

## Consider All Pregnancies In Former Breast Cancer Patients to Be High Risk

BY BRUCE JANCIN  
Denver Bureau

SAN ANTONIO — Pregnancies in women with a history of breast cancer should be considered high risk on the basis of their increased rates of preterm birth, cesarean section, and congenital malformations, Dr. Kristina Dalberg said at a breast cancer symposium sponsored by the Cancer Therapy and Research Center.

One-fifth of women with breast cancer are diagnosed before age 50, and the incidence is increasing. So data on the reproductive impact of the malignancy and its adjuvant therapies are increasingly important, noted Dr. Dalberg of Uppsala

(Sweden) University Hospital. She and her coworkers conducted a Swedish national population-based cohort study in which they cross-checked the 2,870,932 singleton births entered into the Swedish Birth Registry during 1973-2002 against enrollees in the Swedish Cancer Registry database. In this way they identified 331 first births following treatment for invasive breast cancer. The mean time between breast cancer surgery and pregnancy was 37 months.

The former breast cancer patients were significantly older: a mean age of 34 years, compared with 27 years for pregnant women without such a history. Multiple logistic regression analysis adjusted for maternal age, parity, and year of delivery demonstrated that former breast cancer

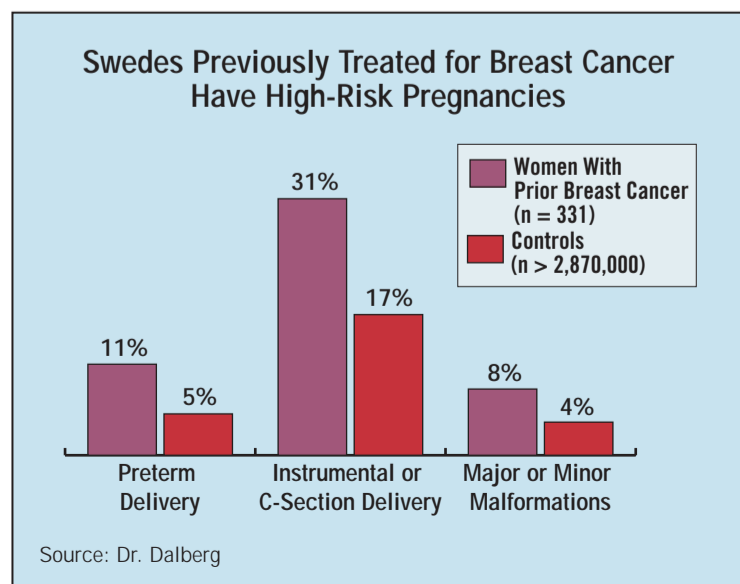
patients had a 3.2-fold increased risk of preterm delivery before 32 weeks, a 2.9-fold increased risk of low birth weight less than 1,500 g, and a 1.3-fold increased rate of C-section, compared with mothers without a history of breast cancer. (See chart below.)

Moreover, women with a history of breast cancer who gave birth during 1988-2002 had a 2.1-fold greater risk of having a baby with congenital malformations than did matched controls. During 1973-1987, when the use of adjuvant chemotherapy in younger breast cancer patients was less common, there was a nonsignificant 1.3-fold increased risk. There was no increase in stillbirths among women with prior breast cancer.

Dr. Dalberg said she and her coinvestigators had hypothesized wrongly that there would be no increased risk of adverse birth outcomes in Swedish women previously treated for breast cancer. This expectation was based in part on a reassuring recent Danish cohort study that showed no increase in preterm birth, low birth weight, congenital malformations, or stillbirth in 216 Danes with previously treated breast cancer (Br. J. Cancer 2006;94:142-6).

The discrepancy might be a result of different ways of classifying outcomes in the two national registries or differences in the use of adjuvant therapies. Additional studies in other countries are needed to resolve the discrepancy. Dr. Dalberg noted that most births in women previously treated for breast cancer are uncomplicated. ■

**Former breast cancer patients had a 3.2-fold increased risk of preterm delivery and a 1.3-fold increased rate of C-section, relative to those without a history of cancer.**



## Simple Questions Can Help Uncover Urinary Incontinence

BY BETSY BATES  
Los Angeles Bureau

SAN FRANCISCO — An office evaluation for incontinence and overactive bladder can begin with one simple screening question, and then a follow-up if the answer is yes, said Dr. Michael Moen, director of the division of urogynecology at Advocate Lutheran General Hospital in Park Ridge, Ill.

The first question is, "Do you have bladder problems that are troublesome, or do you ever leak urine?" If the patient answers in the affirmative, rule out a urinary tract infection and perform a focused history and physical examination.

But don't forget to include one more key inquiry before you move on.

