

HRT For Survivors and Previvors: What You Need to Know

National Webinar Transcript

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Presented by:



SHARSHERET[®]
The Jewish Breast & Ovarian Cancer Community

About Sharsheret

Sharsheret, Hebrew for “chain”, is an international non-profit organization, that improves the lives of Jewish women and families living with, or at increased genetic risk for, breast or ovarian cancer through personalized support and saves lives through educational outreach.

With regional offices in the Midwest, Northeast, Southeast, West, and Israel, Sharsheret serves 275,000 women, families, health care professionals, community leaders, and students. Sharsheret creates a safe community for women facing breast cancer and ovarian cancer and their families at every stage of life and at every stage of cancer - from before diagnosis, during treatment and into the survivorship years. While our expertise is focused on young women and Jewish families, approximately 25% of those we serve are not Jewish. All Sharsheret programs serve all women and men.

As a premier organization for psychosocial support, Sharsheret works closely with the Centers for Disease Control and Prevention (CDC) and participates in psychosocial research studies and evaluations with major cancer centers, including Georgetown University Lombardi Comprehensive Cancer Center. Sharsheret is accredited by the Better Business Bureau and has earned a 4-star rating from Charity Navigator for four consecutive years.

Sharsheret offers the following national programs:

The Link Program

Peer Support Network, connecting women newly diagnosed or at high risk of developing breast cancer one-on-one with others who share similar diagnoses and experiences

- Embrace™, supporting women living with advanced breast cancer
- Genetics for Life®, addressing hereditary breast and ovarian cancer
- Thriving Again®, providing individualized support, education, and survivorship plans for young breast cancer survivors
- Busy Box®, for young parents facing breast cancer
- Best Face Forward®, addressing the cosmetic side effects of treatment
- Family Focus®, providing resources and support for caregivers and family members
- Ovarian Cancer Program, tailored resources and support for young Jewish women and families facing ovarian cancer
- Sharsheret Supports™, developing local support groups and programs

Education and Outreach Programs

- Health Care Symposia, on issues unique to younger women facing breast cancer
- Sharsheret on Campus, outreach and education to students on campus
- Sharsheret Educational Resource Booklet Series, culturally-relevant publications for Jewish women and their families and healthcare Professionals

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Jenna:

All right, we're going to get started. Thank you everyone for joining us for tonight's webinar, Hormone Replacement Therapy for Survivors and Previvors: What You Need to Know. Tonight's Speaker is Rachel Frankenthal, Physician Assistant at UCLA Medical Center and Menopause Society Certified Practitioner.

I'm Jenna Fields, the Chief Regional Officer of Sharsheret. For those of you not familiar with Sharsheret, we provide free, virtual, personalized support, lifesaving education, financial assistance, and genetic counseling to empower those faced with or at increased genetic risk for breast cancer and ovarian cancer.

I want to give a special thank you to tonight's sponsors, Merck, Lily, Novartis, and Pfizer. Without their support, we wouldn't be able to bring you this important educational information.

Before we begin, just a few housekeeping items. Today's webinar is being recorded and will be posted on Sharsheret's website along with the transcript. Participants' faces and names will not be in the recording.

If you would like to remain private, you have the option to turn off your video and rename yourself or you can call into the webinar. We also have closed captioning available. You may have noticed you are muted upon entering the Zoom. Please stay muted on this call. We will hold a Q&A at the end of the presentation, and if you have any questions during the presentation, just type them into the chat box and we'll get to as many as we can during the Q&A.

Please keep your questions as general as possible as we cannot comment on specific medical concerns. I want to remind you that Sharsheret is a not-for-profit cancer support and education organization and does not provide any medical advice or perform any medical procedures.

And our full medical disclaimer is in the chat. A few program highlights. Sharsheret recently launched monthly virtual support groups for those who've been diagnosed with breast cancer and ovarian cancer. We have one for those in survivorship for stage zero to three, and one for the Embrace community, those living with metastatic breast cancer or advanced ovarian cancer. If you're interested in our support groups, the link is in the chat.

I also want to make a plug for our nutrition education sessions. Sharsheret offers 30 minute one-on-one, totally free, virtual nutrition education sessions with cancer nutrition registered dietician, Tamar Rothenberg.

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You can get your questions answered, ideas of what to eat during treatment and methods to meet your nutritional goals. To schedule an appointment, contact your Sharsheret social worker, and information about that is in the chat as well. If you're a member of our Embrace program, someone facing metastatic breast cancer or advanced ovarian cancer, we invite you to stay on this Zoom following the Q&A for a more intimate breakout session with our expert speaker.

This Embrace breakout session is sponsored by Lily and Pfizer. Before we welcome our expert, Rachel Frankenthal, we are inviting a Sharsheret program participant, Natalie Merchal, to come and share her story. It is now my pleasure to introduce Natalie. It looks like you're mute. Perfect, Natalie.

Natalie:

Hi, sorry. I thought it would happen automatically.

My name is Natalie. I'm a wife, a mom, a daughter, a sister, and a friend. I work in market research, not the kind where companies help pick out new packaging, but I actually do medical research. Oops, sorry, I actually do medical research and I work on studies on how to get doctors and everybody to participate.

So when I came across a study several years ago about people testing for the BRCA gene mutation, I'm like, "Okay, I'll help them in LA get to their 1000 people who take the test and everything will be fine." Lo and behold, everything was not fine. I actually found out that I was BRCA2 positive and it was quite shocking, but I was like, "No, this can't be. It's just not possible." The first thing I did, I actually reached out to Sharsheret and I spoke to a genetic counselor and they gave me some options as to what to do for what I can go and do.

