



Menopause and Cancer

Closing the gap

Intro

Menopause Specialist

GP

Role with Northern Cancer
Alliance

Breast Team Newcastle RVI

What is menopause?

MENOPAUSE

- No period for 12 months
- Average age in UK 51



PERIMENOPAUSE

- Starts up to 10 years before menopause
- Changes to bleeds
- Fluctuating hormones and symptoms

POST MENOPAUSE

- No Bleeds

Symptoms

Hot flushes

Night sweats

Vaginal dryness

Painful sex

Low libido

Joint pains

Mood changes

Difficulty
sleeping

Memory and
concentration
problems

Feeling
anxious/irritable

Why bother about menopause in patients with Cancer?

- 9 million women diagnosed with cancer worldwide annually
- Median age for those with Cancer is 8-10 years earlier
- Outcomes are improving but so are the long term sequelae
- How can we care for women across their lifespan after a cancer diagnosis?
- Significant gaps exist in menopause care for cancer patients

Fear

Lack of data

Conflicting information



Causes of menopause in cancer patients

Oophorectomy

Chemotherapy

Radiotherapy

Hormonal therapy

Natural menopause

What we know about menopause after cancer

- Affecting women at a younger age
- Standard diagnostic criteria not applicable
- Increased hot flushes and sleep disturbance
- Vulval and vaginal symptoms often hugely overlooked

But...

- Lack of Data
- When it comes to HRT focus is on safety, not efficacy

Risks of Early Menopause

Cardiovascular

Bone

Osteoporosis
(role of DEXA)

