Hormone Usage

with

Dr. Shari Snow

National Webinar Transcript

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Presented by:

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Eve:

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Eve:

As we move into the webinar itself, I do want to remind you that Sharsheret is a national not-for-profit cancer support and education organization and we do not provide any medical advice or perform any medical procedures. The information that we are going to provide tonight and that Dr. Snow is going to provide tonight is not a substitute for medical advice or treatment for specific medical conditions. You should not use this information to diagnose or treat a health problem and if you have a specific question that is related to your medical care, you may be advised to speak to your medical provider. You should always seek advice of your physician or qualified healthcare provider with any questions you may have regarding your medical conditions. Now, before we hear from Dr. Snow, I want to introduce Suzanne, who'll be sharing her story with us.

Suzanne:

Hi, everybody. Welcome. So my name is Suzanne and I am a breast cancer survivor, and my story goes back to when I was 23 years old and I decided I wanted to be tested for the BRCA mutation based off of my family history, and this was before it was popular to test for BRCA and I remember that we paid cash because we didn't even want insurance to know if I carried the mutation. Sure enough, I carried the mutation. I started being seen by a gynecological oncologist in Los Angeles, and we decided to put me on birth control for obvious reasons, that I didn't want to have a baby at that age, but also because we decided that to put me on birth control to really help reduce any effects of possibly having ovarian cancer early on with the goal of being a previver and taking everything out and off right after having a family.

Suzanne:

However, unfortunately, cancer beat me to it. I was 32 years old. This is in 2013. I had a 16 month old baby boy, and I had just stopped breastfeeding after a year and sure enough, there was cancer. I had got my MRI before trying to have another child and I was thankful that I had the ability to have the MRI because I knew I had the BRCA mutation, so I'm a big proponent of knowing your family history and doing what you can, because it was that MRI which caught my breast cancer. Even though it took multiple ultrasounds to find, it had gone to lymph nodes and so I ended up having to go through chemo, double mastectomies, reconstruction, 33 rounds of radiation, and the cherry on the top was the full hysterectomy at the very end because of the BRCA mutation.

Suzanne:

I will say that prior to going through chemo, and I know this will be the next discussion, but I did go through egg retrieval in hopes that maybe I was going to have another child, that I was given the okay to do that quickly. Let's see. So basically I've been in menopause forever, I feel like, I feel like it's been since my pregnancy. I've never really had my period. Maybe once. It's crazy to think that I'm young and I'm in menopause and people ask me, "So what do you do about it? Are you taking things? Are you taking estrogen?" I'm like, "No, I'm in menopause." So I wasn't allowed to take any hormone replacement because my breast cancer was estrogen and progesterone positive and HER2 negative. I was stage two.

Suzanne:

However, I will tell you before I turn the microphone over that ... and for Dr. Snow, I have created some little hacks for my menopause symptoms. I always love to share these hacks with my breasties. So here are my hacks for all of you. If I'm in the middle of a hot flash, what I would do is I would take a cup of cold water and just put it on the back of my wrist, and that seemed to cool me down really fast. I don't know, I kind of randomly came up with that on my own and it worked. I also installed the ceiling fan that has a remote control to it. So in the middle of the night, if I had a hot flash, I would just go and crank on that ceiling fan, and then I'd be able to turn it off. I'd flip over my pillow. I bought a mattress pad that was cooling. I found that made a really big difference in my ability to sleep.

Suzanne:

The big issue is the breast cancer, and also doesn't like not having estrogen. I will tell you that I was very reluctant, but I did begin taking Vagifem and I don't know if this is something that will be talked about later. I was really nervous and I know a lot of people are really nervous about it because it's like, "I don't want estrogen in my body. It's going to feed any cancer."

Suzanne:

What I ended up doing was I took the Vagifem and I told my doctor, "I'll give it a try if you monitor my estrogen," and sure enough, I went in and I was still in menopause for my blood work. So I'm like, "Okay, so it's systemic. It's not going to go anywhere," and that was my life changer. So that was really, really helpful in addition to lubrication. So on that note, I don't know, is there anything else you'd like for me to share or ready to pass it over?

Eve:

That was perfect, Suzanne. Thank you so much for sharing your story and for being so supportive and sharing all of your tips and tricks. I know that so many women here are going to benefit from those suggestions. Now for this evening, I'm honored to introduce Dr. Shari Snow. Dr. Snow is an expert in the management of women's health and provides care from puberty through menopause, treating menstrual disorders, fibroids, endometriosis, menopause, and hereditary cancer syndrome. In addition to her general gynecologic experience, Dr. Snow is a part of the preventative oncology team at University of Chicago Medicine. She has a strong clinical interest in hereditary cancer syndromes, such as hereditary breast and ovarian cancer syndrome caused by the BRCA gene and other genetic and familial risks for cancer.