And it was either do nothing, get screened every six months or go and have preventative surgery. So for me, going every six months for screening didn't feel right for me. That's not what I wanted. I decided to have a preventative double mastectomy with immediate reconstruction in July of 2019.

I found my team at UCLA. They were amazing and they were wonderful and everything went well. Thank God the recovery was great. Everything was perfect. A few days after my surgery, my breast surgeon called me and she said they found a two millimeter DCIS, which is the earliest form of cancer and it's smaller than the tip of a pencil. She said, "There's no way it would've come up in any screening. They don't know how fast it would've grown or how long it would've taken, when it would've turned into actual cancer." So it helped me feel comfortable that I decided to go and have the surgery.

Three months after my recovery from the double mastectomy, I went and had my ovaries and my fallopian tubes taken out. And that was a little bit more of an intense surgery just because you... There just was a lot more going on in your brain about being 41, going into menopause. So my doctor put me straight away on hormone replacement therapy. I kept my IUD because she said, "It's working. Why not? Why should we take it out for you?" And then I was on the estradiol patch. I've been on the same dosage for the last six years and I have had zero symptoms. I haven't had any kind of side effects. It's been, as they would say, like smooth sailing, perfect patient, however they want to explain it, Rachel could probably say things better.

And it just was, for me, it was the right route because I have less than 1% chance of recurrence or of any form of breast cancer because of the mastectomy.

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I could be on any form of hormone replacement. There were no restrictions for me and then that's it. So that's my story. Thank you.

Jenna:

Thank you, Natalie, so much. We're always moved by your experience that you've shared many times with the Sharsheret community. I'm grateful every time that you share such a personal journey with us. So thank you for doing it today.

Natalie:

My pleasure. Thank you.

Jenna:

Sharsheret is now thrilled to welcome tonight's expert speaker, Rachel Frankenthal. She is a board-certified and licensed physician assistant and Menopause Society certified practitioner with a master's in public health. She specializes in gynecologic oncology, treating women with gynecologic cancers, as well as women at high risk for cancer due to genetic mutations.

She developed the menopause clinic for cancer survivors at UCLA and has played an integral role in developing the GYN Cancer Survivorship Program. She's a certified yoga and Pilates instructor and on faculty at Heather Hirsch Academy, where she teaches a course on hormone therapy for gynecologic cancer survivors.

And I've had the pleasure of knowing Rachel since we first launched the LA Office of Sharsheret and she first came to LA almost 10 years ago. And I'm thrilled to welcome her tonight for one of our best attended webinars of the year. This is certainly a hot topic and we're just so glad to have you, Rachel.

So thank you and welcome.

Rachel Frankenthal:

Thank you so much for having me. I'm truly so honored and so excited to be here tonight talking about... It is a hot topic for good reason, and we're going to get into that. I'm going to share my screen. We're going to get right into the slides. Let me know if you can't see this. Hold on one second. All right.

Jenna:

Looks good.

Rachel Frankenthal:

We good?

Jenna:

You are good.

Rachel Frankenthal:

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All right, cool. So let's just jump right in. Thank you, Jenna, for the wonderful introduction. I'm going to skip this slide. Our objectives for tonight, I want to make sure that we are all on the same page. So we are going to go over menopause basics, okay? It's important that we all are speaking the same language.

We're then going to get into the hormone replacement therapy guidelines for previvors, our genetic mutation carriers. Then we're going to go into the systemic hormone therapy guidelines for gynecologic cancer survivors.

So when I say systemic hormone therapy, I'm talking about delivering hormones into the body where they go everywhere, the brain, into the bloodstream throughout the entire body and the brain. So that's considered systemic hormone therapy. So we're going to talk about that for GYN cancer survivors. Then we're going to talk about the systemic hormone therapy guidelines for breast cancer survivors.

Then we're going to switch gears and talk about the vaginal hormone therapy guidelines. So when I say vaginal hormone therapy, this is topical low dose vaginal estrogen therapy or combining estrogen and testosterone. But the point is that it is vaginal hormones, vulvar hormones. They are not systemically absorbed. They're local. There's skincare for down there, okay? So that's what we're going to do tonight.

All right. Okay. Starting off with menopause basics. So menopause occurs when the ovaries stop producing eggs as well as the hormones, estrogen, progesterone, and to a lesser degree, testosterone. So that's what's actually happening in the body.

We are losing our reproductive function and we are losing these hormones. The medical definition, if you look it up, is 12 months without a period, but this definition does not apply to many of our survivors and our previvors. So many survivors and previvors will experience treatment-induced menopause. So that can happen in a few different ways. They can undergo surgical removal of the ovaries, and that's what a lot of our previvors and ovarian cancer and other GYN cancer survivors experience.

Chemotherapy induced menopause. So chemotherapy is toxic. The ovaries are very sensitive organs. Sometimes the ovarian function shuts off and people lose their periods. Sometimes they regain ovarian function.

They get those periods back. Sometimes they don't. Radiation-induced menopause, so if someone has pelvic radiation therapy and the ovaries have not been moved out of the radiation field, they will 100% go into menopause because the ovaries can't withstand that level of toxicity from the radiation. And then there's medically induced menopause from medications like Lupron that shuts off the ovaries or medications like aromatase inhibitors, which really suppress systemic levels of estrogen.

Sorry. Okay. The average age of menopause in the United States is 51 to 52 years old. Early menopause is defined as anyone who goes into menopause before the age of 45, and premature menopause is anyone who goes into menopause before the age of 40. We're not going to talk about perimenopause tonight, but I want to mention it briefly. This is the transition to menopause. This can take up to 10 years where the ovaries, again, are losing ovarian function. We start to see periods become more erratic, hormone fluctuations.