Brain

Impaired cognition
and risk of dementia

Mood

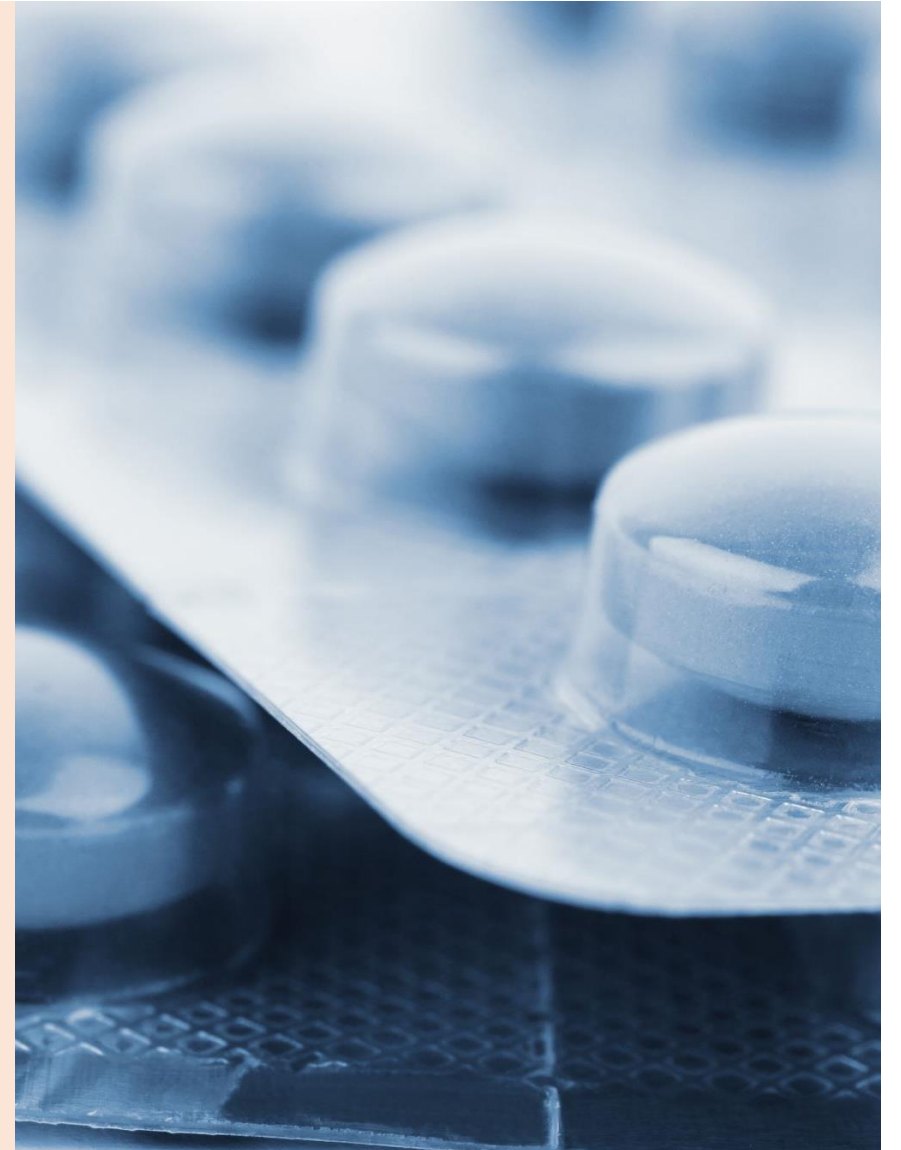
Sexual Dysfunction

Treatment decision Regret

- Rush to get treatment started
- Can we take a step back 'how can we optimise this patients long term health'
- Do we discuss menopause / side effects – when is the best time?
- JOINT UP THINKING – oncologists , Specialist Cancer team, menopause specialists working together

Common themes

- 'Shock - I had no idea
- 'Overwhelming'
- Putting up with symptoms
- Hard to know is this the cancer or the effect of treatment, recurrence or menopause?



Discussing Menopause with Patients

Sleep

VSM

Genitourinary symptoms

Sexual dysfunction

Mood

Approach



? Is it menopause / treatment induced

Drug holiday
Switching within /out of class
Reviewing treatment



Lifestyle – optimising **sleep/nutrition/movement/stress**



Non hormonal options/treatments – CBT, acupuncture, Venlafaxine, citalopram, oxybutynin, (veozah)



Specific GSM focused treatments – Vulval Care, moisturisers and Lubricants, Vaginal Oestrogens



?? HRT – Individualised shared decision making with patient and breast team

Vasomotor Symptoms (Hot Flushes/Night Sweats)

Drug therapies

SSRI's

Venlafaxine

Gabapentin

Oxybutinin

Clonidine

Non-drug therapies

Acupuncture

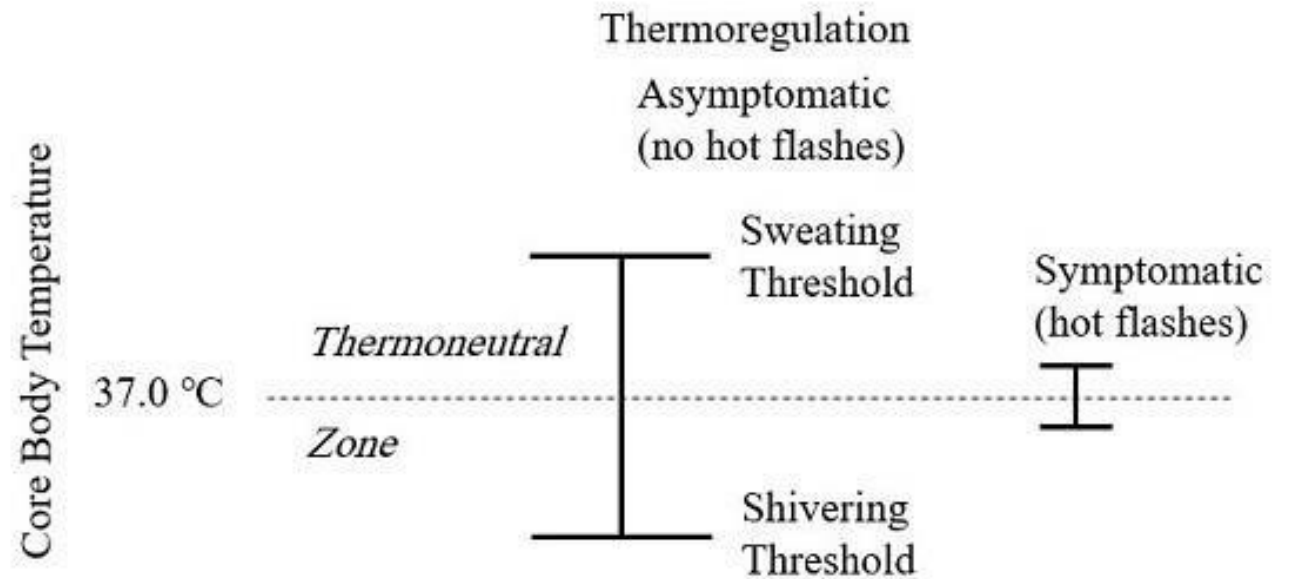
Hypnosis

CBT

LIFESTYLE MEASURES

NK3 antagonists – The future?