Eve:

She's an expert in screening technologies, medications, and surgical procedures to decrease the risk of cancer in patients with a strong family history of cancer. Dr. Snow has previously served on the clinical oncology board for Myriad Genetics. Dr. Snow is a certified menopause practitioner for the North

American Menopause Society with expertise in management of menopausal symptoms, including easing women's transition into menopause using both hormonal and non-hormonal treatments. Dr. Snow, thank you so much for joining us this evening. The screen is all yours.

Shari Snow:

Thank you, Eve, and thank you everyone who has chosen to spend an hour or so today with us here today. I'm going to go ahead and share my screen and then we'll get going.

Shari Snow:

All right. So as you said, my name is Shari Snow and I am chief of gynecology and minimally invasive surgery and part of the preventative oncology team at the University of Chicago. I want to thank Merck for sponsoring us today, but also to make mention that I am in no way affiliated with Merck and that anything that I speak of today is without any affiliation and I have no disclosures to make. But I do want to talk a little bit today about birth control and we'll touch upon fertility. I'm sorry. I don't mean to step on toes for the next talk, but we'll be brief. Then we'll really talk a little bit more about menopausal treatments as well, hormonal and non-hormonal and who can and who shouldn't. We'll talk a lot about risk, benefits and alternatives, all regarding breast cancer today, and everything we're going to talk about is very evidence based.

Shari Snow:

I'm going to have references at the bottom regarding the studies that I'm referencing if I'm talking about a study and we're going to try and make this as scientific as possible and at the same time, make it as approachable as possible so we all can walk away, hopefully, feeling like we've learned something or been able to at least share a little bit.

Shari Snow:

So let's talk about contraception. The contraception is a topic that oftentimes comes about before someone has been diagnosed with a breast cancer, and before we dive right into contraception, let's talk a little bit about what a hormone receptor is. So a lot of times when someone is diagnosed with a breast cancer, they're often told whether or not they're ER. Or estrogen receptor, or PR, or progesterone receptor, positive or negative. Well, what is a hormone receptor? It is a protein that sits on the cell service of a mammary cell. Just going to move this over there, excuse me. It increases gene expression. Basically it turns on and off a woman's DNA in their cells to make it so that they make or don't make more proteins. These proteins in return will modulate cell growth, tell a cell to grow, to not grow, or, even if it is a damaged cell, to die.

Shari Snow:

When there is a cancer that has an estrogen receptor or progesterone receptor on its surface, that can act as an effective target for treatment for an estrogen or progesterone positive breast cancer. But a lot of people get confused with estrogen and progesterone receptor positivity and sort of what causes or doesn't cause a breast cancer. So we all know that many birth control pills or many contraception options are estrogen and progesterone driven. So with birth control pills, they typically have both an estrogen and progesterone in them, but do they increase a women's risk of cancer? So oftentimes with these cancers that are pretty common, like breast cancer, one in every nine women, it's hard to figure out what actually makes an effect on it because it's so very common.

Shari Snow:

So the best way to look at this is with large, large populations of women. So the Danish Healthcare Database was an ideal place to study this and they looked at 1.8 million Danish women, total of 14 million years of women's lives were evaluated, and what they found was one extra case of breast cancer per 7,690 women. So only one extra case of breast cancer for over 7,000 women. This was for either people that were on estrogen and progesterone, or just progesterone only birth control pills. So that's a teeny tiny amount. So with that, the ACOG, American College of Obstetrics and Gynecology Society, they came out with a practice advisory that discussed this and said the risk of breast cancer is very low with using birth control pills. In fact, the overall risk of cancer is lower with birth control use than with no use at all, and that's due to the significant decreases in ovarian, uterine and colon cancers.

Shari Snow:

But why does everyone think it does? Well, we know, again, that breast cancer affects one in nine women, but birth control pills only cause one extra case for 7,690 women and a lot of this is because people attribute their behaviors to their disease. So when a survey was done, 80% of women with breast cancer attributed a cause for them getting breast cancer and about a third of them attributed their breast cancer to hormones. But clearly that wasn't the reason, or it's certainly not the only reason that these women did get cancer. The data study, albeit a large study, it took all comers. So it took women who had risk, had normal risk, had increased risk. So let's look at special populations who might be at increased risk of breast cancer and see what holds for them.

