Living with an Induced Menopause

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Obstetrics and Gynaecology
University of Glasgow

2 February 2017
70% of women in UK living with breast cancer have hot flushes

1/3 >69 years are still symptomatic

<table>
<thead>
<tr>
<th>Cases</th>
<th>Deaths</th>
<th>Survival</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>55,222</td>
<td>11,433</td>
<td>78%</td>
<td>27%</td>
</tr>
</tbody>
</table>

New cases of invasive breast cancer, 2014, UK
Deaths from breast cancer, 2014, UK
Survive breast cancer for 10 or more years (females only), 2010-11, England and Wales
Preventable cases of breast cancer, UK
What are menopausal symptoms?

1. Vasomotor symptoms:
   - hot flushes
   - night sweats
2. Vulvo-vaginal dryness
3. Sleep disturbance
4. Mood disturbance
5. Sexual dysfunction

Why do breast cancer patients get menopausal symptoms?

- Young women after chemotherapy or oophorectomy
- Peri and postmenopausal women who stop taking HRT
- Pre and postmenopausal women taking endocrine therapy for 5-10 years
  - Vasomotor symptoms are more frequent and severe after breast cancer compared to natural menopause
    - Vaginal dryness particularly severe with aromatase inhibitors
    - ATAC: Vaginal dryness; Anastrozole 18.5% Tamoxifem 9.1%
      - Dyspareunia; 17.3% 8.1%

Why are menopausal symptoms after breast cancer problematic?

1. May lead to discontinuation of endocrine therapy
   
   ➢ Up to 50% stop due to hot flushes, which may lead to 20% increase in mortality

All women with incident breast cancer between 1993 and 2000 who were prescribed tamoxifen in the Tayside region of Scotland. 475 (38%) patients had low adherence, which was associated with reduced time to recurrence of 52% (P<0.001).

Time to other cause mortality was also reduced by 23% (P <0.055) but this was not statistically significant.
"We reported on 576 women classed as having low adherence with 266 dying (46%). High adherence had 2785 with 928 dying (33%). That gives a crude difference in deaths of 13% between the two groups (page 1518). The hazard ratio between the groups was 1.20…. this actually means that women with low adherence have a 20% increased risk of death at any given point of time compared to women with high adherence."

C. McCowan

Why are menopausal symptoms after breast cancer problematic?

2. May have implications for prognosis

➢ ? Indicate better prognosis in breast cancer

Figure 1. Hot flashes in association with breast cancer recurrence, SBCSS.


http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0075926
Why are menopausal symptoms after breast cancer problematic?

3. May impair quality of life:
   - Worse than the cancer treatment for some women

4. May exacerbate common post-cancer problems such as sleep disturbance and fatigue

5. Risks of early menopause may contribute to morbidity and mortality: Osteoporosis and cardiovascular disease

LIVING WITH AND BEYOND CANCER

The impact of cancer often doesn’t end when treatment does. Everyone should be supported to live as well as possible for as long as possible after a cancer diagnosis.

AROUND HALF OF THOSE DIAGNOSED WITH CANCER TODAY WILL LIVE FOR AT LEAST 10 YEARS.
What works for vasomotor symptoms?
### Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes

