Scottish Cancer Network

BREAST CANCER SUPPORTIVE CARE

EDUCATIONAL SYMPOSIUM

CONTRACEPTION & MENOPAUSE MANAGEMENT

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BREAST CANCER SUPPORTIVE CARE
EDUCATIONAL SYMPOSIUM

Contraception and menopause management after breast cancer

Lack of robust direct evidence

Why?

- Avoidance of use of contraceptive/ MHT hormones after breast cancer

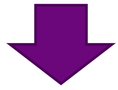
- Differences between progestogens
- Differences between hormonal preparations (systemic exposure and effect on endogenous hormonal activity)

- Prescribing bias where there are additional (e.g. gynae) indications

- **Diversity of patients and their breast cancers**

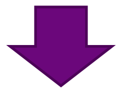
Contraception and menopause management after breast cancer

Lack of robust direct evidence

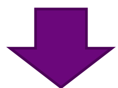


Lack of clear, consistent published clinical guidance

Lots of strong expert opinions and assumptions



Inconsistent messages for same patient across and between services
AND
Strong (debatable) messages in the media



Confusion, needs going unmet, feeling of “being denied options that other people are getting”

Contraception

Contraception: why is it important?

- Control of fertility

Hugely important to avoid pregnancy during use of teratogenic drugs

Incident pregnancy could affect ability to proceed with cancer treatments and/or breast cancer outcomes

Ongoing requirement until age 55 unless clear diagnosis of menopause

Avoid using elevated FSH before age 50 as an indicator that contraception can be stopped

- (Management of e.g., heavy menstrual bleeding/ menstrual migraine/ PMS symptoms)

Given potential adverse effect of use of contraceptive estrogens and progestogens on risk of breast cancer recurrence and occurrence of further primary breast cancer….

….ideally avoid all hormonal contraception after breast cancer

Advise use of non-hormonal contraception first line

But

Contraception is not all equally effective or equally acceptable

It’s not appropriate to tick a box indicating that the person has ‘contraception’ if that means that they are being given condoms that they are unlikely to use reliably

“Avoid use of hormonal contraception”

First year typical use failure rate		
High	**Medium (6-9%)**	**Low (<1%)**
condoms	combined pill	Cu-IUD
diaphragm	combined patch	LNG-IUD
fertility awareness	combined vaginal ring	progestogen implant
contraceptive apps	progestogen-only pill	female sterilisation
withdrawal	progestogen injection	male sterilisation

Non-hormonal options

First year typical use failure rate		
High	**Medium (6-9%)**	**Low (<1%)**
condoms	combined pill	Cu-IUD
diaphragm	combined patch	LNG-IUD
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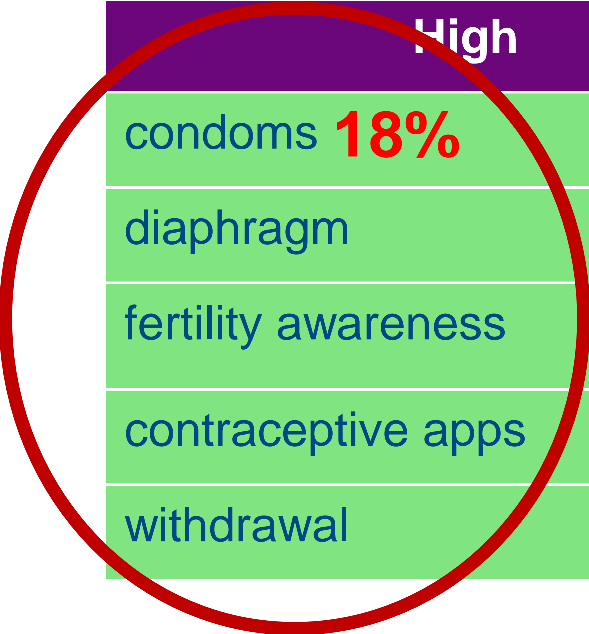
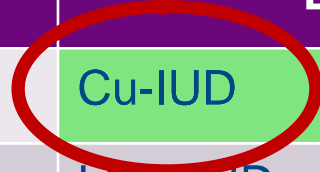
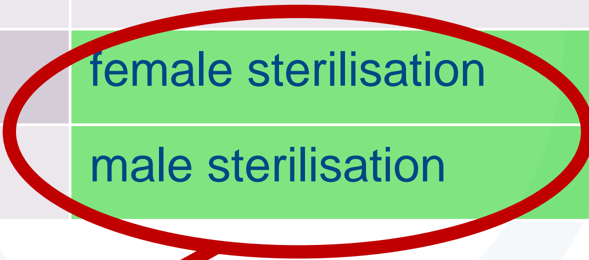
Problems with non-hormonal options







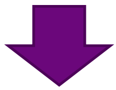
Heavier, longer, more painful periods

First year typical use failure rate (%)		
High	**Medium (6-9%)**	**Low (<1%)**
condoms **18%**	combined pill	Cu-IUD
diaphragm	combined patch	LNG-IUD
fertility awareness	combined vaginal ring	progestogen implant
contraceptive apps	progestogen-only pill	female sterilisation
withdrawal	progestogen injection	male sterilisation

**Irreversible
Surgical procedure
Long wait**

What do we actually know about effect of HC use on breast cancer outcomes?