Shari Snow:

So how about people with a family history of breast cancer? Can they take birth control pills? Well, there was a meta-analysis done. A meta-analysis means that they look at a whole number of studies all together to pool all of those patients into one big category to say, "Can we think about a more global rule if we look at all of these patients together?" They looked at the results of 64 studies and across all the studies together, the risk is small to really non-existent of an increased risk of birth control pills, even if someone has a family history of breast cancer.

Shari Snow:

How about, as Suzanne talked about, people with a BRCA mutation? So as Suzanne referred to, there is a 50% reduction in ovarian cancer in women with a BRCA mutation if they take birth control pills for about five years. What the studies have shown is that there really is little to no increased risk of breast cancer by taking these birth control pills. So the bottom line here is for patients who have a BRCA mutation, the birth control pill will decrease the overall cancer risk and, very importantly, the risk of the cancer that doesn't have good screening and has a much worse prognosis being ovarian cancer. Without significantly increasing the risk of breast cancer, it leads to an increase in life expectancy in patients with BRCA.

Shari Snow:

So let's go off of birth control pills for a moment and let's talk a little bit about other forms of contraception. How about IUDs? Now, there are two forms of IUDs. There is the IUD that is made out of copper called ParaGard, and there's IUDs that have progesterone in them, which have a number of different names. There is Mirena, there's Kyleena, there's Liletta, there's Skyla, there's a whole bunch of them. So with the copper IUD, because it is non-hormonal, we wouldn't expect that there would be any increase in breast cancer and there isn't. But what about the progesterone IUDs? The same Dana study

looked at progesterone IUDs and found exactly the same risk as with birth control pills. The risk is really nominal. It is about one extra case of breast cancer in 7,690 women. So we think that progesterone based IUDs are safe for women who have risk of breast cancer.

Shari Snow:

Let's be clear, let's stop for a moment. If someone has a very early diagnosis of breast cancer, someone who's been diagnosed with breast cancer in their 20s, their 30s or 40s, at the time where they're diagnosed, hormonal contraception is no longer an option for them and this would include progesterone based IUDs. Because even though they work really locally right in the uterus, there still is some systemic or whole body absorption and so we would really recommend against any hormonal contraception with someone who has a diagnosis of breast cancer, but in women who have not yet had breast cancer, then all these hormonal birth control options are actually options for them.

Shari Snow:

There are other forms of contraception as well. So let's vary off the breast cancer track right now and let's talk a little bit about ovarian cancer. There's been a lot of study lately about whether or not taking out the fallopian tubes will decrease the risk of ovarian cancer. Let's start at the beginning. About 50% of what we call ovarian cancer, at least 50% arises in the fallopian tube. So we think of fallopian tube cancer, ovarian cancer, and extra ovarian cancer or primary peritoneal cancer is all the same entity. We know that removing the tubes and ovaries definitely decreases a woman's risk of having ovarian cancer or all the other cancers. We'll call them all ovarian cancer for right now. But a study was done taking a look at whether salpingectomy alone would decrease the risk of these cancers when compared to just tying a woman's tube or tubal ligation, or in doing a hysterectomy and leaving the tubes behind, not taking them out.

Shari Snow:

What they found is that taking out the fallopian tubes in normal risk women, that taking out the entire fallopian tube instead of just tying the tube or at the time of his hysterectomy, taking out the tube as well, instead of leaving them behind, had a significant decrease in ovarian cancer if you took the entire tube out. So really gone are the days where we recommend just tying woman's tube. We typically would recommend removing them all together if that is the choice that a woman had as far as contraception. So the bottom line is that most contraception options are safe for women who do not have a personal history of cancer, and this does include women with a family history of breast cancer or a BRCA mutation.

Shari Snow:

So let's very briefly talk about fertility and breast cancer. Does fertility treatment cause breast cancer? There were, again, one of these meta-analysis where they take all the studies and kind of put them together and it looked at 25 studies, including over 600,000 women and over 30 years of data and found that there was no increased risk of breast cancer with either Clomid or in vitro fertilization. Furthermore, women who have been recently diagnosed with breast cancer are oftentimes put in a difficult position, as Suzanne so graciously shared with us, that when she was facing her young breast cancer diagnosis, that she still wanted to leave the door open with further possibility of having another baby.

Shari Snow:

So her doctors talked with her, she talked to her doctors, about the possibility of wanting to do some fertility preservation or egg harvesting at that time. In fact, when surveyed, about 50% of young women diagnosed with breast cancer have a desire to consider future fertility to preserve their fertility. So what can be done is ovarian stimulation, basically the first half of in vitro fertilization, where they harvest the eggs and they can either freeze the eggs alone, or if they have a partner that they'd like to preserve embryos with, then the embryos can be made and those embryos can be frozen. This whole process takes about two to four weeks. With that very brief interlude, we can preserve a woman's fertility options and the data shows that there's no difference in either the short term outcome, as far as their breast cancer or in their long term survival.