**Comparison:** Any HRT versus placebo: vasomotor outcomes at end of study

**Outcome:** Hot flush frequency/week

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>HRT N</th>
<th>Mean(SD)</th>
<th>Placebo N</th>
<th>Mean(SD)</th>
<th>Mean Difference IV,Random,95% CI</th>
<th>Weight</th>
<th>Mean Difference IV,Random,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baerug 1998</td>
<td>73</td>
<td>3.7 (6.85)</td>
<td>33</td>
<td>33.5 (31)</td>
<td></td>
<td>10.7 %</td>
<td>-29.80 [-40.49, -19.11]</td>
</tr>
<tr>
<td>Conard 1995</td>
<td>35</td>
<td>0.98 (2.87)</td>
<td>15</td>
<td>32.2 (35.56)</td>
<td></td>
<td>5.6 %</td>
<td>-31.22 [-49.24, -13.20]</td>
</tr>
<tr>
<td>Coope 1975</td>
<td>15</td>
<td>2.87 (6.35)</td>
<td>15</td>
<td>21.93 (26.8)</td>
<td></td>
<td>7.9 %</td>
<td>-19.06 [-33.00, -5.12]</td>
</tr>
<tr>
<td>Coope 1981</td>
<td>29</td>
<td>4.9 (14.4)</td>
<td>26</td>
<td>16.3 (26.9)</td>
<td></td>
<td>9.8 %</td>
<td>-11.40 [-22.99, 0.19]</td>
</tr>
<tr>
<td>Derman 1995</td>
<td>34</td>
<td>0.85 (16.6)</td>
<td>36</td>
<td>12.64 (16.6)</td>
<td></td>
<td>14.0 %</td>
<td>-11.79 [-19.57, -4.01]</td>
</tr>
<tr>
<td>Notelevitz 2000a</td>
<td>225</td>
<td>13 (24)</td>
<td>55</td>
<td>28 (29)</td>
<td></td>
<td>13.4 %</td>
<td>-15.00 [-23.28, -6.72]</td>
</tr>
<tr>
<td>Symons 2000 Study 1</td>
<td>149</td>
<td>7.6 (3.9)</td>
<td>38</td>
<td>25 (29)</td>
<td></td>
<td>12.0 %</td>
<td>-17.40 [-26.89, -7.91]</td>
</tr>
<tr>
<td>Symons 2000 Study 2</td>
<td>199</td>
<td>14.1 (26.2)</td>
<td>67</td>
<td>39.4 (32.7)</td>
<td></td>
<td>13.0 %</td>
<td>-25.30 [-33.93, -16.67]</td>
</tr>
<tr>
<td>Viklyaeva 1997</td>
<td>32</td>
<td>13.84 (15.3)</td>
<td>28</td>
<td>23.68 (16.5)</td>
<td></td>
<td>13.6 %</td>
<td>-9.84 [-17.93, -1.75]</td>
</tr>
</tbody>
</table>

**Total (95% CI):** 791 313

Heterogeneity: Tau² = 29.47; Chi² = 17.38, df = 8 (P = 0.03); I² = 54%

Test for overall effect: Z = 7.12 (P < 0.00001)
# Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes

## Review: Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes

**Comparison:** 2 Any HRT versus placebo: vasomotor outcomes at end of study  
**Outcome:** 5 Hot flush severity (all scales, continuous) - SMD

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>HRT N</th>
<th>Mean (SD)</th>
<th>Placebo N</th>
<th>Mean (SD)</th>
<th>Std. Mean Difference (IV, Random, 95% CI)</th>
<th>Weight</th>
<th>Std. Mean Difference (IV, Random, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conard 1995</td>
<td>35</td>
<td>0.11 (0.32)</td>
<td>15</td>
<td>0.81 (0.16)</td>
<td>-2.44 [-3.22, -1.65]</td>
<td>12.2%</td>
<td>-2.44 [-3.22, -1.65]</td>
</tr>
<tr>
<td>Bech 1998</td>
<td>68</td>
<td>0.13 (0.35)</td>
<td>37</td>
<td>0.8 (0.9)</td>
<td>-1.1 [1.53, -0.68]</td>
<td>16.3%</td>
<td>-1.10 [-1.53, -0.68]</td>
</tr>
<tr>
<td>Chung 1996</td>
<td>43</td>
<td>0.35 (0.65)</td>
<td>40</td>
<td>0.78 (0.89)</td>
<td>-0.55 [-0.99, -0.11]</td>
<td>16.2%</td>
<td>-0.55 [-0.99, -0.11]</td>
</tr>
<tr>
<td>Blumel 1994</td>
<td>25</td>
<td>0.04 (0.2)</td>
<td>23</td>
<td>0.57 (0.79)</td>
<td>-0.92 [-1.52, -0.32]</td>
<td>14.4%</td>
<td>-0.92 [-1.52, -0.32]</td>
</tr>
<tr>
<td>Paterson 1982a</td>
<td>11</td>
<td>0.26 (0.2)</td>
<td>9</td>
<td>0.57 (0.08)</td>
<td>-1.88 [-2.97, -0.78]</td>
<td>9.1%</td>
<td>-1.88 [-2.97, -0.78]</td>
</tr>
<tr>
<td>Baerug 1998</td>
<td>78</td>
<td>0.43 (0.66)</td>
<td>41</td>
<td>2 (1.1)</td>
<td>-1.86 [-2.31, -1.42]</td>
<td>16.1%</td>
<td>-1.86 [-2.31, -1.42]</td>
</tr>
<tr>
<td>Derman 1995</td>
<td>39</td>
<td>4.5 (3.66)</td>
<td>39</td>
<td>9.4 (4.53)</td>
<td>-1.18 [-1.66, -0.70]</td>
<td>15.7%</td>
<td>-1.18 [-1.66, -0.70]</td>
</tr>
</tbody>
</table>