No robust direct evidence



Extrapolation from studies relating to risk of occurrence of breast cancer in the general population:-

- Reasonable body of observational evidence for combined HC
- Very little evidence for progestogen-only HC until Fitzpatrick 2023 (UK case-control and MA)
- Apparent similar small increased risk of breast cancer occurrence with CHC and POC
- (Avoid the common assumptions e.g. greater safety of LNG-IUD because of low P dose)

When might we offer HC after breast cancer?

No one size fits all rule.
Avoid HC if at all possible.

Case by case consideration taking into account:-

- Clinical picture
- Acceptability of non-hormonal methods
- Importance of avoiding pregnancy
- Importance to the individual of non-contraceptive benefits (e.g., management of HMB/ erratic bleeding on tamoxifen)
- Short-term use while awaiting effective non-hormonal contraception

Menopause

Menopause

Menopausal symptoms significantly affect QOL:-

Vasomotor symptoms
Cognitive symptoms
Mood symptoms
Sleep problems
Musculoskeletal symptoms
Urogenital atrophic symptoms

AND

Hypoestrogenemia in younger people adversely affects bone and cardiovascular health

Menopause

BUT

Recent unhelpful trend towards (inappropriate) representation of HRT as:-

- Harmless
- Necessary for health and quality of life
- A magic bullet that cures all the symptoms experienced in menopause but is denied after breast cancer

Important to manage expectation about HRT (avoid perception of being denied a ‘safe wonder drug’):-

- Not all symptoms experienced in menopause respond to use of HRT (especially when people are coping with the physical and psychosocial effect of their breast cancer diagnosis, surgery, chemotherapy, radiotherapy and adjuvant treatment)
- Other management options can be very effective

Genitourinary syndrome of menopause

Systemic menopausal symptoms

Genitourinary Syndrome of Menopause

Hypoestrogenemia causes urogenital atrophic symptoms:-

Dyspareunia

Day-to-day vaginal discomfort

Lower urinary tract symptoms

UTI

Urosepsis

First line management:-

Moisturiser – vulval and vaginal

Lubricant for sex

Ensuring arousal prior to penetration

Genitourinary Syndrome of Menopause

If first line management ineffective:-

Breast specialist might consider if there are changes that could be made to adjuvant anti-estrogen treatments

- Switching/stopping AI can improve GSM
- In post-menopause, tamoxifen can have a beneficial agonist effect at vaginal estrogen receptors

May have to consider local vaginal estrogen as symptoms can be severe

Local vaginal estrogen

Often the only effective option for GSM

Evidence to support safety?

- In general population, no effect of use of low dose local vaginal estrogen (low systemic absorption) on risk of breast cancer occurrence.

- Limited direct evidence suggests little or no adverse effect of use of LDVE on breast cancer outcomes, even potentially during use of AI

BUT

- Even the most recent studies (McVicker,Jama Oncology Nov 2023) have significant design limitations that limit what we can conclude.

Local vaginal estrogen

In practice:-

(Many strong and widely differing opinions)

- Non-hormonal options first line (moisturiser, lube)
- (V)LDLVE generally considered reasonable after breast cancer if significant symptoms despite non-hormonal management (especially urinary tract infection)

BUT
- suggest discussion with oncology if using AI as adjuvant treatment after breast cancer
- must be discussion with oncology if ongoing breast cancer

Local vaginal estrogen

If local VE to be used, try newer very low dose preparations first
(e.g., Imvaggis: 10x lower dose than standard vaginal estriol preparations)

Benefit takes time AND needs to be maintained

Management of systemic menopausal symptoms

Vasomotor symptoms, cognitive symptoms, mood symptoms, sleep problems, musculoskeletal symptoms

- Self-help (WHC, NHS inform, Sleepio)
- Supporting reflection about the benefits of a self-help efforts already being made
- Time (VMS, cognition, mood)

Non-hormonal medical options:-

- SSRI/SNRI for mood and off-label for vasomotor symptoms (fluoxetine and paroxetine inhibit metabolism of tamoxifen to its active metabolite)
- Gabapentin off label for vasomotor symptoms, sleep and musculoskeletal pain
- Oxybutynin if sweats are wet
- ? NK3 antagonists (fezolinetant)

Management of systemic menopausal symptoms

Systemic HRT generally avoided if at all possible regardless of tumour receptor status and use of tamoxifen

Breast specialist could consider alteration to adjuvant anti-estrogen treatment

?change of tamoxifen brand/ dose splitting/ tamoxifen holiday to assess benefit

?change of AI/ AI holiday to assess benefit

Support for bone health

Dietary Ca
Vitamin D
Resistance exercise

(tamoxifen is bone protective)

Key points

Consistent messages within and across services

Achieve **effective** contraception
Non-hormonal methods first line
HC case-by-case if no alternative (amongst progestogen-only methods no clear safest option)

Don’t underestimate GSM – strongly consider local vaginal estrogen

Self-help for menopausal symptoms coupled with realistic expectation
Non-hormonal medical management options for VMS, mood in particular
HRT a last resort for severe refractory symptoms

Acknowledgements:-

I am very grateful for the support in development of this work of:-

- FSRH CEU at Chalmers
- Scottish Menopause Specialists Group

Guidance aligns with:-

- FSRH guidance (November 2023) **Supporting Contraceptive Choices for Individuals Who Have or Have Had Breast Cancer**
- British Menopause Society consensus statements and guidance

Questions

Scan or click the QR code to ask a question:

TOPIC:
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