



C-Gyn 15

Management of the menopause after breast cancer

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) acknowledge the contribution of the Breast Section, Royal Australian College of Surgeons (RACS), in the compilation of this statement.

1. Women who have had breast cancer may need extra help and counselling around menopause. Counselling should include discussion of the uncertain risks / benefits of Hormone Therapy (HT) after breast cancer
2. Quality of life issues should be discussed and assessed together with the risks of developing osteoporosis, cardiovascular disease, thromboembolism and dementia.
3. Life style factors should be addressed including adequate exercise, calcium / vitamin D intake, avoidance of smoking, excessive alcohol and caffeine intake, optimal weight maintenance and reduction of stress.
4. Sexual counselling should be considered.
5. Evidence-based non-hormonal options should first be considered (e.g. bisphosphonates or SERMs for osteoporosis, cholesterol lowering agents and aspirin for cardiovascular disease). Some individual menopausal symptoms may be ameliorated with individual selected therapies eg venlafaxine or clonidine for vasomotor symptoms, vaginal lubricants for superficial dyspareunia, and anticholinergics for urinary urgency.
6. Alternative medicines for which there is no established evidence are not recommended.
7. Local vaginal oestrogen therapy after breast cancer is a reasonable therapeutic option for the control of urogenital symptoms. Oestriol preparations may have less systemic absorption than oestradiol preparations. There are no known long term safety concerns with either preparation.
8. Observational studies of systemic HT after breast cancer are generally reassuring. If HT is necessary after breast cancer for quality of life, oestrogen only therapy or oestrogen therapy with local uterine progestogen (eg. MIRENA) may be safer options than combined systemic therapy.^{24, 27, 28}
9. The prescription of HT along with tamoxifen is still inadequately studied. The cessation of tamoxifen may lead to a reduction in vasomotor symptoms. This must be discussed in the context of tamoxifen's absolute improvement in disease free survival and impact on the contralateral breast cancer.
10. The prescription of HT along with Aromatase Inhibitors (AIs) is still inadequately studied. Theoretically, the use of systemic oestrogen-based HT may reduce the efficacy with current use of AIs. Aromatase inhibitors are associated with an increased risk of osteoporosis and so regular bone mineral density measurements (1-2 yearly) are advised.

Adequate calcium and vitamin D intake should be encouraged either by diet or supplement. If a drug therapy is required for osteoporosis, bisphosphonates are the first-line option.

11. Tibolone (Livial) may confer the same risk as combined continuous hormone therapy with respect to breast cancer recurrence.
12. When HT is started the patient's other treating doctors should be advised.
13. The effect of testosterone on breast cancer is not well studied.
14. Annual review including mammography is recommended for women on HT.
15. Management is individualised after thorough counselling about options. The patient may wish to have her partner and family involved in the counselling and decision making.

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Links

Australian Menopause Society (AMS) statement "The risk of breast cancer with HRT use"
http://www.menopause.org.au/public/media_detail.asp?ID=25

Links to other related College Statements

[C-Gyn 9.pdf Management of the menopause](#)

[C-Gen 2.pdf Guidelines for consent and the provision of information regarding proposed treatment](#)

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