**Total (95% CI)** 299 204  
Heterogeneity: Tau² = 0.28; Chi² = 28.72, df = 6 (P = 0.00007); I² = 79%  
Test for overall effect: Z = 5.82 (P < 0.00001)
HRT may increase the risk of breast cancer recurrence or new breast cancer

Figure 2. Cumulative incidence to first breast cancer event by intention to treat. Deaths by causes other than breast cancer are treated as competing events. There were 39 events in the HT arm and 17 in the non-HT arm. HT = hormonal replacement therapy.

HABITS Study Group
Holmberg et al 2008
Tibolone: increased risk of recurrence and new breast cancer

Kenemans et al, Lancet Oncol 2009
What else do we have for vasomotor symptoms?

**Clonidine**

- 25-50 mcg increasing to 50mcg bd
  - Better than placebo but less effective than SSRI / SNRI / gabapentin
  - Side effects limit tolerability
    - Dry mouth, dizzy, constipation
  - Licenced for VMS

Boekhout A H et al. JCO 2011
### What works for vasomotor symptoms?: Antidepressants

<table>
<thead>
<tr>
<th>Name</th>
<th>Reduction in hot flashes vs placebo</th>
<th>Daily reduction in hot flashes</th>
<th>Duration of studies</th>
<th>Additional benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desvenlafaxine 100mg</td>
<td>64% (vs 51%)</td>
<td></td>
<td>12 months</td>
<td>Improved sleep</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nausea, constipation, sexual dysfunction</td>
</tr>
<tr>
<td>Venlafaxine 75mg SR</td>
<td>60% (vs 27%)</td>
<td>-1.8 compared to -2.4 with ultra low dose estrogen</td>
<td>8 weeks</td>
<td>Improved sleep</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Equivalent to very low dose estrogen. Nausea, constipation, sexual dysfunction</td>
</tr>
<tr>
<td>Paroxetine 12.5mg</td>
<td>56% (vs 28%)</td>
<td></td>
<td>24 months</td>
<td>Nausea, fatigue, dizziness, insomnia. No discontinuation syndrome at lower doses. No change in sexual function.</td>
</tr>
<tr>
<td>Escitalopram (10-20mg)</td>
<td>55% (vs 36%)</td>
<td>-1.4 compared to -2.4 with ultra low dose estrogen</td>
<td>8 weeks</td>
<td>Improved sleep, mood, quality of life and hot flash interference. Does not impair sexual function.</td>
</tr>
<tr>
<td>Citalopram 10mg</td>
<td>49% (vs 23%)</td>
<td></td>
<td>6 weeks</td>
<td>Does not impair sexual function.</td>
</tr>
<tr>
<td>Fluoxetine 20mg</td>
<td>50% (vs 36%)</td>
<td></td>
<td>9 months</td>
<td>Nausea, constipation, sexual dysfunction</td>
</tr>
</tbody>
</table>

Venlafaxine 75mg equivalent to ultra-low dose estradiol (0.25mg) estradiol for VMS

Figure 2. Frequency of Vasomotor Symptoms (VMS) by Treatment Group

What works for vasomotor symptoms?:
Pharmacological treatments

Gabapentin (900 mg/day)

- As effective as ultra low dose estrogen
  - Premarin 0.3mg or 25 estradiol mcg patch

