

:: ABSTRACTS ::**Peptic Ulcer and Pregnancy**

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In adults, peptic ulcer is more common in men than in women. This observation applies particularly to duodenal ulcer. Before puberty the distribution between the sexes is about equal. Perforation of a peptic ulcer is more common in men than in women. The complications of ulcer such as perforation and haemorrhage are even more unusual during pregnancy. Death from these complications during pregnancy, are very infrequent.

In the past, it was accepted that pregnancy had a beneficial effect on peptic ulcer. Sandweiss and co-workers reported that of fifty-two pregnancies in twenty-five women who were proven ulcer cases, the symptoms disappeared during pregnancy. Numerous explanations have been offered to explain this absence, healing or inactivity of peptic ulcer during pregnancy. Perhaps the rising uterus supported the stomach in a way that improved circulation and hence healed the ulcer. However, this did not account for the relief of ulcer symptoms during the first trimester of pregnancy.

Endocrine etiology was ascribed to peptic ulcer because of the relationship between sex and incidence of

peptic ulcer. Sex hormones were used in peptic ulcer therapy but results are not conclusive and there is some suggestion of adverse effects.

The literature shows that up until 1943 there were only thirteen maternal deaths from haemorrhage or perforation of peptic ulcer. The diagnosis was confirmed by autopsy. Since then four more cases of maternal deaths from these complications have been reported.

Analysis of the seventeen cases reveals that (1) twelve died of perforation and five died of haemorrhage, (2) diagnosis of peptic ulcer complications were considered in three cases, (3) ten of the patients had duodenal ulcers and seven had gastric ulcers, (4) past history of gastro-intestinal symptoms appeared in six cases.

As stated previously pregnancy was considered to have a beneficial effect on peptic ulcer. Two facts which discredit this statement are that (a) ACTH has been extracted from the placenta, and, (b) the known effect of ACTH on peptic ulcer. Because so little is known about pituitary and placental ACTH in pregnancy, one should not have a false sense of security. Gastro-intestinal symptoms during prenatal and postpartum period should not be universally assigned to pregnancy but should receive some investigation.

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Pregnancy and Cancer of the Breast

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Many authors regard pregnancy coinciding with malignant tumor growth as a serious complication. Their view is that pregnancy enhances tumor growth. Ewing states "pregnancy has a tendency to accelerate the growth of most tumors". This acceleration is attributed by Ewing to the increased metabolism of pregnancy. Numerous investigators such as Zuirfield and Simpson claim that pregnancy activates growth in malignant tumors, while others conceive that pregnancy retards growth. Smith, in a study of 54 pregnant women who had concomitant malignant tumors assert that pregnancy is detrimental to such tumors, that an active malignant tumor can be retarded by pregnancy, but that the growth is more accelerated after pregnancy is terminated.

Such conflicting views can only lead to one conclusion, and that is, that in all probability there is no significant correlation between pregnancy and malignant tumors. It is quite definitely known that pregnancy accompanied by myelogenous leukemia and Hodgkin's Disease is not influenced by their co-existence. Pregnancy has not a detrimental effect on these particular malignant diseases.

Hochman and Schreiber have recently made a study of the outcome of cancer of the breast when complicated by pregnancy. Only twenty cases constituted their material. The study can best be summarized in the following paragraph.

The prognosis of cancer of the breast is very poor when complicated by pregnancy irrespective of the type of treatment. It was found that the five year survival rate is primarily dependent on the stage of the disease. In early cases (where the tumor is confined to the breast), the survival rate is comparable with those rates complicated by pregnancy. The method of treatment, that is, surgical, hormonal, or radiological, influences the outcome.

Even though pregnancy co-exists with cancer of the breast, the indications for treatment should be the same as if cancer existed alone. The prognosis seems to be improved with artificial menopause. However, interruption of pregnancy has apparently no influence on the course of cancer of the breast.

There is no experimental nor clinical proof that pregnancy or the estrogenic hormone augments the malignant nature of a cancer cell of the human female breast.

Finally, if cancer of the breast takes an unfavourable course, even in its early stage, the explanation should be based on the increased vascularity of the breast during pregnancy. This marked vascularity could conceivably contribute to the rapid appearance of metastases via the blood stream.

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