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## Care of the Pregnant Patient with Cancer Should Include Unfettered Access to Abortion

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On June 24<sup>th</sup> 2022, the Supreme Court of the United States overturned nearly fifty years of federal law protecting access to abortion. In the *Dobbs v. Jackson Women’s Health Organization* decision, the Court has opened the doors for states to restrict or outright ban abortion access without exception. Thirteen states now ban abortion altogether, five have new gestational age restrictions, and at least ten have bans blocked by court action, but may enact a ban in the near future.

In this issue of the journal, there is an informative review article on the management of pregnant patients with a concurrent diagnosis of malignancy by Nguyen et al. The manuscript was submitted prior to this decision, and was clearly in preparation long before the *Dobbs* decision was leaked in May of 2022(1). However, whatever the intentions of the authors, this article must be considered in the context of the Supreme Court ruling, a decision which vastly changed the sociopolitical and health consequences of malignancy in pregnancy and will require medical providers to navigate the legal complexities of abortion access currently evolving in the US.

The article is written with the tacit assumption that protecting fetal viability is in the interest of the patient, which for some patients is undoubtedly the case. For example it is stated that “*The goal of management is to maximally treat the oncological disease while minimizing interference with fetal growth and development*” and that “*(s)pecialists need to balance risks and benefits to mother and fetus in the selection of a diagnostic and treatment approach*”, amongst other instances. However, this presupposes a decision on the part of the patient to prioritize fetal health over their own, a decision which state legislatures now make for patients in much of the country. This presupposition also risks normalizing the priority of fetal viability over the most effective cancer treatment. Current diagnostic and therapeutic standards of care are optimized for the patient’s eventual outcome, and most put a fetus at

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risk of injury, if not being an outright abortifacient. Compromising these for the sake of a fetus should be an active and available choice, rather than legislatively dictated.

Take the example of cervical cancer, which is often a curable disease with standard diagnostic and therapeutic practice. This is also one of the most commonly diagnosed cancers during pregnancy. For staging, a FDG-PET scan is the most sensitive and specific means to determine the extent of disease outside of the pelvis(2). However, FDG poses risks for a developing fetus. An MRI abdomen and pelvis can be substituted, but at the expense of diagnostic accuracy. Nodal disease and distant metastases in the lung or liver are better evaluated by FDG-PET and alternative imaging may lead to treatments that may compromise outcomes by missing extrapelvic or abdominal disease. Radical hysterectomy and lymph node dissection for early-stage disease and concurrent chemo-radiotherapy in early stage disease are well established curative treatments – however patients in restrictive states may no longer be able to choose this optimal care. Radiotherapy is an essential part of treatment for a large portion of cervical cancers, though both abortifacient and teratogenic; patients will be denied access to this if they do not have the choice to end a pregnancy. Neoadjuvant chemotherapy may be used in the hopes of temporizing disease until a curative treatment can be performed, but this compromises treatment success(3).

It is a real possibility that illegalizing “fetal endangerment” will be a natural consequence of abortion bans; it may be that any test or therapy an oncologist recommends that exposes a fetus to even a slight increase of negative outcome could be considered a punishable offence(4). Many of the deviations from standard practice discussed in this review may reduce fetal risk, but do not eliminate it. The authors admit this in many instances, including a passage that states “*The stochastic effect of fetal carcinogenesis and genetic defect follow a linear no threshold model, which means they can occur even at a low radiation dose to the fetus....*” Eleven states have granted rights to fetuses, independent of the pregnant person’s rights, and these laws have new weight with the Dobb’s decision(5). Returning to the example of cervical cancer, when patients choose to continue the pregnancy, a simple trachelectomy or large conization procedure can be considered in early-stage disease. Risks of these procedures include an up to 15% risk of spontaneous abortion, and providers may fear that this risk may not be seen as legally acceptable in many states. These restrictions unacceptably prevent providers from offering patients standard-of-care treatments because the state has decided that they must prioritize the potential life of a fetus over their patient. Texas law already levies a \$10,000 fine for anyone aiding or abetting an abortion; this will expose health care providers to personal financial harm in the course of practicing optimal care. The thought that evidence-based cancer treatment might expose medical professionals to felony charges is untenable.

Oncologic compromises for fetal preservation may also become mandatory for ectopic or otherwise non-viable pregnancies. For those that are unfortunate enough to find they are pregnant in the middle of treatment after fetal injury may have already occurred, bans on abortion may prevent them from having a timely care, further endangering their lives and delaying treatment. This has already occurred in women who have had intrauterine fetal demise and were unable to receive surgical management due to poorly defined law; we should expect for these situations to arise in cancer patients, as well(6).