Limitations
- Drowsiness, confusion, ataxia

Start at 300mg/day and increase slowly

Can be used by women already taking SSRI/SNRI

What works for vasomotor symptoms?
Mind Body therapies

Cognitive behaviour therapy

Reduced problem rating (but not frequency) of vasomotor symptoms

Nearly 80% reported improvements in vasomotor symptoms

“Side effects”

- Improved mood
- Reduced anxiety

What works for vulvovaginal symptoms?
Managing vulvovaginal atrophy after breast cancer

Vaginal estrogens effective but are systemically absorbed

• Vaginal estradiol (25 mcg) significantly increased systemic E2 in aromatase inhibitor users

➢ Current dose is 10 mcg (“vagifem low”)

  o Less systemic absorption

  o Effect on TAM users unknown

• Many oncologists avoid vaginal estrogen but clinical implications unknown

Minimized estradiol absorption with ultra-low-dose 10 μg 17β-estradiol vaginal tablets

M. Eugster-Hausmann, J. Waitzinger & D. Lehnick

Pages 219-227 | Received 22 Dec 2009. Accepted 31 Mar 2010. Published online: 14 May 2010

![Graph showing time course of mean estradiol (E2) plasma concentrations](image)

**Figure 1** Time course of mean estradiol (E2) plasma concentrations during 24 h after vaginal administration of 10 μg E2 tablets on day −1, 1, 14, 82, and 83 of treatment
Managing atrophic vaginitis after breast cancer

Avoid vaginal estrogens in AI users

Consider vaginal estrogens in TAM users
  ➢ Still discuss with oncologist

Relative efficacy of vaginal lubricants unknown
  ➢ Silicone based products reduce pain at intercourse more than water based
  ➢ Vulval lignocaine (4%) reduces dyspareunia and sexual distress in breast cancer survivors

Sexual dysfunction, sleep disturbance, osteoporosis, cardiovascular disease?
Members include:
- patient advocates
- nurses
- researchers
- oncologists
- psychologists
- statisticians
- molecular biologists
- physiologists
- gynaecologists
- complementary therapy specialists
- representatives from:
  - Breast Cancer Care
  - Breast Cancer Now (secretariat)
Working Party Symptom Management

Initial Priority:
• Survey Patient & Healthcare perspectives
• Raise Awareness
• Educate Healthcare Professionals

Hot Flush Surveys

• Breast Cancer Patients (n=666)
• Healthcare Professionals 1850 invited (n=185)
• GPs (n=79)
Do You Have Hot Flushes

Yes: 94%

No: 3%
GPs and HCPs significantly underestimate the impact of HF/NS on the lives of breast cancer patients.

65% of patients say that they have severe HF/NS BUT only 5% of GPs and HCPs thought that 65% of their patients have severe hot flushes.
30% considered stopping endocrine therapy

If you are having hot flushes/night sweats while on hormone therapy, are they bad enough to make you want to stop taking it?

- Yes: 30%
- No: 70%

Percentage of those who answered the question yes/no. N = 506
Most believe that treatment of hot flushes in breast cancer patients is an unmet need.
If you treat hot flushes medically what do you use?

- HRT
- Clonidine
- Paroxetine
- Venlafaxine
- Citalopram
- Gabapentin
- Progesterone

GPs prefer Clonidine and HCPs SSRIs

Worrying level of HRT prescribed by GPs (27%)
90% of professionals reported prescribing drugs to alleviate HFNS, **BUT** only 26% of the patients reported being offered drugs and fewer than 2% said they helped.
Managing hot flushes following breast cancer
Imperial College London
Young Woman's Breast Cancer pathway

Hormonal problems relating to breast cancer
The West London Menopause Service
Queen Charlotte's and Chelsea Hospital
Du Cane Road, London W12 0HS
Tel: 0208 383 8164

Dr N Panay and Dr E Horner lead a service which specialises in restoring quality of life, improving psychological health and long-term wellbeing. Advice is given on a range of interventions including lifestyle, dietary, counselling and complementary, hormonal and non-hormonal therapies. Advice and treatment is given according to individual circumstances and a helpline is provided. There are two clinics: general menopause and young menopause (below age 40).