That question is whether she has nocturia, which points strongly in the direction of overactive bladder rather than stress incontinence.

"If you have overactive bladder, it doesn't take the evening off," said Dr. Moen at Perspectives in Women's Health sponsored by OB.GYN. NEWS.

In contrast, urodynamic stress urinary incontinence is triggered by activity, not rest.

Many women will not volunteer the fact that they leak urine when they exercise, laugh, or cough, or that they rise four times a night to urinate—unless they're asked. "They think it's part of aging or part of having children."

While symptomatic pelvic organ prolapse may propel a woman to make an appointment, it may take significant lifestyle disruption or a profoundly embarrassing public episode of leakage to make women seek care for urinary incontinence, which affects 20%-55% of American women.

Dr. Moen targets four important areas in a review of pelvic symptoms:

► **Anatomic function.** Is there a bulge? A mass? Pressure?

► **Urinary function.** Does she void at intervals of less than 3 hours? Experience urgency? Rise more than twice a night to urinate? Leak with urge? Leak with laughing, coughing, or sneezing? Leak with exercise? Does she have difficulty voiding? Does she need to wear pads?

► **Bowel function.** Does she experience leakage? Constipation?

► **Sexual function.** Does she have pain with intercourse? Anatomic issues? Embarrassment or avoidance due to urinary issues?

Constipation is a surprisingly frequent concurrent issue, said Dr. Moen, occurring in at least 30% of patients he sees for any pelvic floor disorder. It is uncertain whether constipation causes or is caused by pelvic floor dysfunction, but it needs to be addressed. "Some people think it is more normal to push and strain their insides out than to take fiber every day."

He frames the issue within the context of modern life and the American diet. "I tell women it is virtually impossible to get enough usable fiber in their diet without consuming too many calories," he said, suggesting that supplements are the answer, not a medicine.

Before conducting an examination, Dr. Moen also brings up the possibility that a woman's quality of life may have been affected by her problems with incontinence or overactive bladder. Perhaps she has restricted her exercise, social activities, and travel. In line with several studies on an association with incontinence, she may be suffering from clinical depression.

The visual and physical examination are aimed at detecting urogenital atrophy, "one of the most overlooked and easily treated conditions in

women," and/or pelvic organ prolapse, he said. A simple cough stress test approaches a 95%-98% sensitivity and specificity in identifying incontinence.

Neuromuscular function should be assessed by eliciting perineal sensations with a light touch near the anus and an assessment of pelvic muscle strength, facilitated by asking the patient to isolate and squeeze pelvic floor muscles while one of the physicians' fingers is inserted 3-4 cm into the vaginal canal.

In an examination of young, asymptomatic women, Dr. Moen and associates found that 20%-30% were unable to properly contract their pelvic floor muscles, with 10% "actually perform[ing] a Valsalva" maneuver and believing they were doing a Kegel contraction, said Dr. Moen.

"This is critical, because even if you don't suggest to them that they do these types of exercises, they're reading about them in Elle, Self, and Good Housekeeping."

Doing Kegel exercises improperly can actually exacerbate pelvic floor weakness. On the other hand, proper use of the exercise as few as 30 times, 3 times a week, can be effective in preventing or improving symptoms of stress and urge incontinence.

If simple instructions don't work, physical therapy, perhaps including biofeedback, electrical stimulation, and electromagnetic therapy, may be helpful in strengthening pelvic floor muscles.

Other potentially important therapeutic options for incontinence and/or overactive bladder may include medications, pessaries, and in 25% or fewer cases, eventual surgery if other measures fail.

The most important intervention, according to Dr. Moen, is bladder retraining. "If you do nothing else, tell patients to go to the bathroom on schedule. They will get better."

If a woman estimates she is urinating every hour, he begins with that target, telling her to urinate every hour. Then, she is instructed to begin to "outsmart her bladder," by stretching the intervals to 2 hours, then 3, and so on.

OB.GYN. NEWS is published by the International Medical News Group, a division of Elsevier. ■

### Tampons 'Mimic' Pessary Effects

Even very young women—and certainly many older women who lead physically active lives—may leak urine during vigorous exercise, but that doesn't mean they all need pessaries or surgery to get them on the court or the playing field, according to Dr. Michael Moen.

"For any woman who has stopped exercising due to leaking, the tampon trick is great," said Dr. Moen. He instructs such women to use the largest tampon they can comfortably accommodate using lubrication to act as a buttress supporting the urethra, just as a pessary would.

The tampon trick should only be used during the period of time when a woman knows she will be engaged in doing vigorous activity.

"There's nothing wrong with using a tampon and wearing a pad and getting some biker shorts [for] support," he emphasized. The point is to work with women to allow them to engage in activities they enjoy.