cancer in a Pregnant Woman without Performing Abortion

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ABSTRACT

Gastric cancer during pregnancy is extremely rare and there are problems in its diagnosis and treatment due to the presence of fetus. Beside the difficulties in diagnosis owing to the common symptoms of pregnancy, there are different practices during treatment procedure. Major concern in these cases is the situation of the fetus. There are different views on whether terminate the pregnancy or keep it until the term. It is undisputable that there must be not only medical but also ethical, social, cultural and religious considerations during decision making process. In this report, we planned to present our treatment process, medical outcomes, ethical issues and family involvement in a 23 weeks pregnant woman with gastric cancer. We performed total gastrectomy to the patient before the termination of pregnancy. There was no problem either in the mother or in the fetus at post-op stage. After 3 months, the patient gave birth to a healthy child in term. There was no recurrence or metastasis in post-op 9th month control. This information suggests us to be more sensitive on trying to keep fetuses alive until the term and re-evaluate our 'reflexive' attitude on terminating the pregnancy. Furthermore, we believe that terminating the pregnancy may -and will- cause biological and psychological trauma on mother which may -and will- affect the prognosis negatively.

***Key Words**: Gastric Cancer, Pregnancy, Abortion*

INTRODUCTION

Gastric cancer during pregnancy is extremely rare and its prognosis is generally poor. Like many other cancers, early diagnosis of gastric cancer is crucial for a better outcome (1). However, most tumors are far advanced at the time of diagnosis in pregnancy and most patients rapidly die (2).

The diagnosis of gastric cancer in pregnancy is difficult, because early symptoms are usually misinterpreted as the common pregnancy-induced nausea, mild epigastric pain, fullness, etc. (3).

CASE

A 37 years old female patient applied to our clinic with lack of appetite, early fullness, vomiting. Patient was 6 months pregnant in her admittance. However, she had not gain any weight within last 6 months despite the pregnancy. The patient had linked all other symptoms to her pregnancy. A tumor extending from corpus to the antrum region of the stomach was observed in the endoscopic examination. The patient was diagnosed as gastric signet cell cancer by the histopathological examination. Pregnancy was dated as 23 weeks in obstetric ultrasound examination. Everything was normal with the fetus. There was no abnormal finding other then thickness in gastric wall on abdominal ultrasound examination. The patient was informed about her condition and advised for the termination of the pregnancy. However, the patient did not agree to terminate the pregnancy and surgery was planned without termination. Laparotomy revealed a 5x6 cm. size subseros tumor at the junction of corpus and gastric antrum. Total gastrectomy and Roux-NY eusophagojejunostomy was performed. There was no peroperative complication. Routine obstetric controls were done and everything was normal with the baby and the mother. The patient was discharged from the hospital in post-op 12th day without any complains and gave birth to a healthy child in term. Everything was normal with her until post-op 9th month. The patient was hospitalized in post-op 10th month for iron deficiency anemia. All the screening procedures were performed and there was no relapse sign or metastasis. We were informed that the patient died post-op 14th month.

DISCUSSION

Since pregnancy in gastric cancer patients are rather rare, there is very limited information in literature on these cases. The largest series was presented by Ueo et al. in 1991 where they had 61 cases (1). There are also some case reports which were presented by Scharl et al and Jaspers et al. (2,3). Due to the lack of the literature, many issues need to be discussed on these cases. The prognosis of gastric cancer with pregnancy is generally considered as poor. And the reason for it is the late diagnosis of the cases. However, the information is very limited about early stage gastric cancers in pregnancy.

In these cases, the key point is the condition of the fetus. The stage of pregnancy determines how we shall act. Ueo et al. suggested a guideline regarding to the termination of pregnancy (1). They, briefly, recommended the termination of pregnancy in these cases until 25 weeks. According to the suggested guideline, in early pregnancy, termination must be discussed to allow optimal treatment. In advanced gastric cancers diagnosed in the first trimester, like ours, the standard approach is palliative chemotherapy following termination of pregnancy. Thus, the patient's pregnancy was terminated before the chemotherapy. Beyond 24 weeks of gestation, the decision depends on the stage of gastric cancer. If the cancer is advanced and considered resectable, immediate resection of the gastric cancer is recommended despite the risk to the fetus. After week 30, the fetus is suggested to be delivered followed by radical operation on the gastric cancer (1).

As we have mentioned above, our case was 23 weeks pregnant and the pregnancy was not terminated because of the patient's refusal. We applied all the surgical procedures without any limitation due to the pregnancy. Ueo et al. suggest termination but, in these cases it is always a surgical and a psychological trauma for the patient and her family. Abortion has always been a moral dilemma for the patients and the doctors. Bioethics literature is full of articles and books which discusses pros and cons of the termination of pregnancy (4-8). In case of the termination of pregnancy, the ethical positions are very much related to how one see the moral status of a fetus or an embryo. Even the people who are prolife –against abortion- support the idea to terminate pregnancy if the continuation of pregnancy becomes a thread to mother's life. Therefore, termination of pregnancy in a cancer patient seems morally unproblematic. However, it is still a very hard decision to make.

The 'famous' four principles of bioethics, namely beneficence, non-malfeasance, respect to autonomy and justice (9) provide help in many ethical dilemmas in clinical settings. There is not a consensus which principle should be prioritized in cases where these principles are contradicting to each other. It is commonly accepted in western societies that 'respect to autonomy' is the most important principle that a health care professional should follow. In our case, although the information in the medical literature had suggested abortion, the legal regulation in Turkey allows the termination in these conditions (10) and the rulings of Islamic authorities permits abortion, we informed the patient in detail and leave the decision to the family. At first look, although it

looks medically –and ethically- wrong, or risky, to delay the therapy of the patient for 3 months, the result had shown us that neither medical nor ethical decisions are absolute. Our patient gave birth to a healthy child, and there was no relapse sign or a metastasis in screening after 7 months from the delivery and 10 months from the operation. All these period was without any medication. We gave chemotherapy after that point but she died after 4 months. The chemotherapy protocol could not be applied due to decline of the patient. Since the sudden death occurred at home and autopsy was not performed, we do not know the reason of death.

In conclusion, we believe that terminating the pregnancy may –and will- cause biological and psychological trauma on mother which may –and will- affect the prognosis negatively.

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