Coping with the Menopause for Women with a History of Cancer

With life expectancy currently around 88, we are living half our lives as postmenopausal, but for some women the menopause may have come earlier and more abruptly as a consequence of treatment for cancer.

Menopause after cancer therapy may be surgical, disease-related or treatment induced. Ovaries are removed for most uterine and ovarian cancers, and sometimes for breast cancer treatments. Other cancers such as leukaemias or lymphomas may involve chemotherapy which is associated with a 50-60% ovarian failure rate and cancers treated with total body irradiation will guarantee ovarian closedown. Recently approved hormone therapy with drugs like tamoxifen, offered as a preventive to young patients at high risk of breast cancer, will induce early menopause.

Cancer survivors have a more difficult menopause to manage. Already dealing with the shock of cancer, the menopause feels like an extra insult, something for which they are unprepared. There is an onslaught of menopausal-type symptoms, of sleep disturbance, hot flushes, loss of energy and libido, vaginal dryness and soreness. The early menopause induced by cancer treatments in a young patient impact on her sexuality and fertility and she will have to make decisions about whether she wants to harvest and freeze eggs or embryos prior to treatment or accept that fertility options will be limited to donor IVF, adoption or surrogacy. Altered libido, loss of fertility and likely loss of self-esteem may challenge intimate relationships.

The menopause which occurs after cancer treatment for young patients is associated also with long term physiological problems. We know that an early menopause is associated with osteoporosis. Mayo Clinic studies which involved 4780 women who had undergone oophorectomy showed that life expectancy is reduced by two years (compared with women whose menopause is at 55). Those women with untreated early menopause also had a more than double risk of cardiovascular disease, score less well on memory and cognitive function testing and seem to be 3.3 times at greater risk of Parkinson's disease.

Clearly female cancers occurring premenopausally are the hardest to manage. Breast cancer affects 1 in 8 women, 20% of whom are under 50. Most are oestrogen receptor positive and treatments aim to block the patient's own oestrogen production. Endometrial cancers are probably not influenced by oestrogen, but there is only one study supporting its safety. Hysterectomy and removal of ovaries for ovarian cancer induces an immediate menopause, although with the exception of one rare form, ovarian cancers are not hormonally influenced and so oestrogen replacement is considered safe. Cervical cancers are most common in 35-45 year olds: the majority of cervical cancers will be prevented by the screening programme, by HPV vaccination and only advanced cases require extensive pelvic surgery; hormonal therapy can be used safely in all cervical cancer survivors. Most other cancers such as lymphomas, leukaemias and colon cancers are not considered to be influenced by female hormones so HRT can be offered when appropriate.

In 2008 we set up a clinic at Northwick Park for patients with menopause problems who have had cancer, most of whom are patients with breast cancer. Many of these women take Tamoxifen or aromatase inhibitors both of which affect oestrogen receptors. Patients on oestrogen receptor blockers may suffer more severely with hot flushes. Tamoxifen is a gentler drug in as much as it is a receptor blocker at the breast but does not affect the vulva and vagina, whereas aromatase inhibitors block all oestrogen receptors throughout and is often therefore associated with severe vaginal symptoms. Some oncologists will not permit use of even the lowest strength topical oestrogen therapy for those patients, and for those women with the most severe vaginal symptoms we will swap from aromatase inhibitors to tamoxifen instead.

The majority of breast cancer patients are not suitable for HRT because they have had oestrogen and/or progesterone-receptive breast cancers. Fortunately there are a variety of prescribable non-hormone medications available although none will address the full range of problems which can be helped by hormones. Hand in hand with HRT use comes uncertainty regarding safety of treatment, we often experience conflict of opinion from oncologists and breast surgeons, as well as media misinformation. It is worth noting that there are a few breast cancer patients, namely those with oestrogen and progesterone receptive negative status who can be offered hormonal therapy and very occasionally a receptor positive patient whose quality of life is overwhelmingly damaged, who has not responded to other therapies, might be offered very low-dose hormonal therapy,

Shortly after establishing our clinic, a survey of our patients revealed that whilst symptoms were severe and overwhelming, many felt traumatised and more worried about their cancer. Although some would have benefitted from prescribable medications, they valued most the opportunity to discuss their experience in the clinic setting. Exploration of lifestyle modifications and alternative therapies such as relaxation, hypnotherapy and homeopathy are considered and although none has scientific validation, some such as acupuncture are viewed as useful and safe treatments. Natural alternative therapies including phytoestrogens may not be as safe as previously believed.

Menopause after cancer can therefore be a traumatic experience, with an abrupt, unexpected menopause in a young patient. The menopausal needs of the cancer survivor may be delayed until the impact of the cancer diagnosis and treatments decline. Cancer treatments cause damage to the ovary which results in loss of fertility and of ovarian hormones. The impact of cancer-induced menopause includes the full range of menopause symptoms but also has psychosexual and fertility consequences and long-term sequelae for bones, brain, cardiovascular, cognitive function and life expectancy. The last insult is that many of these cancer patients are not suitable for hormone replacement therapy; they will be offered lifestyle interventions and non-hormonal therapies.

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