Additional contacts for extra support
Breast Cancer Care
5-13 Great Suffolk Street, SE1 ONS
Tel: 0845 092 0800

Breast Cancer Care works hard to provide the best information and support for people affected by breast cancer, wherever in the UK they may be. Please email info@breastcancercare.org.uk or call the main switchboard on 0845 092 0800, where someone will be able to answer your query or forward you on to the relevant department.

The website also features a section dedicated to younger women with breast cancer, highlighting resources of specific relevance: www.breastcancercare.org.uk/younger-women

The Haven Breast Cancer Support Centres
The London Haven
Ella Road, SW6 1TB
Tel: 020 7384 0000

The Haven aims to help people through the physical and emotional experience of breast cancer by offering free, in-depth, personalised programmes of psychological support and complementary therapies.

Macmillan Cancer Information and Support Services at Charing Cross and Hammersmith Hospitals.
The information centre at Charing Cross Hospital and the Infoline at Hammersmith Hospital provide emotional and practical support, as well as signposting advice to anyone affected by cancer. These drop-in services are set in friendly, non-clinical environments in which people affected by cancer can discuss private and emotional needs with dedicated Macmillan information professionals.
The information centre is located on the ground floor of Charing Cross Hospital and is open (except bank holidays): Monday and Tuesday 09:00-17:00; Wednesday, Thursday, Friday 09:00-16:00
Telephone: 020 3313 0171

The infoline is located on the ground floor of the Garry Weston Centre at Hammersmith Hospital and is open (except bank holidays): Monday and Tuesday 09:00-17:00; Wednesday, Thursday, Friday 09:00-16:00
Telephone: 020 8313 4248

Maggie's Cancer Support
Maggie's London
Charing Cross Hospital
Fulham Palace Road
W6 8RF
Tel: 020 7386 1750
Fax: 020 7386 1751

Maggie's provides emotional, practical and social support to people with cancer and their families and friends. All services are free and you don't need an appointment or a referral.

Information for patients and carers
www.imperial.nhs.uk/breastservices

Information for young women with breast cancer

Imperial College Healthcare NHS Trust
This leaflet is intended to provide important contact details for support services to young women diagnosed with breast cancer.

**Oncoplastic breast surgery**

Breast Services  
Charing Cross Hospital  
Fulham Palace Road  
London W6 8RF  
Tel: 020 3311 1077

Mr R Al-Mufti, Mr D Hadjiminas, Mrs K Hogben and Mrs J Lewis are specialist breast surgeons performing oncoplastic breast surgery. Oncoplastic surgery combines modern cancer surgery with plastic surgery to obtain the best aesthetic outcome. The unit is equipped to provide state-of-the-art image-guided localisation, sentinel node biopsy and acellular dermal matrix-based reconstruction, as well as nipple reconstruction.

**Specialist breast care nursing support**

Matron Victoria Harmer - team leader  
Breast Services  
1st Floor  
Charing Cross Hospital  
Fulham Palace Road  
W6 8RF  
Tel: 020 3313 0659

Victoria Harmer, Ann Alexander, Vanessa Cross, Sue McNerney, Addie Mitchell and Ann Murphy are breast nurse specialists, offering a comprehensive service. This dynamic team has a wide range of expertise on breast reconstruction, prosthesis fitting, oncology, survivorship issues and prevention of lymphoedema (arm swelling). There is also a nurse-led nipple tattoo clinic.

**Plastic surgery**

Plastics Department  
Charing Cross Hospital  
Fulham Palace Road  
W6 8RF  
Tel: 020 3311 1243

Mr N Jallali and Mr S Wood are reconstructive surgeons with specialist experience in breast surgery. Both surgeons offer a range of options including autologous reconstructions (using tissue from your own body) which provide great long-term results and are available to young women. The Charing Cross Hospital Plastics Department has a high success rate with this surgery.

**Clinical genetics**

Tel: 020 8869 2795

Clinics are held throughout the North West Thames region and patients are usually seen at the clinic most convenient for them. Dr A Brady is the cancer lead and one of the nine consultant clinical geneticists from the North West Thames Regional Genetics Service offering genetic counselling and genetic diagnosis to the population of 3.6 million across the North West Thames region. If appropriate, genetic testing is offered to patients. The service also offers predictive testing to other family members if a specific mutation is identified.