And most women, if they're not going into induced menopause, again, are going to have 10 years for the body and the brain to adjust to these changing hormones before they actually go into menopause.

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Historically, the hormones, estrogen, progesterone, and testosterone have been labeled reproductive or sexual hormones, but this very narrow view undermines the extensive role that these hormones play throughout the body and the brain. So as you can see in this picture, we have receptors for these hormones on every single cell of the body, every organ system of the body.

So these are not just sexual reproductive hormones. This is why we have so many potential menopause and perimenopausal symptoms, because remember, this is a full body, brain experience. Everyone experiences perimenopause and menopause differently. There is not one universal experience.

People who get put into treatment-induced menopause or induced menopause because they're preivors, oftentimes experience more severe menopausal symptoms. And that's because you're not getting that 10-year time for your body and your brain to adjust. You are going into abrupt menopause. And in your whole body and brain, they're experiencing that exquisite drop in hormones, so it can be a real shock for the body and the brain.

What I want you to notice here are the underlying symptoms. So these underlying symptoms are some of the most common bothersome symptoms of menopause, anxiety, brain fog, depression, hot flashes, memory issues, mental health changes, sleep disruption. What do you notice about all of these symptoms is that they're actually neurological symptoms. So these hormones are neuroendocrine hormones, and some of the, I think, most kind of scary symptoms are these neurological symptoms.

These are the symptoms why women really don't feel like themselves, right? The mental health changes, the brain fog, inability to think in the same way, tolerate stress, resiliency. So again, I really want us to shift the way we think about these hormones, again, from being just about reproduction to really full body hormones.

Estrogen is a very powerful anti-inflammatory hormone. So when estrogen drops, we see an acceleration of chronic diseases and inflammation in the body. So when we lose estrogen, we see an increased risk in cardiovascular disease. So without changing anything about your diet or the way you move or anything like that, you might notice that your cholesterol goes up, your blood pressure goes up.

We lose a significant amount of our bone mineral density during the menopause transition. So that leads to osteopenia, osteoporosis. This is bone thinning. This leads to increased risk of bone fractures, which can be very, very debilitating and are associated with a really high risk of mortality. Insulin resistance, this directly leads to an increased risk of diabetes. So you might notice your A1C goes up without doing anything. This is also why women gain weight, why they have body composition changes is from this insulin resistance from the drop in estrogen.

Brain, neuroinflammation. So this is where we get our brain fog from, difficulty with words. You walk into a room, you forget why you're there. All right, that's the neuroinflammation and the loss of blood flow to the brain. The genitourinary syndrome of menopause and sexual health challenges, this is from the loss of hormones, mostly in the vagina, the bladder, the vulva, and the pelvic floor. We're going to talk about it.

And then there's a 30% decrease in collagen in the first five years of menopause, and this is what causes a lot of the skin, hair, and nail changes. So I'll have patients come in and say, "I went into menopause a year ago from my cancer treatment, but I feel like I've aged five years." And I'm like, "Well, you kind of have in a sense, right? Because we really see these changes when we lose estrogen."

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So because of all these changes happening in the body, there is not one medication, including hormone therapy that is enough to fully optimize midlife health. The backbone of our health moving forward, starting when we start to lose these hormones is lifestyle.

So even though we're going to talk about hormone therapy for the rest of this webinar, I cannot overemphasize the importance of a healthy lifestyle to maintain both your quality of life and your long-term health as you age when you're going through this transition.

We're not going to get into it today, but this is how we eat, how we move, prioritizing sleep, mental health, stress reduction, and then of course using medications, maybe non-hormonal medications, hormone therapy, supplements to support our goals as well. And if you cannot take hormone therapy, I also need to mention that it is not all doom and gloom. We have many non-hormonal options.

And again, really the most important thing is your lifestyle. All right, but now we're going to move into the hormone therapy section. What we know about hormone therapy and the safety of hormone therapy is that there's something called the timing hypothesis.

For the vast majority of women, starting hormone therapy before the age of 60 or within 10 years of menopause is going to offer more benefit than risk. So when you start matters. That's not to say you can't start hormones out of this window, but again, it is the safest to start during this time.

When you start estrogen within 10 years of menopause, here are the benefits that we see, a 40 to 50% reduced risk of heart disease, a 30 to 40% decrease in death from all causes, 33% reduction in hip fracture, reduced risk of colorectal cancer and diabetes. It's going to help with those neurological symptoms by increasing blood flow to the brain. It is the most effective treatment FDA approved for hot flashes, night sweats, and also to treat the genitourinary syndrome of menopause.

Well, we're going to talk about that, but that's everything from vaginal dryness, painful sex, urinary frequency, incontinence, UTIs, et cetera. When you use transdermal estrogen, so that's delivering estrogen through the skin in the forms of patches, gels, sprays, vaginal rings, there is no increased risk of blood clots. Okay? So if you have a history of blood clots, if you have a mutation, like Factor V Leiden and you're at increased risk of blood clots, you can absolutely use transdermal estradiol.

When we talk about using oral estrogen, it's still a low risk of developing clots, but that risk is there. It's about four, maybe a little more per 10,000 women will develop a blood clot on oral estrogen, but it's still a great option for most women.

There is so much fear and there's so much misinformation about estrogen and hormones, mostly that everyone is so scared that estrogen causes breast cancer, and especially with this community, I want to debunk that myth right now. There was a big, huge, randomized controlled trial, the largest randomized controlled trial that's been done on hormone therapy and the safety of hormones and the benefits, and that was called the Women's Health Initiative, the WHI.

