COLLÈGE NATIONAL
DES GYNÉCOLOGUES ET OBSTÉTRICIENS FRANÇAIS
Président : Professeur F. Puech

Troisième partie

Réunion annuelle de l'Académie internationale de médecine périnatale

C N G O F

36ES JOURNÉES NATIONALES
Paris, 2012

Maternal-fetal conflict of interest: introductive lecture

S. UZAN
(Paris)

Public declaration of interest

I hereby, Serge Uzan, acknowledge do not have direct or indirect interest (financial or in kind) with a private organization, industrial or commercial in connection with the subject presented.

Pregnancy increasingly gives rise to situations liable to generate a conflict of interest between the health of the mother and that of the fetus.

The mother's life has always been considered to take precedence over that of the unborn child, but although this position appears logical and reasonable, it has led to sometimes inappropriate decisions to terminate the pregnancy in order to protect the mother's life.

Dean of the Faculty of Medicine Pierre et Marie Curie
Member of the International Academy of Perinatal Medicine
Hôpital Tenon - Service de gynécologie-obstétrique - 4 rue de la Chine - 75020 Paris
Institut universitaire de cancérologie Pierre et Marie Curie - Université Pierre et Marie Curie - 91 boulevard de l'Hôpital - 75013 Paris

Correspondence to: serge.uzan@tnn.aphp.fr

The first step in these situations must be a discussion on the ins and outs of the case, an accurate assessment of the risks, an assessment of the chances of success of the proposed treatments, and an assessment of any long-term complications. However, in the vast majority of cases, we do not have enough data - and particularly long-term data - on which to base these assessments. The discussion is therefore often based on ethical, medicolegal and personal considerations. The personal dimension, quite reasonably, refers to the patient's wishes, but is also influenced by her family, her community, and her religious and « social » beliefs. It therefore seems obvious that the discussion and assessments should be underpinned by a multidisciplinary team and should result in proposals that are the fairest possible to the patient and those around her. While in some cases the balance between the risk incurred by the mother and the chances of treating the pregnancy and foetus makes the solution obvious, decisions are very often based ultimately on a choice and a shared decision-making process involving the patient and the medical team. Note that the notions of a medical team, a fair assessment, and having the real means with which to analyse the situation are essential. It has led to the emergence of the concept of multidisciplinary meetings of teams capable of rapidly obtaining the relevant information and of providing the most objective assessment possible.

The debate and developments in our ideas have often been patient-led. Patients themselves have led us to adopt sometimes completely innovative strategies and to take the risk at their request. They have led us to « dare » decide on certain strategies, to implement, evaluate and monitor them, and gradually to offer them as feasible options. This emphasizes the importance of collecting these cases together and recording all of the data on them prospectively, if possible over the long term, because pooling these experiences from large series will enable us firstly to offer fair, relevant information and secondly to help patients come to a decision.

These experiences in which we are forced to make particularly difficult decisions leave very strong memories that leave a mark on our professional life.

Sixteen years ago, we had to treat a 35 year-old, Orthodox mother of 7 children who was 4 months pregnant with her 8th child. She presented with a rapidly progressing breast cancer and refused to consider terminating her pregnancy. We administered what was rather uncommon at the time - 6 cycles of chemotherapy, and proceeded to perform radical surgery. She gave birth to a little girl whose subsequent development was normal. The mother relapsed but never

regretted her decision [1]. A 43 year-old nulliparous patient with limited pelvic carcinomatosis from ovarian cancer at 15 weeks of gestation was treated in Institut Gustave Roussy. She refused to have an abortion and received neoadjuvant chemotherapy. A caesarean section and complete resection of peritoneal and nodal disease were performed at 34 weeks of gestation. She is currently free of disease with an eight year-old daughter [2]. The message from these two women was clear, we want to treat our cancer but our wishes for childbirth are just as (even more) important. The lesson is that in these situations we have to push back the limits, by challenging physicians' convictions and by defining new *standards*. We should not be dogmatic, since one could fill an encyclopaedia with medical dogmas which have since been totally refuted.

