Overall, outcomes in patients diagnosed with HL in pregnancy in the modern era of chemotherapy and radiation are good. As in HL not diagnosed during pregnancy, outcomes are better in patients with a complete response following initial therapy. Delaying all therapy until the postpartum period is appropriate in properly selected patients and is not associated with poorer outcomes.

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PURPOSE: Hodgkin lymphoma (HL) is the fourth most common malignancy diagnosed during pregnancy. However, the appropriate management of HL during pregnancy is disputed, and the effect of suboptimal staging imaging and modified treatment regimens is unclear. Here, we report treatment approaches and survival outcomes of pregnancy-associated Hodgkin disease at our institution.

METHODS: We performed a single-institution, retrospective analysis of 36 women diagnosed with HL during pregnancy between 1991 and 2014. Kaplan-Meier and chi-square analyses were used to determine survival outcomes.

RESULTS: Of the initial 36 charts reviewed, 6 patients were excluded due to inadequate long-term follow-up. Among the 30 remaining patients, 24 patients (80%) had stage I/II disease. Six patients had B symptoms (20%). The median gestational age at diagnosis was 20 weeks (range: 2–37 wk), with most patients (60%) being diagnosed in the second trimester. A total of 19 patients (63%) initiated treatment while pregnant (4 with radiation, 15 with chemotherapy). Two women terminated their pregnancies to initiate treatment, and there were two spontaneous abortions in women who initiated chemotherapy at 4 weeks and 15 weeks of gestation. Further, 18 women (60%) had full-term pregnancies (> 37 wk gestation); the median gestational age at delivery was 37 weeks (range: 26–42 wk). A total of 15 women (50%) received both chemotherapy and radiation, 10 (33%) received chemotherapy alone, and 5 (17%) received radiation alone. The majority of patients had a complete response after finishing therapy, but six women (20%) had progressive or primary refractory disease, and six women (20%) relapsed.

After a median follow-up of 57.5 months, the mean progression-free survival (PFS) was 43.4 months (range: 1–261 mo), and the mean overall survival (OS) was 80.8 months (range: 8–273 mo). Patients with progressive or primary refractory disease had poorer outcomes (mean PFS: 10.3 mo vs 49.3 mo, \(P < .0001\); mean OS: 31.2 mo vs 93 mo, \(P = .0031\)). Initiating treatment during pregnancy was not associated with improved outcomes (mean PFS: 13.4 mo vs 46.7 mo, \(P = .89\); mean OS 41.5 mo vs 85.3 mo, \(P = .81\)).

CONCLUSION: Overall, outcomes in patients diagnosed with HL in pregnancy in the modern era of chemotherapy and radiation are good. As in HL not diagnosed during pregnancy, outcomes are better in patients with a complete response following initial therapy. Delaying all therapy until the postpartum period is appropriate in properly selected patients and is not associated with poorer outcomes.

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