From that study, we learned that women who took estrogen alone, so these were the women in the trial who did not have a uterus. If you have a uterus, you do need to be on some form of a progesterone to protect the lining of the uterus. If you're on estrogen by itself without a progesterone, over time, you can be at increased risk of uterine cancer. So the women who had had a hysterectomy who were on estrogen alone in the WHI had a 23% decreased risk of developing breast cancer, a 40% reduced risk of breast cancer death and were less likely to die from all causes after a breast cancer diagnosis.

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In the study, in the women who had a uterus, they added a synthetic progesterone called medroxyprogesterone acetate. We don't prescribe this really that much anymore, but that's what they used at the time. And that is the drug that led to a rare, not statistically significant increased risk of breast cancer. It was still very small, less than 10 women per 10,000 per year. But again, it's important to understand that it wasn't the estrogen that led to a rare increased risk of breast cancer. Those women had a reduced risk of developing breast cancer. It was adding that synthetic progesterone.

Now, in modern day menopausal hormone therapy, we often start with body identical progesterone, not a synthetic progesterone. When we use body identical progesterone, we do not see an increased risk of breast cancer. It is breast neutral. This is incredibly important. And you often, if you're going in to talk about having risk reducing surgery, talking about hormones, not everyone is going to understand this.

So you might need to advocate for yourself.

Now moving into our HRT guidelines for previvors. So as many of you know, previvors are our genetic mutation carriers at increased risk of cancer due to inherited predispositions. There are many different mutations that increase risk of breast and gynecologic cancers. I've listed some of them here. Many of you have heard of BRCA1 and 2, our Lynch Syndrome mutations. There's RAD51 mutations, BRIP1, PALB2, there are others, but now we're going to move into how we prescribe hormones, the guidelines for these genetic mutation carriers that have their ovaries and tubes removed to reduce their inherited risk of ovarian cancer.

I'm going to focus on BRCA1 and 2 in the interest of time. So if we look at our NCCN guidelines, because of the significant increased risk of ovarian cancer, standard of care recommendation is to have surgical removal of the ovaries and tubes. This is our best risk reducing strategy.

Unfortunately, we don't have great screening for ovarian cancer. I think we will at some point. We're not there yet. And unfortunately, pelvic ultrasounds and CA125s have not been proven to improve death from ovarian cancer or to pick up ovarian cancer early. So the best thing you can do is to have your ovaries and tubes removed, and also because unfortunately this is a lethal cancer and is often caught at late stages.

For BRCA1, the recommendation is to have surgical removal of the ovaries and tubes between ages 35 and 40. For BRCA2, it's to have your ovaries and tubes removed between the ages of 40 and 45. So if you look and remember back to our definitions, we're talking premature induced menopause for BRCA1 and early menopause for BRCA2. These are individualized conversations though, depending on family history, it might be slightly different. This surgery is called a bilateral salpingo oophorectomy or a BSO.

Now, this is why hormone replacement therapy is so important. If we do not replace hormones, if someone goes into premature or early induced menopause, remember how important estrogen is and how it protects us from developing these chronic diseases. If you lose your estrogen very early, we are seeing significant increased risk of multiple chronic diseases. Cardiovascular disease, up to 100%, 100% of osteoporosis, significant increased risk of dementia and other neurological conditions like Parkinson's, significant mental health consequences, anxiety, depression, OCD. It runs the gamut, and a 40% increase in all cause mortality. This is why this conversation is so important.

Let's talk about the guidelines. What do the professional societies have to say about HRT for previvors following risk reducing surgery? These are our NCCN guidelines. HRT is not contraindicated and is

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recommended for premenopausal women without a previous history of breast cancer. So these are our NCCN guidelines.

This is supported by all of these professional societies, okay? So you can look this up. You can find these recommendations, these guidelines, and bring them with you to your appointments. The British GYN Cancer Society, which is endorsed by the British Menopause Society, NCCN, the Society of Gynecologic Oncology. These, again, this is not debatable. This is the science. These are the guidelines.

And yet, less than 50% of our previvors are offered any HRT following premature or early surgical menopause. If they do receive any hormones, they are often on inadequate doses for short amounts of time. Why is this happening? Number one, our surgeons across the board, our clinicians are not required to undergo menopause education, which is kind of insane. So we're inducing menopause, we're removing ovaries, but yet these surgeons don't quite understand the impact and the fallout. That's a big problem. They don't understand the safety of hormone therapy.

They don't understand how to prescribe hormones. And again, there is so much fear that estrogen causes or increases the risk of breast cancer. And so when you look at previvors who are already at increased risk of breast cancer who may not have had their breast tissue removed, people are petrified to put them on hormone therapy because they think they're going to further increase their risk of breast cancer. But let's look at the data. We have multiple large studies that show there is no increased risk of breast cancer in BRCA mutation carriers who still have their breast tissue following surgical menopause on hormone replacement therapy. So we don't have time to get into these studies today, but I'm listing them and I want to give you, I want to equip you with all of this information so that you have it, again, so that you can advocate for yourself.

I do want to show you one study though, because I think this one's fantastic and this is recent. This was data presented last year at the San Antonio Breast Cancer Symposium. This was a study where they put 676 previvors on hormone therapy, and they compared them to 676 previvors who did not take hormone therapy. Okay? Most of them had had surgical menopause. On average, these women used hormones for six years and they were followed for 15 years.

Most of these previvors had not undergone a bilateral mastectomy. The group on menopausal hormone therapy had a reduced incidence of breast cancer. Transdermal estradiol, so your patches, your gels, your sprays, your rings had a significant benefit. Oral estrogen still had benefit, wasn't significant, but showed a benefit. When we put women on estrogen and that progesterone, that body identical progesterone, there was no increased risk of breast cancer.

Remember, progesterone is breast neutral. There were no cases of breast cancer developed in BRCA mutation carriers on a medication called Duavee, which we're going to talk about, which is a really cool drug.