**Sexual dysfunction associated with breast cancer**

Jane Watkinson Sexual Function Clinic  
Jefferson Wing  
St Mary’s Hospital  
W2 1NY  
Tel: 020 3312 6754  
Email: david.goldmeier@imperial.nhs.uk

Dr D Goldmeier is a specialist in sexual dysfunction and can help if you have sexual problems such as issues with desire, sexual arousal, orgasm or pain at intercourse. You may self-refer by calling or emailing via the email address above.

**Psychological adjustment and breast cancer**

Clinical Health Psychology  
St Mary’s Hospital  
London W2 1NY  
Tel: 020 3312 1658

Dr A King is a consultant psychologist and leads a team of psychologists and counsellors specialising in cancer. They offer specialist support with the psychological challenges of cancer, at any point of the journey. Areas of support include deciding about treatment, talking to family, coping with the ups and downs of treatment, moving back into everyday life and dealing with advanced disease. The team have clinics on all Imperial hospital sites and welcome referrals from any cancer-care professional.

**Fertility preservation**

3rd Floor Hammersmith House  
Hammersmith Hospital  
Du Cane Road  
W12 0HS  
Tel: 020 8383 4152

Mr S Lavery is a member of the fertility team based at Hammersmith Hospital and can give detailed advice on all aspects of fertility preservation. A comprehensive service is offered including ovarian reserve screening, IVF and embryo storage. Egg freezing for women without a partner is also available. A dedicated fertility preservation clinic is held every Wednesday afternoon.
Breast cancer and early menopause

A guide for younger women

Over 30,000 copies distributed
New model of care for cancer patients with menopausal symptoms
Patient referred to MSAC Clinic

Patient seen by menopause specialist

Patient seen by nurse specialist

Management Issues resolved by Multidisciplinary team

Assessment
Treatment plan

Information

Evidence-based
Clinical guidelines

Data collection

The Joint Breast Cancer and Menopause Symptom Clinic
Women Services, London North West Healthcare NHS Trust.

Prescribing Guidelines

Consultant leads:
Joan Pitkin, Consultant Gynaecologist & Menopause Services Lead, LNWHT & Director, The Northwick Park Menopause Clinical & Research Unit
Robert A Reichert, Consultant Breast Surgeon, Breast Unit, LNWHT
Nuttan Tanna, Pharmacist Consultant, Women’s Health & Older People, LNWHT & Associate Director, The Northwick Park Menopause Clinical & Research Unit

The LNWHT menopause team, breast unit team and genetics team:
Dr Jane Woyka, GP Associate Specialist, Menopause Team
Kathy Abernethy, Senior Nurse Specialist, Menopause Team
Dr Andreas Makris, Consultant Clinical Oncologist, Breast Team
Dr Arshi Denton, Consultant Clinical Oncologist, Breast Team
Dr Inge Peerlinck, Consultant Breast Surgeon, Breast Team
Dr Marijka Colquhoun, Breast Surgeon, Breast Team
Nicola Capurro, Team leader, Breast Care Nurses, Breast team
Anna Veal, Macmillan Clinical Nurse Specialist, Breast Team
Emma Carroll, Macmillan Clinical Nurse Specialist, Breast Team
Dani Singer, Counsellor & Clinical Psychotherapist, Menopause Team
Demetra Georgio, Genetics Unit Counsellor
Vicki Kiesel, Genetics Unit Lead Counsellor
Living with an Induced Menopause

Aims

The aims of the group were discussed which will be to:

Assess the level of need in clinics attended by young women following cancer treatment

To form an Advisory Group

To develop appropriate Guidelines and suitable Patient Information Leaflets.
Managing Vulvovaginal Atrophy after Breast Cancer

Introduction

Cancer treatment may result in loss of ovarian function through surgical removal of the ovaries, chemotherapy, or radiation. While menopausal symptoms, such as hot flashes, night sweats, sleep disturbance, memory concerns, and mood issues can be extremely bothersome to some women going through menopause naturally, women who undergo an induced menopause usually experience more sudden and severe symptoms.

