Management of menopause in patients with breast cancer

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But sometimes when the night is slow
The wretched and the meek,
We gather up our hearts and go
A thousand kisses deep."

The incidence of breast cancer begins to rise from 50 years of age, however, according to data from the Globocan 2012, in Venezuela around 40% and globally 32% of cases will be diagnosed in women below that age. When it occurs in young women, there is a high probability that early menopause or hypoestrogenism induced by the blockage of ovarian function will occur as a side effect of treatment, with a less range of possibilities of treatment than patients who do not have contraindication to the use of hormone replacement therapy (HRT). Breast cancer is in most cases a hormone-dependent neoplasm and so far there is insufficient evidence to support the safety of HRT use, even in negative hormone receptor tumors.

The treatment of the menopause in patients with history of cancer of breast must focus is in two objectives: relief the symptomatology and decrease the risk of develop long term diseases product of the lack of estrogen at early ages.

1. Management of vasomotor symptoms: hot flashes are caused by a narrowing of the thermoregulation zone induced by alterations in serotonin and norepinephrine levels as a result of the abrupt decrease of estrogen at the central nervous system. Patients with ovarian failure induced by chemotherapy, surgery or by GnRH agonists analogues, experience more severe symptoms than reported in natural menopause. The most effective treatment are estrogens; however, given the absolute contraindication, other therapies that regulates changes of neurotransmitters that generate hot flashes can be used. The most effective treatments are:

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a. *Cimicifuga racemosa:* It binds to serotonin receptors improving the climacteric symptoms. It is the only natural therapy that has shown utility in control of vasomotor symptoms in patients with breast cancer with and without treatment with tamoxifen. The rest of natural therapies as vitamin E, isoflavones of soy, melatonin has no effects in the control of the symptoms.

b. **Selective serotonin reuptake inhibitors (SSRI)**: Fluoxetine, sertraline, citalopram, escitalopram, paroxetine. The latter should not be used in patients on tamoxifen therapy until there is strong evidence that it does not affect the efficacy of antiestrogen treatment, as mentioned in an earlier article in this blog.

c. **Serotonin-Norepinephrine Reuptake Inhibitors (SNRI):** venlafaxine, desvenlafaxine, mirtazapine, moclobemide and bupropion. The SNRIs which have proved most effectivity are desvenlafaxine and venlafaxine. SSRIs and SNRIs are the treatment of choice in patients with vasomotor symptoms associated with a mood disorder such as depression or anxiety.

d. **Gabapentin:** as an \(\gamma\)-aminobutyric acid analog regulates hypothalamic activity. It has drowsiness as a side effect, so it is recommended, administered at night, in patients with vasomotor symptoms and insomnia.

e. Dopamine agonists: highlights methylodopa, used sometime in hypertensive patients and with climacteric symptomatology, currently not recommended by the high incidence of side effects that limit long term therapy.

f. Adrenergic agonists: clonidine has been used, but its marked side effects such as hypotension, insomnia, mucosa dryness and depression, limited indications only in hypertensive patients who tolerate the medication.

2. **Management of genitourinary symptoms:** genito-urinary atrophy is a medium and long term sequel of hypoestrogenism, affecting sexual activity and increasing the incidence of vaginal and urinary tract infections. Lubricating gel or polycarbophil is the initial treatment. If the symptomatology does not improve, local low-absorption estrogens can be used at the lowest possible dose since there is evidence that they do not affect the recurrence of the mammary disease, as commented in an article of this blog.

3. **Management of sexuality:** 90% of breast cancer patients have some sort of sexual disorder. Although it is a complex issue, it is necessary to explore and improve local and physical appearance which could have an impact on sexual performance. It is necessary to refer the patient to a sexologist if there is no improvement with the initial steps.

4. **Prevention of osteoporosis:** a patient that is going to be subjected to aromatase inhibitors treatment must be evaluated to establish the risk of osteoporosis: determination of medical conditions of risk for osteoporosis, performing basal and successive controls bone densitometry, as well as a determination of parathormone (PTH) and vitamin D levels. In patients under treatment with tamoxifen it is not necessary to carry out prevention with
Bisphosphonates, since this drug has estrogenic action at the bone level similar to that known with raloxifene.

Recommendations for any patient with breast cancer are:

a. Healthy nutrition and regular exercise, including muscle toning with light weight use.

b. Oral supplementation of calcium (1,000 mg/d) and vitamin D (800-1,000 U/d).

c. To reduce the consumption of alcohol, soft drinks and avoid the use of tobacco.

d. Use of bisphosphonates in patients with bone densitometry which report a T score < -2 or with two or more risk factors for osteoporosis. Zoledronic acid is recommended in pre-menopausal patients and oral bisphosphonates in the case of post-menopausal patients who are going to start adjuvant therapy with aromatase inhibitors.

5. Prevention of cardiovascular disease: the hypoestrogenism in young women is associated with an increased risk of cardiovascular disease. In patients with a history of breast cancer treatment with chemotherapy, especially with anthracyclines, the risk is particularly significant. The recommendations in this regard are aimed at the control of cardiovascular risk factors:

a. Maintain a body mass index below 25 kg/m².

b. Control of lipemia and glucose.

c. Diet low in fat and meat product

d. Regular aerobic exercise at least 4 weekly sessions of 40 minutes each.

Increased survival due to breast cancer obliges to take all these aspects into account in the menopausal patient to ensure a better quality of life, in addition to the strong current trend of extending endocrine adjuvant treatment for 10 years requires improved adherence to treatment by controlling the effects thereof. The patient should be evaluated and treated together to ensure that cancer therapy has achieved its ultimate goal: a higher life expectancy with the best possible quality.

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References