If you walk away, if you're a previvor and you walk away with anything from tonight, I want you to understand that you deserve an HRT consultation prior to your risk reducing surgery. So if you're seeing a surgeon and they are not up-to-date and they are not educated, you demand that they refer you to someone who can help because if you don't have a contraindication to hormone therapy, like a breast cancer diagnosis, it is imperative that you are put on HRT to preserve your quality of life and your long-term health.

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You should have your hormones before surgery so that when you go into surgery that day, you bring your patch with you, you walk out of surgery, you have your hormones, okay? This is incredibly important. And I say this all the time. If you have trouble finding someone who can help you, reach out to me.

I will connect you with a menopause expert who can help. Now we're moving into hormone therapy for our GYN cancer survivors. So there's five gynecologic cancers, ovarian, uterine, cervical, vaginal, and vulvar cancers. These are our current American Society of Gynecologic Oncology hormone therapy guidelines. We are in the process of updating these and they will be more comprehensive, but for now, this is what they are.

For early stage uterine cancer, so stage one or two, low risk uterine cancer, hormone therapy is safe. We want to avoid systemic hormone therapy. Remember, we're talking about systemic hormones right now in our stage three and four advanced uterine cancers and our uterine sarcoma patients. For ovarian cancer, hormone therapy is acceptable for our high grade serous ovarian cancers, this is 70% of our ovarian cancers and what BRCA mutation carriers are most likely to develop, so it is safe for high grade serous.

We want to avoid systemic hormone therapy in our estrogen sensitive ovarian cancers, our endometrioid and low grade serous. For cervical, vaginal, and vulvar cancer, systemic hormone therapy is safe. The British GYN Cancer Society has a fantastic hormone therapy practice statement, and they expand on the SGO guidelines. They're more comprehensive. So if you look at the ovarian cancer part of this beautiful chart, they include all different kinds of ovarian cancer. What I've done for us today is combined these guidelines and synthesized the data and the guidelines for us.

So when we think about ovarian cancer, systemic hormone therapy is acceptable for our high grade serous, mucinous, borderline ovarian cancers without invasive implants. So very important you check your pathology report. If you have invasive implants, that's considered a low grade serous ovarian cancer. We would not want to recommend systemic hormones. Also find for clear cell ovarian cancer.

Systemic hormone therapy is not recommended for our estrogen sensitive ovarian cancers that we sometimes treat with anti-estrogen therapies like aromatase inhibitors, our low grade serous ovarian cancers, endometrioid, granulosa, sertoli-leydig. Now we do have some data that suggests that for early stage, so stage one, endometrioid and granulosa ovarian cancers, that systemic hormones is likely safe, but we have limited data for these cancers. So these are ovarian cancer guidelines for systemic hormone therapy. Now let's move into systemic hormone therapy for our breast cancer survivors. I'm just going to take a sip of water, if you guys don't mind. Hope everyone's doing okay. You guys with me?

Jenna:

You're doing great, Rachel. You've got about 15 to 20 minutes.

Rachel Frankenthal:

All right, perfect. All right. So I need to figure out how to move this little thingy. Okay. Let me read to you 2022 Menopause Society Hormone Therapy Position Statement. Although systemic use of hormone therapy and survivors of breast cancer is generally not advised, if symptoms of estrogen deficiency are severe and unresponsive to non-hormone options, women in consultation with their oncologists may choose hormone therapy after being fully informed about the risks and benefits.

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This is a beautiful review article of the data we have on systemic hormone therapy after breast cancer. Lead author is Dr. Sarah Glynn, who's amazing out of the UK. She brings up another point, which is that up to one half of breast cancer survivors may choose to accept a small increased risk of recurrence in breast cancer death in exchange for improvement in their quality of life and/or to reduce future risk of osteoporosis.

And I think this is really important. I don't think we talk about quality of life and patient autonomy enough in cancer survivorship. Meaning, if a patient desires systemic hormone therapy, even if it's contraindicated, but if she desires it because she has no quality of life and accepts a potential increased risk of recurrence or even breast cancer death, in my opinion, that should be acceptable because it's her body and she gets to decide what she wants to do with it. And that's what I love about Dr. Glynn and what they wrote in this article.

This is an article that was just published in March of 2026 by two oncologists. They're also experts in menopause and sexual health. Dr. Linda Bosserman here at City of Hope and Dr. Dondizon at Tufts. They also bring up another point. The positive trial evaluated temporary interruption of adjuvant endocrine therapy to attempt pregnancy in women with hormone receptor positive early breast cancer.

At follow-up, recurrence rates appear to be comparable with historical controls despite months of pregnancy-associated estradiol and progesterone levels thousands of times higher than post-menopausal or menopausal hormone therapy levels. So we prioritize fertility, we prioritize reproduction. We allow our younger breast cancer survivors to pause their endocrine therapy, which is lowering their levels of estrogen so that they can have babies and breastfeed. They're having crazy high levels of systemic estrogen. We do not see an increased risk of recurrence, but yet we don't even allow the conversation of baby doses of menopausal hormone therapy for quality of life?

We have to zoom out and look at the entire patient. And also look at this from a common sense standpoint. We don't have time to get into the data today, but if you want to read a beautiful review of all the studies that we have on hormone therapy after breast cancer, this is one to read.

It's written by Dr. Avrum Bluming, who has revolutionized menopause, especially for breast cancer survivors. This is called Hormone Replacement Therapy After Breast Cancer. Is It Time? It is a review article of 25 studies on hormone therapy after a breast cancer diagnosis. Of the 25 studies we have, there was no increase in breast cancer mortality associated with hormone therapy.

