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Gynecological Care after Stem Cell Transplant: A Mini Review

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ABSTRACT

Haematological cancers are treated with haematopoietic stem cell transplantation. With treatment efficacy improving, extensive long-term follow-up by competent professionals in a multidisciplinary context has become critical. This article discusses the gynaecological consequences of haematopoietic stem cell transplantation, including pre-treatment counselling, the onset of menopausal symptoms, bone loss, graft-versus-host disease, and secondary genital cancers. Wherever possible, the information around the occurrence, symptoms, and management of these problems is summarised using current clinical guidelines. Although there are few high-level data on this patient population, observational data and data from other immunocompromised populations are discussed.

Keywords: Stem cell; Gynaecological cancer; Critical treatment

INTRODUCTION

HSCTs (hematopoietic stem cell transplantation) are a critical treatment for haematological cancers. Patients will live longer if malignancies are detected earlier and treatment efficacy improves, highlighting the importance of complete, multidisciplinary follow-up with skilled clinicians. This page provides a summary of standard gynaecological treatment for HSCT patients. It gives clinicians with a clinical checklist to examine, as well as suggestions for future research in the HSCT population [1].

Gynaecological Care

HSCT patients should have a baseline gynaecological assessment with a physician trained in posttransplant gynaecological care prior to pre-transplant chemotherapy. This examination should include discussion of the patient's potential gynaecological consequences of treatment, such as menopausal symptoms, genital graft-versus-host disease (GVHD), fertility preservation, and the significance of pregnancy prevention during and for six months after treatment.

Menstrual and sexual histories should be included in a full history and assessment. This will help determine contraceptive and thrombocytopaenia-related menorrhagia care alternatives [2].

It's a good idea to check your gonadal function in the start. Herpes simplex, cervical dysplasia, and anogenital condylomata are examples of conditions that can be aggravated by immunosuppression.

An examination of the breasts and pelvis should be performed. Given the increased risk of solid organ tumours following treatment, any concerns raised during the examination should be examined before transplantation. Preventative screening may include pregnancy testing, cervical screening and HPV testing, sexually transmitted infection testing, and, if necessary, a mammography [3].

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Menopausal Symptoms

Up to 90% of premenopausal women who undergo SCT will experience vasomotor symptoms (hot flushes and night sweats) and roughly 50% will experience vulvovaginal atrophy symptoms (vaginal dryness and dyspareunia). Anxiety, despair, and irritability are typical in natural menopause, but they may be more widespread in this group, with roughly 54% reporting them. The Oral Contraceptive Pill (OCP) may be a more known and acceptable medication for younger women and those who stay premenopausal after SCT. However, the OCP administers larger amounts of sex hormones than the HT, which may be linked to an increased risk of problems including VTE.

Individual risk factors and patient preference will determine how MHT is administered. In the SCT population, there are numerous factors to consider. An increased risk of venous thromboembolism (VTE) has been linked to oral preparations. In addition, treatment-related mucositis may limit absorption, and pre-existing liver damage from chemotherapy or GVHD may be aggravated. However, if there are cutaneous abnormalities after transplant treatment, the application and absorption of transdermal preparations may be hampered. In this demographic, it is unclear whether oral or transdermal formulations are preferred, and treatment should be tailored to the person [4,5].

Vulvovaginal symptoms and the requirement for vaginal estradiol therapy should be taken into account. Multidisciplinary care, including psychology and sexual counseling, should also be available. According to current guidelines, screening for mood and sexual issues should be done at six months and one year after the transplant, with annual monitoring after that.

Bone Health

There are few high-level investigations on the prevalence of osteopenia and osteoporosis in patients after SCT. However, observational data suggests that bone loss after SCT may be as high as 75% in the lumbar spine and over 60% in the femoral neck. Chemotherapeutic drugs, irradiation, corticosteroid medication, and hypogonadism, as well as lifestyle variables like inactivity, all contribute to bone loss in this population.

Genital Tract Malignancies

Secondary solid tumours, including as vulvovaginal, cervical, and endometrial cancers, are more likely to develop after SCT. Immunocompromised patients are more prone to acquire HPV-related illness after SCT; one study found that up to one-third of HSCT survivors had HPV-related cervical dysplasia.

This post-treatment should be given to women who have not yet been vaccinated against the Human Papilloma Virus (HPV). Despite the lack of data on the best time to provide vaccines or dose intervals for developing immune responses, current guidelines recommend starting vaccination 12 months after treatment. It's uncertain whether women who have already been vaccinated should be inoculated again. Immune deficiency is recognized after HSCT [6]. However, no evidence of a specific effect on HPV immunity or the requirement for booster immunisation has been found. While there is no data on the efficacy or safety of HPV vaccination in the HSCT population, it is not a live vaccine, and data from other immunocompromised patient groups, including HIV, suggests that there are no immediate safety concerns.

Genital GVHD

The prevalence of genital GVHD after SCT is unknown, which could be due to both patients' aversion to discussing genital symptoms and practitioners' inability to investigate. There is data to show that roughly 50% of HSCT patients may experience this. Symptoms of GVHD in the genital area include genital discomfort, itch, paraesthesia, pain, dryness, and dyspareunia [3].

Typically, cutaneous, oral, ophthalmic, or gastrointestinal illness precedes genital GVHD. However, whether non-genital GVHD is a risk factor for genital disease and whether disease severity is comparable between organs are unknown [7].

Clinicians should promote non-pharmacological genital disease management by emphasizing proper skin care and avoiding soaps and other irritants. Topical pharmacological medications such as vaginal estrogens, corticosteroids, and immunosuppressive therapy such as cyclosporine can be added in stages. Manual dilators or sexual intercourse should be used in conjunction with pharmacological treatment to achieve gentle and frequent vaginal dilatation. For severe cases that do not respond to treatment, surgery may be recommended.

CONFLICT OF INTERESTS

The authors declare that they have no conflict of interest.

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