- Role of the thermoregulatory zone in hot flashes
- Disruption in the thermoneutral zone threshold
- NK B is a part of this pathway and mediator of hot flashes
- Blocks the receptor



Genitourinary Syndrome of Menopause - GSM




- Symptoms in
 - Vulva
 - Vagina
 - Urinary system
 - Sexual dysfunction



“it feels like sandpaper”

“I can no longer wear underwear as it’s too painful”

“I’ve given up on exercise, especially cycling”



“I can’t even contemplate my smear test”

“Sex is just excruciating; my partner and I just completely avoid it”

How might
GSM
present?

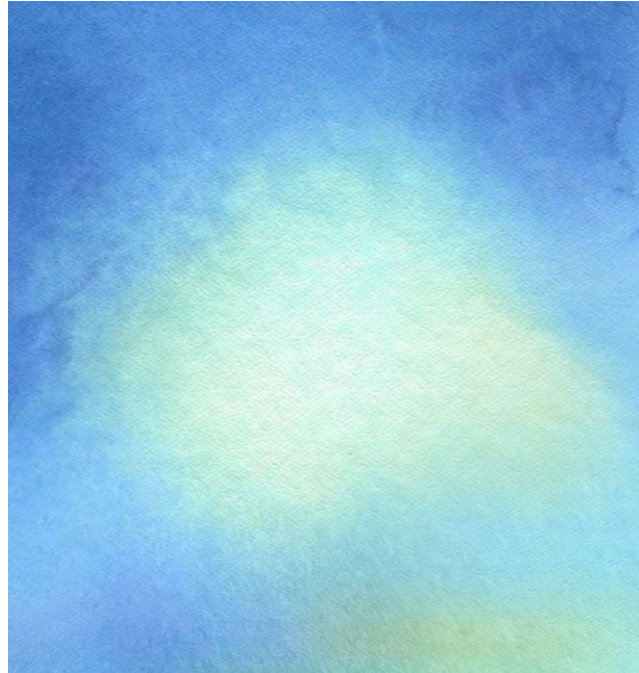
Dryness

Painful sex

Soreness/Irritation

Urinary symptoms

Bleeding



Treatment of GSM

Good vulval care

Vaginal
moisturisers and
Lubricants

Vaginal
Oestrogens (and
alternatives)

Vaginal Moisturisers and Lubricants

- Ph balanced, Hypo-osmotic
 - Better than placebo
- Vaginal Moisturisers
 - 'YES'
 - Coconut oil
- Lubricants
 - Oil based/water based 'YES'



Who can have HRT?

Should have

Colorectal, vulval, vaginal, cervical, leukemia, lymphoma, renal, Liver, thyroid, pancreatic

Should *not* have

Breast, some ovarian, uterine sarcoma, meningioma, glioma, gastric, bladder (Lung?)

May have

Endometrial, ovarian (high grade serous, endometrioid), melanoma, prolactinoma

Summary

Significant gaps exist in menopause care for cancer patients

Sleep, VSM, Sexual dysfunction and GSM are often the most problematic for patients

Multi-modality interventions are best

Being listened to is the most important thing

Promote treatments that have a good evidence base such as CBT

Avoid conflicting advice – working on guidance for professionals and patients

Joined up thinking – working together



Thank you!

Thank you for joining today's Lunch and Learn, we hope you found it interesting and of benefit.

Should you have any questions or if you would like to be involved in ongoing work focused around cancer and the menopause, please contact Kate Cockbain, Breast Delivery Lead for the Northern Cancer Alliance.

kate.cockbain2@nhs.net