Five of the studies reported fewer breast cancer events, so like less recurrence in survivors given systemic hormones. Four studies reported reduced mortality in survivors given hormone therapy. Of the studies that we have, there is only one study called the HABITS trial that reported an increased risk of breast cancer recurrence in women given hormone therapy, but not an increase in breast cancer mortality. When you hear about the HABITS trial, you must understand there was a major limitation to the study. Participants were not required to have a baseline mammogram prior to entering the study.

So while it showed an increased risk of recurrence, it's possible that some of these women already had a recurrence brewing prior to entering the study.

You might say, "But the data's so reassuring. Why are the guidelines so black and white that anyone with a history of breast cancer can't have systemic hormones?" Well, there are limitations to the data. So most of the studies are observational. Any observational study has limitations and biases, many different hormone regimens and dosing was used, so it's hard to draw conclusions.

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None of the studies provided a definitive answer. All conclusions can be challenged, et cetera, et cetera, et cetera. So there are limitations to these studies. I highly encourage you to read this book, Estrogen Matters by Dr. Avrum Bluming and Dr. Carol Tavris if you want to really understand the data. All right. It is a beautiful book and has... It's hard to express really what this book has done, at least for me and my practice. I wouldn't be doing what I'm doing today if I had not read this book and really understood the data.

So highly encourage you to read that.

When we think about systemic menopause hormone therapy and breast cancer risk, we can think about it from our lowest risk, intermediate to high risk women. This is a slide from Dr. Elenora Teplinsky. She's an amazing breast and GYN oncologist. Some of you may know her. I took this slide from one of her lectures.

So when we think about giving systemic hormones, our lowest risk women are going to be women, like previvors who have genetic mutations, who have family histories of breast cancer, benign but high risk lesions, atypical hyperplasia, lobular carcinoma in situ, ductal carcinoma in situ. These are preinvasive breast cancers. Then we think about our triple negative breast cancer survivors. So this is a breast cancer where hormones do not play a role in the prognosis or the treatment. When people have triple negative breast cancer, they don't get put on medications to suppress their systemic levels of estrogen.

They don't go on Lupron. They're not recommended to have their ovaries removed. They can go on to have periods until they go into natural menopause. So they're making their own hormones. And when you have periods, you're creating estrogen at much higher levels than we would give someone with menopausal hormone therapy and we do not see an increased risk of recurrence.

Our highest risk breast cancer survivors are going to be the survivors who have a history of estrogen receptor positive breast cancer. When we talk about ER-positive breast cancer, it's not that estrogen caused the breast cancer. Remember, every cell of the body has estrogen receptors. In those cancers, that receptor is just turned on and we manipulate that receptor in managing the breast cancer.

And then we think of those patients in lowest risk from stage one to highest risk stage four. We would never consider starting systemic hormones in someone on endocrine therapy. So you would definitely always finish your treatment. No one would stop an aromatase inhibitor and put you on hormone therapy. So this is kind of how we think about risk with our breast cancer survivors. I want to mention the medication Duavee and this study, the PROMISE study that was presented at an oncology conference in 2025.

This was a randomized controlled trial, that's the best kind of trial we have studying this medication. It is a combination of estrogen. It's an oral pill that combines estrogen with bazodoxifene. Bazodoxifene is a selective estrogen receptor modulator. It is in the same class of medication as tamoxifen.

In a very simplistic way, it blocks estrogen in some tissue and it acts like estrogen in some tissue. It blocks estrogen receptors in the breast. So it blocks estrogen in the breast tissue and in the uterus. They put 141 postmenopausal women... Or they took 141 postmenopausal women with a history of DCIS who had been newly diagnosed. This is, again, non-invasive breast cancer. They randomized them to a placebo or Duavee for four weeks between their diagnosis and their breast surgery. They found that women who are on Duavee both had improvements in their menopausal symptoms and had reduction in the cell proliferation of the tumor.

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So this medication was able to basically simply kind of shrink the tumor, but also treat menopausal symptoms. So this medication, even though we need more studies on this, might be a great medication to consider if you're high risk for breast cancer, if you have a history of breast cancer and you want to be on hormone therapy, this is an exciting drug that shows how we can both treat menopausal symptoms and potentially reduce the risk of cancer.

Why an absolute ban on hormones doesn't make sense for breast cancer survivors? Not all breast cancers are the same. We cannot treat an ER-positive breast cancer the same as a DCIS or a triple negative breast cancer. You all deserve individualized conversations. Again, survivors are encouraged to child bear where they have very high levels of estrogen and we do not see an increased risk of recurrence. While the data is imperfect, no studies on breast cancer and hormone therapy show an increase in breast cancer associated mortality.

Everyone deserves an individualized conversation. It should never be black and white. I'm going to move on for the sake of time, but even if you have a history of any kind of cancer, breast cancer, GYN cancer, if someone flat out will not have a conversation with you, that is not good care. Okay? You deserve to have an individualized conversation about your menopause.

All right? And that could be use of non-hormonal medications, hormone medications, lifestyle, all of it.

We're going to go into GSM. So up to 90% of our cancer survivors are affected. Many women are affected by this. This is caused by the loss of estrogen and androgens in the vagina, vulva, bladder, and pelvic floor. This is a chronic, progressive condition. If it is not treated, it gets worse and worse and worse. This is most severe in our survivors who undergo induced menopause on aromatase inhibitors or who undergo pelvic radiation therapy.

Symptoms are everything from pain with sex, like can't even have sex, feels like shards of glass. Vaginal dryness, bleeding with sex, recurrent UTIs, waking up five times a night to pee. The clitoris actually shrinks so we have issues with arousal and orgasm. So it's all of these symptoms. Low dose vaginal estrogens, remember this is not systemic estrogen. This is what my colleague Kelly Kasperson calls skincare for down there, is approved to treat GSM.