Shari Snow:

So we really should be able to offer our patients with breast cancer a option to preserve their fertility treatment, and in people who need to undergo fertility treatment who don't have any present diagnosis of cancer, that certainly they're not putting themselves at excess risk by considering fertility treatment.

Shari Snow:

So now onto the ... we've gone through the entrees, let's talk about the main course here and menopause. So menopause can affect breast cancer women in a number of different ways, all due to a decrease in estrogen levels. The first is that there can be premature onset of menopause due to breast cancer treatment itself. Oftentimes, if a woman undergoes chemotherapy, as Suzanne shared with us, the chemotherapy will actually create or put them into an early menopause. Because breast cancer oftentimes affects women in their 40s and early 50s, a woman may be spontaneously entering menopause during or just after their breast cancer treatment, just because their clock was due to do this and not related to the breast cancer treatment itself.

Shari Snow:

Women who have a BRCA mutation are advised to have their ovaries and fallopian tubes removed between the ages of 35 to 40 in women with BRCA1 or between 40 and 45 for women with BRCA2. So with the removal of the tubes and ovaries, specifically the ovaries, this would create what we call a surgical menopause or very abrupt menopause in these women. Some women are postmenopausal when they are diagnosed with breast cancer, but have been on hormone replacement therapy at the time of their diagnosis and are told that they should stop their hormone replacement therapy, leading into an abrupt onset of their menopausal symptoms.

Shari Snow:

So what do we know about hormones and the risk of breast cancer? The largest study that we have to date is the women's health initiative or the WHI study that was done about 15 to 20 years ago. It was a large population base study, and they took women who were menopausal and they placed them on hormone replacement therapy and they took a look to see whether or not they had an increased risk of breast cancer. What they found is not only did they look at breast cancer, but at all sorts of different problems and they found about 25 adverse events or complications per 10,000 women per year. So they found this in heart disease and stroke and blood clot and breast cancer, and in breast cancer in particular, they found about five extra cases per 10,000 women years. Again, a super, super small number.

Shari Snow:

So if we think about one out of every nine women is destined to get breast cancer, and this increases the rate of breast cancer by about five extra breast cancers per 10,000 women, what we really know about hormonal placement therapy is that the risk is very, very low. So let's talk a little bit about menopause for those who are perhaps not in it yet and/or those who are in it but may not have the full menopausal spectrum. What is most bothersome about menopause is oftentimes vasomotor symptoms or hot flashes and night sweats. These occur in about 60 to 80% of women, but only about 30% of women seek treatment. Sometimes because these hot flashes or night sweats are really manageable and sometimes because women don't understand that there are options for them and that they should talk to their clinician, their physician, or mid-level provider about what options are available to them.

Shari Snow:

How long do hot flashes last? Well, the average median is about seven and a half years. About 15% of women will still have hot flashes at 15 years and the unlucky 8% of women may still have them at 20 years after their periods end. Oftentimes women will have sleep disturbance. This happens in about a third of women, and it may be confounded. It may be associated with depression, anxiety, sleep apnea, restless leg syndrome, and certainly maybe the side effect or be caused by having hot flashes and night sweats, which arouse their sleep and keep them from sleeping soundly. Many women will experience depression or anxiety. There's about a two and a half time increase in the likelihood of developing depression or anxiety post-menopausally as there is premenopausal. Again, this may be confounded by sleep disturbance and not feeling well.

Shari Snow:

Cognitive changes or memory. This is really difficult to measure or quantitate, but it's broadly reported and most people do perform more poorly in cognitive studies when they are menopausal and not taking estrogen. Joint pain. This can be up to 50% of people have aches and pains that oftentimes will go along with depression or anxiety. So there's that commercial on TV that is depression hurts and this medication helps, and oftentimes joint pains are associated with not feeling well.

Shari Snow:

Lastly, as Suzanne talked to us about, is genital urinary symptoms, which affect the bladder, the vagina, the libido, and this is a common occurrence as well. You can see how they're all very interrelated. Hot flashes and night sweats can cause sleep disturbance. Sleep disturbance can cause depression or anxiety, not sleeping well can make you not think so clearly. Any of us who have had a baby remember not thinking so clearly postpartum when you're not sleeping. Joint pain oftentimes is associated with depression/anxiety, so all of these can sort of play off of each other.

