Pregnancy and Breast Cancer

Special considerations:
- There should be open communication with the patient, obstetrician, and oncologists (medical, surgical and radiation)
- Surveillance of children exposed in utero to chemotherapeutic agents should be documented
- Surgery will not be performed at MD Anderson post 22 weeks gestation

1 If metastatic disease at diagnosis, individualize treatment with multidisciplinary planning
2 Patients with DCIS should not receive chemotherapy

INITIAL EVALUATION

Palpable mass > 2 weeks1
- History and physical
- Bilateral mammogram with fetal shielding/ultrasound of breast and nodal basins

Core biopsy

Pathology review:
- ER/PR status
- HER2 status

Ductal carcinoma in situ2 (DCIS)

Invasive breast cancer

See Breast Cancer Non-Invasive algorithm (Ductal Carcinoma In Situ)

See Clinical Stages on Pages 2-3

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.
Is patient a candidate for pre- or post-operative systemic therapy?

Individualize surveillance program based on clinical indication.

No

Pathology review:
- ER/PR status
- HER2 status

Yes

Clinical Stage I

Surgical consult for primary treatment

Maternal Fetal Medicine (MFM) consult to determine fetal age and delivery date

Systemic therapy: anthracycline or taxane chemotherapy as medically appropriate once fetal age is ≥ 12 weeks

Medical Oncology consult

Response?

Yes

MFM follow-up prior to each anthracycline chemotherapy or every 3-5 weeks prior to taxane chemotherapy
- Consider holding chemotherapy by week 35 of gestational age or approximately 3 weeks prior to a planned delivery

No

Individualize therapy based on multidisciplinary conference recommendation

Surveillance

Individualize follow-up treatments to ensure the best care for patient, primary surgery, or delivery date

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1 Anthracycline therapy prior to taxane therapy is the preference

CLINICAL STAGE
CLINICAL STAGES

Clinical Stage II or III or suspicion of distant metastatic disease

Pathology review:
- ER/PR status
- HER2 status

Evaluate tumor response as clinically indicated, consider at least after 4 cycles of anthracycline-based chemotherapy or 12 cycles of taxane-based chemotherapy

Tumor response?
- Yes
- No

Initiation of systemic therapy should be delayed until fetal age ≥ 12 weeks

Surgical resection

Systemic therapy

Fetal age ≥ 12 weeks?
- Yes
- No

- Continue systemic therapy until completed, followed by
- Surgical resection, followed by
- Radiation therapy (after delivery of baby)

Special Considerations:
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1 Anthracycline therapy prior to taxane therapy is the preference
2 Following the delivery of the baby:
   - Additional chemotherapy, endocrine, biologic therapy and/or radiation as clinically indicated
   - Review labor, delivery, and neonatal records

Note: Any pregnant patient presenting to MD Anderson should have a Maternal Fetal Medicine (MFM) consult prior to initiation of any treatment.
Pregnancy and Breast Cancer

SUGGESTED READINGS


Invited Articles


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DEVELOPMENT CREDITS

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