Again, this is not absorbed into the bloodstream.

When it comes to our guidelines for vaginal estrogen for gynecologic cancer survivors, vaginal estrogen is safe for all cervical, vaginal, vulvar, ovarian cancers, and for our early stage low risk uterine cancers where we also give systemic hormones.

We do lack data for our advanced recurrent aggressive uterine cancers. So it's not contraindicated, but we do have more concern about putting estrogen into the vagina because uterine cancers are most likely to come back in the vagina. So sometimes with these patients, we'll start them with aggressive moisturizer therapy, especially in the first few years when recurrence risk is the highest.

The only cancer survivor where we really don't want to use vaginal estrogen, and I mean cancer survivor holistically, like any kind of survivor, are uterine sarcoma survivors. And that's because these can be very aggressive tumors. They can be highly estrogen sensitive. They do often recur in the vagina and they're very hard to treat.

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So we try to avoid recurrence of uterine sarcomas. But I will also say that these are always individualized conversations. And I have patients in these red light contraindicated categories who choose to use vaginal hormones and systemic hormones, and there's nothing wrong with that as long as they understand the risks.

Vaginal estrogen is safe for all breast cancer survivors. I'm going to say it again. Vaginal estrogen is safe for all breast cancer survivors. So even if you have an ER-positive breast cancer and you're on an aromatase inhibitor, you can use vaginal estrogen. We do not have one study, not one, that shows an increased risk of breast cancer mortality with the use of vaginal estrogen.

The American Urologic Association has these new guidelines that say for patients with GSM who have a personal history of breast cancer, clinicians may recommend low dose vaginal estrogen in the context of multidisciplinary shared decision making as an expert opinion. This is endorsed by all of these professional societies. I'm going to move on for the sake of time, but this is well accepted. I will share one study because I think it's very powerful. This was presented recently at a conference, an oncology conference.

It was a database study that showed vaginal estrogen among breast cancer survivors showed an increase in overall survival, as well as breast cancer specific survival in breast cancer patients who use vaginal estrogen. They saw a statistically significant increase in overall survival in those who use vaginal estrogen for over seven years. Why might this happen?

Remember, vaginal estrogen reduces risk of UTIs. Women as they age die from urosepsis, which are UTIs that spread into the bloodstream. Women who have UTIs as they age, they get dizzy, they get lightheaded, they pass out, they fall, they fracture a hip. There's a high mortality associated with hip fractures and spine fractures from osteoporosis. So vaginal estrogen is a life-saving medication that also greatly improves quality of life and is so important for our sexual and vaginal health. So I hope I didn't run over too much. I did include some resources for you and that's it.

Thank you so much for having me.

Jenna:

Rachel, that was absolutely fantastic. And you did not run over time and we have time for questions. Really just so much good information here. So I'm going to take questions in the chat. My request is that you try and keep your questions as general as possible. And I know some of these questions have been addressed since you put them in, so I'm going to just prioritize general, and questions that haven't been answered. So I'm going to start with the data because I just found your presentation so wonderfully jampacked with data, Rachel. And Lisa asked, "What studies are currently underway that are going to yield even better results? You said a few times that the data's a little imperfect." So what's in the pipeline?

Rachel Frankenthal:

Man, it's sad because unfortunately right now, women's health is not being prioritized in terms of studies and research, and a lot of people are actively advocating for increased funding for these studies. I do not think, sadly, we are going to have any randomized controlled trials, which are the best kind of trials that are going to answer these questions anytime soon, which is very upsetting, which is why we have to use the data that we have right now to make decisions.

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Even though the data's not perfect, this is the data we have. And if we wait for those studies, another generation of women and survivors and previvors may suffer unnecessarily. So I believe women are smart. They can take the data, they can take the guidelines, and they can think about what's important to them. Every woman has a different history, different medical conditions, different values and priorities, and everyone's going to decide... They make different decisions about their health, but we can't avoid these conversations just because we don't have perfect data.

Jenna:

Okay. This is great. Can you just address a little bit about testosterone?

Rachel Frankenthal:

So you mean specifically, I'm assuming for cancer survivors?

Jenna:

Yes, yes.

Rachel Frankenthal:

So we don't have really any data on testosterone for gynecologic cancer survivors. So I extrapolate. When I do testosterone and think about testosterone, I use the data we have for breast cancer. Now, we don't have a lot of data. We have some on testosterone, systemic testosterone for breast cancer survivors.

It's limited, but it's reassuring. When we deliver physiologic doses of testosterone, meaning not through injections and pellets, but when we use smaller doses of testosterone to bring testosterone back up in just a normal range, number one, we don't see an increase in estrogen. So part of the concern of using testosterone for breast cancer survivors is that testosterone can be aromatized to estrogen.

So if you have a estrogen receptor positive breast cancer survivor who's on an aromatase inhibitor or not, we don't want to increase their systemic levels of estrogen. But again, if we're using just smaller doses of testosterone, we do not see that happen.

We have small studies on testosterone therapy and breast cancer survivors, some with aromatase inhibitors, and we don't see any negative outcomes, meaning the testosterone does not increase estrogen in the body. We don't see an increased risk in recurrence or a negative impact to overall survival.

But again, these studies are small studies and we don't have a lot of them. So every breast oncologist feels different about this. I work at UCLA and I have some breast oncologists who have no issues with me putting breast cancer survivors on testosterone. I have other breast oncologists who are... They're not as comfortable with testosterone, but the data is limited and it is always an individualized conversation, but it is reassuring.

Jenna:

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That was great. Thank you. Starting from the top, can you address previvor information for women who have a family history, but no known genetic...

Rachel Frankenthal:

Oh, Jenna, you went... I lost you.