Abortion ban exceptions for medical necessity, while highly supported even amongst those who otherwise agree with anti-abortion policies, are very limited and ill-defined in many state laws(7). In our own state of North Carolina, the current medical exception is vague, leaving physicians questioning who is sick enough to merit care. As an induced abortion is 14 times safer for a patient than delivering a full term infant, even outside of a cancer diagnosis, presumably a simple improvement in survival percentage will not be enough to justify a ban exemption (8–10). Who will define what is medically necessary, using what criteria, and in what time frame? Oncologists may be called upon to make judgements in these situations or make arguments for the benefits of optimal cancer care. There is also a danger that the article by Nguyen et al could be intentionally misinterpreted as proof that cancer can be effectively managed without fetal endangerment and exploited for a political argument against medical exceptions to abortion bans. We must be clear that treatment delays or deviations will have mortal consequences for many.

There are many reasons why someone with a cancer diagnosis may choose to have an abortion, from the time, effort, and financial burdens that cancer therapies often entail, but also reasons that may be completely unrelated to the cancer diagnosis. Many may find out they are pregnant due to a test performed prior to a diagnostic or therapeutic maneuver due to institutional policies, and must be afforded the same fundamental right of bodily autonomy that all should have. They may be faced with incurable disease, and have no one who can raise a child in their stead. Or they may simply desire what we all deserve: the right to decide for ourselves what is the best option for us. Our patients are the experts of their lives and the decision should remain between them, their doctor, their family, and their personal beliefs.

In the review article, the authors do have a section on consideration for termination of pregnancy, but it is with the caveat that “...*given the complexity of the subject, legal consultation and practice should be done in accordance to local and federal legislation.*” We assert that local and federal legislation is in direct opposition to many patients’ best interests, and that it is our duty as physicians to oppose legislation that undermines our ability to optimize our patients’ health outcomes.

Oncologists must therefore speak out as strong advocates for patient autonomy, as it will impact our patients directly. At a minimum, we need to understand our state laws, and be prepared for how best to serve our patients in a very difficult time. We need to be prepared to discuss all options for our patients, even if it means transferring care out of state. We should support travel funds and advocacy for those that need to be seen out of state, and have limited resources to do so. These steps, however, are at best a stop gap, given the distance and hardship many will face simply to access health care; many will simply not be able to regardless of additional resources. Fundamentally, we need to advocate for universal access to abortion for all at a federal level, so that the rights to make these life changing decisions can again reside with the patients, rather than state legislatures.

## References

1. Nguyen T, Bhosale P, Cassia L, et al. Malignancy in pregnancy: Multimodality imaging and treatment. *Cancer* 2022.

2. Choi HJ, Roh JW, Seo SS, et al. Comparison of the accuracy of magnetic resonance imaging and positron emission tomography/computed tomography in the presurgical detection of lymph node metastases in patients with uterine cervical carcinoma: A prospective study. *Cancer* 2006;106:914–22. [PubMed: 16411226]
3. Gupta S, Maheshwari A, Parab P, et al. Neoadjuvant chemotherapy followed by radical surgery versus concomitant chemotherapy and radiotherapy in patients with stage ib2, iia, or iib squamous cervical cancer: A randomized controlled trial. *J Clin Oncol* 2018;36:1548–1555. [PubMed: 29432076]
4. Donegan M. States are prosecuting women in the name of ‘fetal rights’. We should all be alarmed. In: Editor, editor editors. Book *States are prosecuting women in the name of ‘fetal rights’. We should all be alarmed*. Online: The Guardian; 2019.
5. Butler K, Hurtado P. Is a fetus a person? The next big abortion fight centers on fetal rights. In: Editor, editor editors. Book *Is a fetus a person? The next big abortion fight centers on fetal rights*. Online: Bloomberg; 2022.
6. Belluck P. They had miscarriages, and new abortion laws obstructed treatment. In: Editor, editor editors. Book *They had miscarriages, and new abortion laws obstructed treatment*. Online: The New York Times; 2022.
7. Ziegler M. Why exceptions for the life of the mother have disappeared. In: Editor, editor editors. Book *Why exceptions for the life of the mother have disappeared*. Online: Atlantic Media Company; 2022.
8. Gerdts C, Dobkin L, Foster DG, et al. Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy. *Womens Health Issues* 2016;26:55–9. [PubMed: 26576470]
9. Stevenson AJ. The pregnancy-related mortality impact of a total abortion ban in the united states: A research note on increased deaths due to remaining pregnant. *Demography* 2021;58:2019–2028. [PubMed: 34693444]
10. Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the united states. *Obstet Gynecol* 2012;119:215–9. [PubMed: 22270271]