Shari Snow:

So if someone has a history of breast cancer themselves, can they take RT? So although there are studies in Europe that show that in people who have a remote history of breast cancer, they are at least five years out from their breast cancer and they have no detectable active disease, there actually is no difference in survival if people take hormone replacement therapy. But the question is is this doesn't make a lot of sense to me. This conflicts with our Tamoxifen data that shows that if you decrease the estrogen level, that there should be a better survival, a decrease in recurrence. Most oncologists, certainly in the United States, will advise against using systemic or whole body hormone replacement therapy after a diagnosis of breast cancer, and this is typically even in women who have a triple negative

or estrogen receptor negative breast cancer. It just doesn't seem wise to take hormones after breast cancer.

Shari Snow:

Can you, though, if you have never had a history of breast cancer? Can you or should you take hormone replacement therapy if you've had your tubes and ovaries removed? So again, women with a known mutation in BRCA typically will have a risk reducing bilateral salpingo-oophorectomy or taking out their tubes and ovaries between the ages of 35 and 45. We know that actually this taking out of the tubes and ovaries decreases the risk of breast cancer by about 50% in women who have a BRCA mutation and even if they take hormone replacement therapy. We know from other studies that removing the ovaries before the age of 45 years old and not giving back hormones, not giving back estrogen, increases the all cause mortality, or actually shortens the life expectancy slightly.

Shari Snow:

So in women who are undergoing a risk reducing bilateral salpingo-oophorectomy, or taking out the tubes and ovaries, who do not have a history of breast cancer, the ASCO, or the Association of Clinical Oncologists, recommends that hormones should be taken and should be offered to these women. Again, only if they've not had a history themselves of breast cancer.

Shari Snow:

So what about women who have had breast cancer? Let's really talk about that. What can you do that is non-hormonal? Let's start with the behavioral, the non-medication types, and then we'll work into some of the medications. So there's a lot of talk about what works, what doesn't work, what can you try, what can't you try? There is some modest data about things that do work, and that includes weight loss, cognitive behavioral therapy or CBT, taking increased amounts of vitamin E, hypnosis and mindfulness, meditation and mindfulness. There's actually conflicting data. So certainly the ones with modest data should absolutely be tried by women who are trying to decrease the severity of their vasomotor symptoms. There's conflicting data, or very limited data, in some of the other treatments. Some of the over the counter phytoestrogens that you can find in the supplement section. There's, first of all, no data as far as breast cancer, and they should not be used by anyone who has had breast cancer, and the data on whether or not they're effective is pretty low to begin with.

Shari Snow:

Black cohosh is another supplement. It is a regulator of estrogen, and therefore, I believe it should not be used in women who have a history of breast cancer, because it just hasn't been studied in large populations. Acupuncture exercise certainly can be used in women with breast cancer, but there's fairly conflicting data as to whether or not it's really effective. So let's talk about some medications that have proven data that are effective. The first category I want to talk about is the SSRIs and SNRIs. So these are the anti-depressants and anxiolytics such as the ones that are listed here on the slide. They are pretty effective in decreasing the severity of hot flashes and night sweats and it's pretty interesting as how this came about. This was actually found in patients who had breast cancer.

Shari Snow:

Remember I said that one of the populations of menopausal women that are really affected by breast cancer are the people who were already menopausal and on hormonal replacement therapy. In this population who were told to go off of their hormone replacement therapy, many of them had onset or

return of their menopausal symptoms or hot flashes or night sweats. A subset of these women also happened to have anxiety or depression and perhaps because of both their menopausal symptoms and/or their cancer diagnosis, and so they were given antidepressants or antianxiety medications to treat their anxiety or depression and they found that their hot flashes went away. So that's how we first got the clue that hot flashes and night sweats could be helped by this brand of medication.

Shari Snow:

In fact, there are a couple of these medications that have actually undergone FDA approval for the actual treatment of hot flashes. However, most of them actually work. Whether or not they've gone through the FDA approval process for this indication, almost all of them decrease hot flashes and night sweats. Of course, these medications, because they do treat anxiety and depressions, may have mood side effects. So you may find in women who you try this medication that you find a flattening of your mood or don't feel yourself. Some people that start these medications for anxiety or depression can have other side effects too and of course, those science side effects can be present if you start them for hot flashes or night sweats.

Shari Snow:

There is also the possibility of decreasing the effective of Tamoxifen, the effectiveness of Tamoxifen. So you're going to really want to talk to your oncologist about whether or not it's appropriate for you to take anxiety or depression medications if you are on Tamoxifen, and especially if you're on the five milligram, lowest dose of Tamoxifen. It can be used, but you want to talk to your physician about the implications.

