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MENOPAUSE AFTER BREAST CANCER

WHAT ARE THE ISSUES?

Menopause after breast cancer can present some special difficulties. Breast cancer is much more common at 70 years of age than at 30 years, and so most women who develop breast cancer will already be postmenopausal. However, younger women with a diagnosis of breast cancer might be rendered menopausal by the treatment such as chemotherapy or removal of the ovaries. Some of the hormonal drugs used to treat breast cancer (e.g. tamoxifen or Arimidex®) can aggravate or even cause hot flushes. Also, some women will develop severe vaginal dryness after menopause (natural or induced) and that can present some special problems.

Most physicians treating patients with breast cancer will tell them not to take oestrogen, the main therapeutic agent for treatment of hot flushes and vaginal atrophy.

Therefore the challenge in menopause after breast cancer is to find an alternative to hormone therapy (HT).

WHAT ARE THE ALTERNATIVE TREATMENT OPTIONS?

Managing hot flushes

Common sense

Staying cool and calm can help reduce the number of hot flushes. Some things that can trigger flushes include: hot drinks, spicy food, stress, hot weather.

Slow deep breaths can help reduce the severity of hot flushes.

It might be worthwhile to temporarily stop tamoxifen (or an aromatase-inhibitor) for 2-4 weeks to establish its impact on flushing. If one drug is causing much of the flushing, then it might be worth trying a different one.

Herbals

These should largely be avoided after a diagnosis of breast cancer. Some contain plant-oestrogens (phytoestrogens) and are probably unsafe. Remifemin® is worth a try. This extract of black cohosh has been shown not to stimulate breast cancer cells grown in the laboratory and in a dose of 2-4 tablets per day seems to help around 70% of women with hot flushes. Remember that not all herbal extracts are the same. The most tested black cohosh is Remifemin.

Non-oestrogen drugs

An increasing number of 'brain-drugs' are being used to treat menopausal symptoms. Intuitively, this makes sense, since the vasomotor and mood symptoms are brain-in-origin. Currently, the most popular non-hormonal drugs for managing menopausal brain-symptoms are listed below:

1. Selective Serotonine Reuptake Inhibitors (SSRIs) and Selective Noradrenaline Reuptake Inhibitors (SNRIs) are modern antidepressants. A recent review examined seven clinical trials and clearly showed evidence that they were better than placebo for menopausal flushing. Typically the lowest tablet size was the most effective for treating hot flushes. High doses of these agents can actually cause hot

flushes and sweats as a side-effect. This is not unusual for hormonal agents. Many hormones in low pulsatile doses stimulate the target receptor, in contrast to high continuous doses which often down regulate the receptor. Typical doses used to treat flushes and mood swings of menopause include Venlafaxine 75XR and Citalopram 20mg daily. Side-effects of these agents include nausea, constipation and headaches. Some notice sedation and so take it at night. Others feel stimulated and so take it in the morning.

2. Clonidine®. This is an old blood pressure pill. Most of the Clonidine clinical trials used doses between 0.05-0.15mg daily. These doses were more effective than placebo. Side-effects include low blood pressure, dry mouth, sedation and in high doses – depression. Clonidine might be useful to manage both hypertension and flushes. It can also be used as a prophylactic migraine drug. It is not unusual for migraine frequency to increase around the time of the peri-menopause and to then settle after the last period.
3. Gabapentin. Two RCTs trials of Gabapentin, used doses 300-900mg daily (12); the higher dose being statistically better than placebo. The main side effects can be headache, drowsiness, dizziness, nausea, disturbed sleep, fluid retention and weight gain. When coming off Gabapentin, the dose should be reduced by 300mg at a time every 3-4 days.

It is certainly helpful to have these agents available to the clinician and the patient. For example, consider a woman who has just completed chemotherapy for breast cancer and is now rendered menopausal. Her oncologist starts her on tamoxifen or an aromatase-inhibitor and not surprisingly, her flushes increase dramatically. Remifemin®, perhaps even combined with an SNRI will help around 70-80%. These women are often grateful for a reduction in symptom severity, rather than complete resolution of their symptoms. It can be clinically useful to temporarily cease the endocrine therapy for 2-4 weeks to examine the impact of the drug on flushing severity.

A migrainous, hypertensive peri-menopausal woman might choose to try Clonidine®. A patient suffering from trigeminal neuralgia or epilepsy and significant flushing, might like to try Gabapentin, which would be effective for both problems.

Vaginal dryness

Women taking an aromatase inhibitor should use topical oestrogens very cautiously or not at all as even a little bit of absorption could have an adverse effect on treatment outcome.

Alternatives to oestrogen therapy for vaginal atrophy include:

- moisturisers such Replens®
- $C0_2$ fractional laser treatment of the vaginal walls such at the Mona Lisa Touch® available at WHRIA

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Bones

It is a good idea to have a bone mineral density every 1-3 years after menopause. Tamoxifen tends to help bone mass, whereas aromatase inhibitors tend to aggravate bone loss. Aim to have 2-3 serves of high calcium foods daily and it might be worth having your vitamin D level checked every so often. Regular physical exercise is the main ingredient in maintaining bone mass.

More Information

- Health Information Sheet: CO2 fractional laser treatment for vaginal atrophy