Pain and vaginal dryness can occur whether a woman has a sexual partner or not. In women with breast cancer, the aetiology of impaired sexual functioning, and lowered sexual desire, is often multifactorial, and may be related to physical and/or psychological reasons.

It is important to discuss sexual difficulties and/or discomfort so that appropriate treatment can be offered.

Pain and vaginal dryness in women without a history of breast cancer can usually be safely treated with vaginal estrogens, in the form of a cream, pessary or ring, and simple lubricants or vaginal moisturizers. Safe usage of vaginal oestrogen replacement therapy (ERT) in breast cancer patients has not been studied within RCTs of long duration; the guidelines below reflect a clinical consensus.

Recommendations

...
Questionnaire
Menopause Symptoms in Women who have had Cancer

AGE [ ] AGE at Diagnosis [ ]

Treatments you have had

Surgery [ ] Chemotherapy [ ]
Radiotherapy [ ] Hormone therapy (e.g. Tamoxifen/Letrozole) [ ]

Type of Cancer

Ovary/fallopian tube/peritoneum [ ] Womb [ ] Breast [ ] Cervix [ ]

Symptoms

Flushing [ ] Sweats [ ] Vaginal Dryness [ ] Vulval Pain [ ]

Painful Intercourse [ ] Less/No interest in sex [ ] Hair loss [ ]

Mood Swings [ ] Joint Pains [ ] Muscle Pains [ ] Insomnia [ ]

Forgetfulness /Memory loss [ ] Tiredness/fatigue [ ]

Have you been referred to a specialist clinic for any of these symptoms? [Yes] [No]

Do you think it would be useful to have a service where you could be seen to discuss these issues? [Yes] [No]

Please hand form to nurse or doctor at clinic.

This is an anonymous Questionnaire for us to understand if we need to consider any additional services.
Breast cancer

<table>
<thead>
<tr>
<th>No</th>
<th>Age</th>
<th>Age (at diagnosis)</th>
<th>surgery</th>
<th>chemo</th>
<th>radio</th>
<th>hormone</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>63</td>
<td>60</td>
<td>17</td>
<td>8</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(42-84)</td>
<td>(38-82)</td>
<td>(85%)</td>
<td>(40%)</td>
<td>(65%)</td>
<td>(60%)</td>
</tr>
</tbody>
</table>
# Gynaecological cancers

<table>
<thead>
<tr>
<th>No</th>
<th>Age</th>
<th>Age (at diagnosis)</th>
<th>Ovary/ tube/ peritoneum</th>
<th>uterus</th>
<th>cervix</th>
<th>surgery</th>
<th>chemo</th>
<th>radio</th>
<th>hormone</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>61</td>
<td>58</td>
<td>27 (57%)</td>
<td>4 (9%)</td>
<td>12 (26%)</td>
<td>29 (62%)</td>
<td>38 (81%)</td>
<td>15 (32%)</td>
<td>5 (11%)</td>
</tr>
</tbody>
</table>
Symptoms

- Flushing
- Sweats
- Vag dryness
- Vulval pain
- Painful intercourse
- Low libido
- Hair loss
- Mood swings
- Joint pains
- Muscle pains
- Insomnia
- Memory loss
- Fatigue

Percentage distribution for breast and gynae.
Specialist menopause service

Offered referral:
- yes
- no
- no response

Would like a service:
- yes
- no
- no response
We need to clearly define referral pathways and delivery of care

- Increase awareness of existing menopause clinics
- Provide guidance approved by MDT – with management issues resolved by MDT (Advisory group)
- Should we provide an MDT clinic?

Menopause Symptoms After Cancer Clinic (MSAC)/Abernethy

- Train/Recruit a Clinical nurse specialist
- Pre-op (RRBSO)
- Include Haematological and other pelvic cancers
- Research agenda
Managing menopause after breast cancer

Provide information about menopause and its management prior to chemotherapy

No “magic bullet”

- Review the precipitating and exacerbating factors
- Prioritise: likely >1 symptom
- Individualise: Improving sleep can increase tolerance of daytime symptoms
- Consider multiple approaches
- Consider changing endocrine therapy

Thank you