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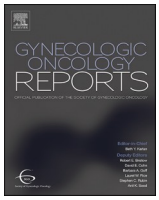

Editorial on vaginal cancer diagnosed in pregnancy and current abortion law on cancer care in Louisiana

I remember exactly where I was on June 24, 2022, when the U.S. Supreme Court overturned the landmark Roe vs. Wade decision and removed the federal protection for abortion. I suspect many of you reading this article do as well. It marked the beginning of a new era for patients, physicians, trainees, and the U.S. legal system. One year later, the downstream effects of the Dobbs decision are starting to become apparent. The case report included in this edition of *Gynecology Oncology Reports* highlights one of many examples of complicated cancer care in the post-Dobbs landscape.

King, et al. describe a case of vaginal cancer diagnosed in the second trimester of pregnancy and the subsequent care of the patient in a climate where abortion law was changing weekly. This patient had several treatment options, including radical vaginectomy and primary radiotherapy, neither of which were compatible with her second trimester pregnancy. By sheer luck, this patient was able to obtain a legal abortion in her own state, a reality that would not have been the case had her diagnosis been made even two weeks later. The multiple legal arguments surrounding abortion legislation in different states have made it nearly impossible to decipher what is legal one week to the next. While this story has a "happy" ending in terms of her cancer outcome, it highlights many of the obstacles faced by both physicians and patients navigating medical care when a life-threatening disease collides with a pregnancy.

First, we must acknowledge the challenges of this case even if the patient had unlimited resources and lived in a state with excellent abortion access and no legal restrictions (let's call this state "Iceland"). In Iceland, she still would have been faced with the heart-wrenching choice of terminating a wanted pregnancy in order to optimize her cancer treatment. However, she likely would have been seen the same day, and perhaps in the same clinic, as her cancer physician. She could have been presented with objective information about how carrying the pregnancy would affect her cancer treatments and offered all methods of pregnancy termination, including dilation and evacuation, which is the safest. The patient described in this case report instead had no choice but to under an induction of labor due to a "dismemberment bill" in place in Louisiana, even though labor induction is less effective, takes longer, and carriers more risk (McLaren et al., 2022). On the day this editorial was written, 33 states had restrictions on abortion that would have affected this patient (Guttmacher Institute). Shared decision-making ensures that individuals are supported to make decisions that are right for them. Today, state legislators are making unilateral decisions for our patients.

Many of the humans reading this article have the luxury of a disposable income with the means to travel anywhere necessary to obtain a legal abortion, should one be needed. However, these contingency plans are available to very few people, and when one considers the price of gasoline, childcare, and missed time from work, even a hundred-mile drive becomes untenable. Further, many states have mandatory waiting periods, or require two separate physician visits, even for medical abortion pills to be dispensed, further burdening the pregnant individual. Obtaining abortion services has been incredibly challenging for low-income women in most of the country since long before the Dobbs decision (Harvey et al., 2023). Healthcare inequities will continue to grow in a nation with disparate abortion access.

Current legislation has unique downstream effects for gynecologic oncologists. Cancer complicates 1 in 1000 pregnancies. As our population becomes pregnant later in life, there will be more overlap with cancer diagnoses and pregnancy. The most common cancers diagnosed in pregnancy are breast, lymphoma, colon and gynecologic cancers. Standard of care treatments for these cancers often include chemotherapy and radiation, which can be teratogenic or pregnancy-ending, depending on gestational age. Delays in care can worsen patient outcomes, particularly in cancers that grow quickly, where any delay in systemic chemotherapy adds significant risk to the mother (Ali et al., 2015). There will be more case reports like this one, where abortion law was carefully navigated in order to respect a patient's autonomy and optimize cancer outcome.

Many states (including my own) are currently relying on antiquated legislation to determine when and if abortion might be legal. In Wisconsin, for example, the current abortion law was written in 1849, long before the existence of ultrasound, prenatal diagnostics, antibiotics, radiation, chemotherapy and frankly, most modern medicine. The language our hospital lawyers are forced to decipher states "it is a felony for any person to intentionally destroy the life of an unborn child except where it is performed by a physician to save the life of the mother". This framework is nearly impossible to interpret. How close to dead does the mother have to be to perform the life-saving abortion? What is an unborn child? A child capable of life? Does this leave an exception for lethal fetal anomalies? Ectopic pregnancies? It is difficult to ask physicians to perform an abortion in the context of possible felony charges (for which hospitals do not provide coverage). I have watched this legislation cause unrest over methotrexate use, the provision of anesthesia for life-saving abortions, and moral distress for our providers who struggle to counsel their patients accurately, ethically, and legally.

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The Dobbs decision has changed medicine in many ways and will continue to shape the future of our field. The Accreditation Council for Graduate Medical Education (ACGME), through its Review Committee for Obstetrics, continues to require that ACGME-accredited OB-GYN residency programs provide "clinical experience or access to clinical experience in the provision of abortions" as part of the program's planned curriculum. New requirements from September 2022 state that "if a program is in a jurisdiction where resident access to this clinical experience is unlawful, the program must provide access to this clinical experience in a different jurisdiction where it is lawful." Flying trainees to other states for abortion training may or may not be tenable long-term. Residency is hard enough without weeks spent away from one's support system. Unsurprisingly, states that have enacted abortion bans saw a decline in OB-GYN residency applications in the last year. This trend further exacerbates the existing shortage of obstetricians and gynecologists in many regions, compounding the already limited access to reproductive healthcare.

The Supreme Court ruling in Dobbs v. Jackson Women's Health Organization has far-reaching implications that go beyond the practice of obstetrics and gynecology. While the number of unique medical school graduates who applied to programs in all states declined in 2022–2023 from the previous application cycle, states with complete bans saw greater decreases in the number of U.S. MD senior applicants *across specialties* than states with no restrictions (Orgera and Grover, 2023). The rapidly changing medicolegal landscape has significant bearings on the fields of neonatology, assisted reproductive technology, emergency medicine, fetal surgery, and radiology. These rulings impact the patient-physician relationship and a shared decision-making approach to care and will further widen long-existing inequities. Ultimately, the Dobbs decision and the subsequent legislation it has spawned threaten not only reproductive rights but also the integrity of the healthcare system as a whole.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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