This example highlights the problems encountered when cancer occurs during pregnancy and is described extensively in a Lancet editorial entitled: *Cancer in pregnancy: a challenging conflict of interest* [3].

Our second example - the « Child Foucault » affair - is much older.

It has been discussed magnificently by Professor Claude Sureau [4], former head of the Maternité Baudelocque maternity unit and former chairman of the French National Academy of Medicine, and is probably the first case of litigation resulting from a complicated delivery.

It occurred in 1825 in Normandy where a 34-year-old woman, Marianne Foucault, was about to give birth to her sixth child.

A midwife was due to assist the delivery, the five first having been straightforward. The midwife was 72 years old, and with hindsight one could say that her professional skills left much to be desired, although this was never mentioned in the ensuing trial.

Briefly, the case involved a grand multipara with a transverse lie which could have been rotated into the vertex position by external version. In fact, the midwife caused the membranes to rupture through ineffectual manipulations and above all a somewhat forceful vaginal examination. The delivery failed to progress of course, and the risk of infection became obvious. Considering the situation critical, the midwife called for the assistance of Doctor Frédéric Helie, a character likened by Professor Sureau to someone out of a storybook, who enjoyed a good obstetrical reputation, but was probably rather condescending, not to say disdainful.

After describing the midwife in the most unflattering terms, he considered (but did he really ask himself the question?) that the baby was no longer alive and began a series of manipulations. These

manipulations were ineffective, so he performed an embryotomy that involved dislocating a shoulder and sectioning a forearm. He finally managed to rotate the foetus into the vertex position before delivery: the mother was saved!

However, the child was not dead and went on to survive, but remained disabled. It is noteworthy that Doctor Helie did not assist in this part of the postnatal period and left as soon as the baby was delivered. He was strongly criticised for this, the affair led to a popular outcry against him, and the family took him to court, a very rare occurrence at the time. Rarer still, on 16 March 1832 he was found guilty, after a trial lasting several months, of failing to safeguard his patient's bodily integrity… the patient in this case being the unborn child. He was ordered to pay the child a life annuity of 100 French francs from the day of the application until the age of 10, and 200 francs thereafter.

Doctor Helie « disappeared », probably after taking a boat to the Americas, and the child died at the age of 6 years.

Doctor Helie's error - a diagnostic error regarding the baby's vital status - was transformed into an offence, a highly questionable interpretation in light of the medical knowledge of the time. Fetal heart auscultation was described at around that period by Le Jumeau de Kergaradec [5] (who was not an obstetrician) but scientific knowledge did not travel fast and Doctor Helie may have been unaware of this possibility for checking fetal viability.

In conclusion, this field, which will be approached from several angles in this session, is necessarily in a state of constant evolution, hence the importance of reference groups capable of analysing information on the strategies adopted in these extreme situations. We wanted this symposium to address certain aspects of maternal-fetal conflict by distinguishing (sometimes artificially) between situations of maternal origin and those of fetal origin, in which a procedure on the fetus is invasive to the mother. Twin pregnancy is a particularly complex issue, illustrating both maternal-fetal conflict, fetal-fetal conflict, or even a combination of both.

Conflicts of maternal origin will be addressed through the topics of mother-to-fetus infection, maternal heart disease, and cancer in pregnancy. We also wanted to discuss maternal-fetal interaction and « biological » conflict, which can be a short-term phenomenon but may equally persist in the very long-term, in situations such as pre-eclampsia, prematurity and microchimerism. Finally, we felt it important to present and compare the data we have on maternal mortality around the world. When managing these patients through

problematic pregnancies, it is also essential to consider and to not jeopardise any future pregnancy. This issue is also valid in patients with maternal disease who are not pregnant and for whom fertility preservation is a major consideration. The new field of oncofertility has therefore emerged, in which the determination to preserve the reproductive potential of young and even very young patients has led to major advances in ovarian preservation and more generally in the storage of male and female gametes. In the future, these situations that arise from conflicts and complex problems will provide and lead to advances of benefit to all.

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