Shari Snow:

The next category of medication I want to talk about is the pollen extracts. Some of the brand names of these medications is Relizen or Sorenel. This is a bee pollen extract from Scandinavian pollen. It typically has no side effects and it has no change in estrogen levels. It has been studied in breast cancer patients. They did do serum levels of estrogen and found that they did not increase estrogen levels. So this is thought to be a safe alternative for women who have breast cancer who want to treat their symptoms. Another medication that has been used in treating menopausal symptoms in breast cancer patients is gabapentin or pregabalin. It can have the side effect of causing sedation, drowsiness. Gabapentin actually tried to undergo FDA approval for the treatment of hot flashes and night sweats. It tried to get that indication from the FDA and it was not successful and it was not successful because it was not found to be effective enough in treat hot flashes and night sweats.

Shari Snow:

Certainly there's a wide variability in individuals who gets help from it and who isn't helped as much for it. It certainly is worth a try in someone who has had a breast cancer diagnosis to think about this as one of the options, even though it hasn't gotten official FDA approval for this particular indication. Of course, it is FDA approved, but is FDA approved for other reasons. Clonidine is an FDA approved blood pressure medication and so it can decrease hot flashes and night sweats. But of course, because it is a blood pressure medication, it can cause low blood pressure and sometimes people get a little woozy upon standing. This typically is a short-lived side effect and after your body adjusts to it, usually those symptoms will go away, but there is also one important caveat and that is if someone abruptly stops the Clonidine, they can get rebound high blood pressure. So the blood pressures can go up very acutely, so

you really want to make sure that you're only doing any changes in taking it under a doctor's supervision.

Shari Snow:

Lastly, there's a medication called oxybutynin, oftentimes used for the bladder, that can decrease hot flashes and night sweats. It has a side effect of causing dry mouth, sometimes dizziness or GI side effects so it's not used quite as often as some of the other medications. There are a number of other medications that are presently either under investigation or have recently been approved by the FDA for hot flash treatment in patients without breast cancer, but there just haven't been any good studies as far as their effect in patients with breast cancer. So I'm not going to talk about them today because I think at this point they should really be considered experimental in a breast cancer patient and probably should not be considered.

Shari Snow:

So let's talk about what Suzanne talked about and that is vaginal dryness. So with being menopausal, having the estrogen levels lower, there is a natural thinning of the wall of the vagina. There can be a sense of dryness and irritation. Sometimes it can even feel like someone has a yeast infection because the symptoms are so similar. Some people get more prone to having urinary tract infections and/or can feel like they have urinary tract infections when they actually don't have any bacteria in their urine, and all of these symptoms can be really bothersome. On top of that, it can really lead to painful sex or inability to have penetrative sex and so many women with breast cancer look for a treatment to try and help all of these symptoms. So the question is can a woman with a history of breast cancer use vaginal estrogens? This would be like the Vagifem that Suzanne mentioned.

Shari Snow:

What we know is that the serum estrogen levels really increased by only about five picograms per milligram, which is a teeny tiny amount, and in many women won't elevate at all. In fact, once you've taken vaginal estrogen for a month or two, because it does help to thicken the vaginal walls, then less estrogen actually gets absorbed into the bloodstream and so those levels, if anything, drop back down toward normal. We know that there isn't any significant bloodstream absorption of these medications because we don't see its effect on the uterus. They've looked at does it thicken the uterine lining back to premenopausal stage, and it does not. Be warned though that although we really think there is no real significant increase in blood levels of estrogen, we know it doesn't have effect on other tissues or organs, that the FDA continues to have what we call a black box warning on all the vaginal estrogen products.

Shari Snow:

Effectively, it has the same warning that it has on people who are taking estrogen by mouth, as far as risk of breast cancer, as far as risk of heart disease, as far as risk of blood clot. The North American Menopause Society and the American College of Obstetrics and Gynecology have petitioned the FDA to remove this warning because we know that so little of this medication does get absorbed. But as of right now, unfortunately, this warning still persists. So I always want to let patients know before I put them on vaginal estrogen that this warning is still there because I don't want them to get worried should they read the package insert. But very clearly the American College of Obstetrics and Gynecology put out a position statement in 2016 that says vaginal estrogens may be used in women with a history of estrogen receptor positive breast cancer if other modalities have failed. So they say it's not only appropriate for

women who have had a history of breast cancer, but specifically in women who have had estrogen receptor positive breast cancer, that it's still okay.

