Management of the menopause after breast cancer

Objective: To provide advice on the management of the menopause after breast cancer.

Target audience: All health practitioners providing gynaecological care, and patients.

Values: The evidence was reviewed by the Women’s Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women’s Health Committee in March 1995 and most recently reviewed in November 2014.

Funding: The development and review of this statement was funded by RANZCOG.

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 1995
Current: November 2014
Review due: November 2017

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

RANZCOG acknowledges the contribution of the Breast Section, Royal Australian College of Surgeons (RACS) and the Australasian Menopause Society (AMS) in the compilation and continuous review of this statement.

A list of Women’s Health Committee Members can be found in Appendix A.
1. **Summary of recommendations**

1.1 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.

1.2 Quality of life issues should be discussed and assessed together with the risks of developing osteoporosis, cardiovascular disease, thromboembolism, and dementia.

1.3 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.

1.4 Sexual counselling should be considered.

1.5 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, desvenlafaxine, escitalopram, citalopram and paroxetine, clonidine and gabapentin for vasomotor symptoms, vaginal lubricants for superficial dyspareunia, and anticholinergics for urinary urgency. Please note that paroxetine and tamoxifen should not be prescribed together.

1.6 Alternative medicines for which there is no established evidence are not recommended.

1.7 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. In women taking aromatase inhibitors oestriol preparations are preferred as local oestralol preparations may transitorily elevate serum E2 levels. When used according to instructions supplementary progestogen therapy is not required with either preparation.

1.8 Current data do not support the use of HRT in breast cancer survivors. Two major trials (HABITS and Stockholm) showed different outcomes with an increased risk of recurrence seen in HABITS but not in The Stockholm trial. As women in HABITS mostly received continuous E+P therapy and women in Stockholm mostly received unopposed estrogen or long cycle progestogen therapy (each 3 months) it may be wise, in women who find HRT necessary for quality of life reasons, for a regimen to be developed with the lowest effective dose of estrogen combined with sequential progestogen, ideally dydrogesterone or micronized progesterone. Evidence for the use of Mirena in these circumstances is lacking although small studies show reduced breast density with Mirena compared to oral norethisterone.

1.9 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.

1.10 The prescription of HT along with Aromatase Inhibitors (Als) is still inadequately studied. Theoretically, the use of systemic oestrogen-based HT may reduce the efficacy with current use of Als. 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.

1.11 Tibolone (Livial) may confer the same risk as combined continuous hormone therapy with respect to breast cancer recurrence. Tibolone may reduce the efficacy of adjuvant therapies and should not be
used concurrently.

1.12 When HT is started the patient’s other treating doctors should be involved in the decision.

1.13 The effect of testosterone on breast cancer is not well studied, and in the absence of these data should not be used for its supposed effect on libido.

1.14 Annual review including mammography is recommended for women on HT.

1.15 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.

2. Other suggested reading


3. Links to other related College Statements

[C-Gyn 09] Management of the menopause

[C-Gen 02a] Consent and provision of information to patients in Australia regarding proposed treatment

[C-Gen 02b] Consent and provision of information to patients in New Zealand regarding proposed treatment

[C-Gen 15] Evidence-based Medicine, Obstetrics and Gynaecology

4. Other useful links

Australasian Menopause Society (AMS)

Australasian Menopause Society (AMS): The risk of breast cancer with HRT use.

Jean Hailes Foundation

5. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:
https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets
Appendices

Appendix A Women’s Health Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Committee</th>
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<tbody>
<tr>
<td>Associate Professor Stephen Robson</td>
<td>Chair and Board Member</td>
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<tr>
<td>Dr James Harvey</td>
<td>Deputy Chair and Councillor</td>
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<tr>
<td>Associate Professor Anusch Yazdani</td>
<td>Member and Councillor</td>
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<tr>
<td>Associate Professor Ian Pettigrew</td>
<td>Member and Councillor</td>
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<tr>
<td>Dr Ian Page</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Professor Yee Leung</td>
<td>Member of EAC Committee</td>
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<tr>
<td>Professor Sue Walker</td>
<td>General Member</td>
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<tr>
<td>Dr Lisa Hui</td>
<td>General Member</td>
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<tr>
<td>Dr Joseph Sgroi</td>
<td>General Member</td>
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<tr>
<td>Dr Marilyn Clarke</td>
<td>General Member</td>
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<tr>
<td>Dr Donald Clark</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Janet Vaughan</td>
<td>General Member</td>
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<tr>
<td>Dr Benjamin Bopp</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Kirsten Black</td>
<td>General Member</td>
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<tr>
<td>Dr Jacqueline Boyle</td>
<td>Chair of the ATSIWHC</td>
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<tr>
<td>Dr Martin Byrne</td>
<td>GPOAC representative</td>
</tr>
<tr>
<td>Ms Catherine Whitby</td>
<td>Community representative</td>
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<tr>
<td>Ms Sherryn Elworthy</td>
<td>Midwifery representative</td>
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<tr>
<td>Dr Nicola Quirk</td>
<td>Trainee representative</td>
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Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 1995 and was most recently reviewed in November 2014. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2014 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members
were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii.  Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.\(^1\)\(^2\) Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
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<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation(s) but care should be taken in its application</td>
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<tr>
<td>D</td>
<td>The body of evidence is weak and the recommendation must be applied with caution</td>
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<tr>
<td>Consensus-based</td>
<td>Recommendation based on clinical opinion and expertise as insufficient evidence available</td>
</tr>
<tr>
<td>Good Practice Note</td>
<td>Practical advice and information based on clinical opinion and expertise</td>
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Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.