Shari Snow:

But what can be tried first? So I'll tell you, even in my patients who haven't had a history of breast cancer, I always go in a stepwise fashion when someone is having vaginal dryness and menopausal effects on their genital urinary tract. The first thing I'll ask is if this is predominantly a problem when they're trying to have penetrative intercourse, when they're trying to have sex. If it really is predominantly limited to having sex and not feeling like they have a yeast infection or feeling like they have a bladder infection, I'll encourage them to try a silicone based lubricant first. There are many different types of lubricants, there's silicone based, water based oil based. Now be careful with oil based. Some of the oil based lubricants get very tacky, sticky. Coconut oil is the one that actually is the least tacky and sticky and works the best.

Shari Snow:

So over the counter, normal find in the grocery stores, coconut oil can be used safely as a vaginal lubricant, as can all of the silicone based and water based lubricants. As well there is a class of medication that are vaginal moisturizers, and these are typically two different categories. One of them is called Replens and it's a proprietary blend, but it is all non-hormonal and this Replens, some people love it, some people don't love it so much, but it's certainly worth trying as a next step, along with a different class of medication, which is the hyaluronic acid, which is a horrible name for something that actually is found in a lot of skin creams that are used on the face that increase the plumpness of the face and moisturize the face to make it appear younger.

Shari Snow:

Well, it has the same effect on the vagina. It will plump the tissues, it will add moisture, it will make them more supple. So all of the vaginal ... don't use the facial products, all the vaginal hyaluronic acid products and Replens can be used as moisturizers. These moisturizers are not used when you want to have sex. They are used kind of routinely, typically about three times a week before you go to bed, and then on top of that, you would want to use a vaginal lubricant when you're actually wanting to have sex.

Shari Snow:

Other things that can be helpful is sexual activity itself. There is sort of something to the use it or lose it old adage, and that is that with sexual activity, it actually increases some of the blood flow to the tissues and can increase the suppleness of the tissues to make sex more comfortable. You do want to be careful not to traumatize the tissue, so I don't recommend having sexual activity if it is very painful without trying the lubricants and the moisturizers along with it. There are other ways to be sexually intimate other than penetrative intercourse, and certainly outer course or being sexually intimate and active without penetrating the vagina is certainly an option. Then the use of dilators and pelvic physical therapy can be very helpful.

Shari Snow:

I have not put on this list the laser treatments and I've neglected to put them on for a reason. The laser treatments, such as the Mona Lisa Touch and other modalities, while they definitely do have a beneficial effect in the beginning as far as making intercourse more comfortable, there have been some warnings that the FDA is put out regarding the need, number one, for follow up treatments, but just as

importantly or more importantly, that there can be an effect afterward of a decrease or scarring of the vaginal tissue. So I think that we do need some longer term studies before I can put this out as something I want everyone to consider, but as we get more studies, it may make it on my list.

Shari Snow:

So let's talk about what we've talked about today. The bottom line is, number one, talk to your doctor. Don't go this alone. Find someone who really is comfortable in talking about the hormonal aspects of both the risks of breast cancer and after you've had breast cancer, what are the options as far as treating your symptoms, because there are many things that we can talk about. So that's the end of what I wanted to prepare and talk about today, but I definitely wanted to leave some time for questions. Even, I'm going to turn it back over to you.

Eve:

Thank you, Dr. Snow. That was an amazing presentation and I know that we all have learned so much. We definitely have many questions that have come in both in advance of this evening, as well as in the chat box this evening. I do want to let everybody know that if there are questions that we aren't able to cover right now, we will follow up with Dr. Snow and hopefully be able to send an email out with some of those answers that we run out of time for. We'll start with some of the menopause related questions, because that's what you just ended with. There were many questions that came in related to hormone replacement therapies after triple negative breast cancer specifically and if there are options or if that applies to [inaudible 00:50:10] restrictions would reply to the vaginal creams or vaginal creams would be permitted after triple negative.

Shari Snow:

Sure, sure. So most oncologists are going to feel a little skittish about giving hormone replacement therapy to women, even who have had triple negative breast cancers. However, I have worked with some oncologists who will allow this for people who have tried other modalities and those symptoms just don't work for the patient and they've got some longevity or they've got a long distance from the time they were diagnosed until the time their menopause starts and they are now symptomatic. So I have used it, seen it used, agreed with oncology in partnership, prescribed it, but pretty rarely. So it's one that has to be considered pretty carefully. We just don't know. We don't have enough data to say whether or not there may be any impact.

Shari Snow:

Regarding vaginal estrogen, I like to make the analogy. If you had a rash, you could put a little cortisone cream on it. That cortisone cream really acts locally just where that rash is. It doesn't get absorbed all through your body and your whole body doesn't feel it. That's really different than, say, taking prednisone that would go through your whole body and has a lot of effects throughout your body and side effects. That's the same as vaginal estrogen versus hormone replacement therapy. So hormone replacement therapy definitely does increase your hormone levels throughout your body in your bloodstream. Vaginal estrogen typically does not significantly increase the bloodstream because it really works locally just on the vagina and vulva.

Eve:

Great. Thank you. A bunch of questions came in as well about the possible use of testosterone treatments as a option that did not involve estrogen post cancer. Can you speak to that?

Shari Snow:

Sure, sure. So the first and most important thing to know about testosterone is what happens to it in the body, and that is that in our fat cells there is a protein called aromatase. What aromatase is entire job is to take testosterone and estrogen and convert them from one to the other. So when you would be taking testosterone, you really are going to be effectively taking estrogen. The converse is true too. So when you're taking estrogen, testosterone levels may rise slightly in the body as well. So I don't believe that testosterone vaginally is any safer than the vaginal estrogen, which we have so much more data on.

Eve:

That makes sense. Then some questions came in regarding ovarian cancer and if one is post ovarian cancer but has never had breast cancer, is it possible that they would be able to use hormone replacement therapies to help with those symptoms?

Shari Snow:

Yes. So again, you'd want to be talking to your gynecologic oncologist about the particular characteristics of your ovarian cancer and whether or not they feel that it would be advisable, but when someone has longevity after having ovarian cancer, many gynecologic oncologist would clear someone to be able to take a hormone replacement therapy. But again, it's a case by case basis and you want to make sure you get excellent advice.

Eve:

Yes, absolutely. Then switching back to the birth control discussion from the earlier part of your presentation, if somebody is either high risk for breast cancer or has had an experience with breast cancer in their own past, you talked about the limited increase, or if at all, of risk from taking hormonal birth control, but is there a preference between birth control pills with estrogen, let's say, versus an IUD if you were in that scenario?

Shari Snow:

Yeah. So let's be really, really clear. If you have had a personal history of breast cancer, you should not use any hormonal birth control period and pause.

Eve:

Sorry. I stand corrected. My apologies.

Shari Snow:

No, it's fine. It's fine, but I just don't want anyone to walk away from this with wrong information. So, again, that big old Danish study, which is the best study we have on contraception and really shook our gynecologic world about five years ago, what we found is a little surprising, but found that the estrogen and progesterone birth control, the progesterone only birth control pill and the progesterone IUD all have the same risk of breast cancer, that teeny tiny increased risk. Again, keep it in perspective, if baseline have a 13% chance of breast cancer and you're adding a one in 7,000 chance of breast cancer, it's kind of a drop in the ocean.

Eve:

Yeah, absolutely. That's great. The other question is if somebody knows, let's say, that they had an estrogen receptive breast cancer, and now they're considering what their daughter should use in terms of birth control, would that same guidance still apply even though they know about the mother's diagnosis?

Shari Snow:

Yeah. So those other studies really showed that ... they looked at ... I think it was 64 studies altogether in patients who had a family history of breast cancer and found no increased risk. So I do think that it is safe to consider birth control pills if someone has a relative with breast cancer.

Eve:

Great. Thank you. I know that we had many other questions that came in and as I mentioned, we will send those to Dr. Snow and hopefully get some responses for you all. I apologize that we are running out of time, but I do want to thank Dr. Snow for educating us on such an important topic for all of our callers and for all of us on screen. Your presentation has answered so many of our questions and I know that everybody here has benefited. I also want to thank our sponsor for this evening, Merck. It was thanks to support from Merck that we were able to have webinars like tonight. For information on our future webinars, you can check out Sharsheret's website and I also want to link our brief evaluation survey this evening. It's going to be put in the chat box right now. You can click on it now, and you'll still be able to hear me in the background, but our evaluations really do inform our future programming.

Eve:

So if you're able to take a moment and fill out that survey, that would be helpful for us as we plan our future webinars. Please also check out our website regularly. We do have a busy summer ahead with exciting events that are being offered both in person and virtually, and you'll be able to see upcoming events as well as access any of the recordings and transcripts from our past webinars. If you are interested in the recording or transcript from tonight's webinar, that should be available next week in that same section. Please never forget that Sharsheret is here for you and for your loved ones during this time. Sharsheret provides emotional support, mental health counseling, and other programs designed to help you navigate your cancer experience. All of our programs are free, completely private, and one on one. Contact information for Sharsheret is in the chat box now and our social workers and genetic counselor is available to each and every one of you. You're our priority so please do not hesitate to reach out. I want to thank everybody for participating this evening and have a great night.

Shari Snow:

Thanks to everyone.