Jenna:

Oh, one more time. For women with a family history, not genetic mutation positive, does any of this guidance change? And do you mind just removing your slide deck so we can get a full picture of you for the recording?

Rachel Frankenthal:

Yeah, absolutely.

Jenna:

There you are.

Rachel Frankenthal:

Yeah, there I am. So a family history of cancer is not a contraindication to hormone therapy. So that's a myth, that's a misconception. It is not a reason to withhold systemic hormones. It is a reason to pursue expanded panel genetic testing, to get to make sure that you aren't at significant increased risk.

And when I do hormone therapy for women at increased risk, whether it's a strong family history or they have a known genetic mutation, this is where I look at the data and I say, "Look, women on estrogen alone, they have a reduced risk of developing breast cancer." And we also see that in some of these studies with our previvors. So I listed some of those studies. In the previvors who use hormone therapy on estrogen alone that still have their breast tissue, some of those studies show a reduced incidence of developing breast cancer with just estrogen.

So sometimes with those women, we'll start on estrogen alone. That could be by giving them an IUD into the uterus and delivering local progestin therapy to the lining of the uterus, but then she still benefits from estrogen alone. This might be a place where we think about Duavee. So it's not a contraindication, but it's an opportunity to think about how we might utilize hormone therapy to potentially reduce incidence of developing a cancer. Again, we don't have perfect studies for that, but that's how I think about our patients at high risk.

Jenna:

Okay. This person shared that they were told that they had to remove their ovaries if they were on progesterone because it would increase their breast... I'm sorry, remove their breasts if they were going to take progesterone because it will increase their breast cancer risk. Is that true? Is that wrong?

Rachel Frankenthal:

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So remember when we talked about the... I did that slide on the WHI, and I said, everyone's so scared that hormones cause cancer. What actually happened in that study, and again, I'm going to keep saying it, estrogen alone reduces risk of breast cancer. Where we sometimes see a rare increased risk of breast cancer is with synthetic progestogen. So when we think about progesterones, they're called progestogens. That's the umbrella term. You have body-identical progesterone, and then you have synthetic progestins. When you take body-identical progesterone, it is breast-neutral. There's no increased risk of breast cancer. There's no decreased risk of breast cancer. So breast-neutral. When you're put on a progestin, which by the way, are in birth control pills that we use all the time and we don't talk about it, there is a potentially rare increased risk of breast cancer, but it is certainly nothing to... I don't think anything to fear. It's such a small, small risk.

Jenna:

How would you advise folks who are really getting pushback from their providers other than walking away from their providers, which you did share, but what's some language people can use to feel confident after today in talking with their provider?

Rachel Frankenthal:

The first thing I would do is gather your data and gather your guidelines. So when you go in for your visit, you are prepared because you cannot expect clinicians to have this information and this education. They were not taught this. The reason I know this is because I educated myself. No one taught me any of this. The only thing I learned in school was that hormones were dangerous.

So the first thing I would do is if you're seeing someone that you've never seen them before, I would call in advance or message in advance and ask if they prescribe hormones and if this is something that they're knowledgeable on. Don't waste your time. If someone doesn't know this stuff, see someone else. And then I would tell them, I would say, I'm coming in to talk about menopause or perimenopause or hormone therapy before my risk reducing surgery.

Is this something you're comfortable with? Do you do this? Do you prescribe hormones? And tell them in advance, tell them what the visit is for, because these are visits that are longer visits. I get at least 30 minutes for these visits. You cannot do this in a 10-minute visit. So I would request a longer visit and I would either send the data and the guidelines along or bring them with you. You want to go in there, your time is valuable and this is important.

So I would really set yourself up for success. That's what I would do. I would bring the data, bring the guidelines, send them in advance. You can attach these to a message in a MyChart app and prepare the clinician, prepare yourself so when you go in, you can have a really productive conversation. But I think if you have the data and the guidelines, this is science. People can't argue that.

Jenna:

I really appreciate not only your push for self-advocacy, but also just quality of life, Rachel. And I hope everyone today is just thinking about their own quality of life and how this information might help them look at it a little differently.

Rachel Frankenthal:

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And Jenna, just piggybacking off that, the other thing is I always want you to remember that this transition when you lose your hormones is this window of vulnerability because we learned what happened when we lose estrogen, but it's also this window of opportunity.

So you get to decide how you want to live the rest of your life. And again, you can do that without hormones. We didn't get into lifestyle today, but there's so much that we can do to protect our long-term health and our quality of life. Hormones are an important piece of that, but not the whole piece.

Jenna:

I feel like we're already talking about our part two of this series-

Rachel Frankenthal:

Lifestyle.

Jenna:

Rachel. Okay. Next question. Must we take progesterone when taking low dose vaginal estriol?

Rachel Frankenthal:

No. Vaginal estrogen, great question. So this is not systemically absorbed, has not been shown to increase risk of uterine cancer. So no, you do not need to be on a progesterone if you have a uterus if you're only on vaginal hormones.

Jenna:

Great. Is it too late to start taking vaginal estrogen if you're more than five years into menopause? I know you said 10 was the window, is there like [inaudible 00:54:52].

Rachel Frankenthal:

That was for systemic hormone therapy.

Jenna:

Oh, excuse me.

Rachel Frankenthal:

This is a great question. I'm so glad it was asked because you can literally start vaginal estrogen any time. I personally think it should be on a work order in all nursing homes. It reduces risk of UTIs by 50%. I just put my 97-year-old great-grandmother on vaginal estrogen. Think about how many women die from urosepsis.

We can also use it postpartum when our estrogen level drops and you have those symptoms, pain with sex, you feel like you have a UTI, but you don't. Perimenopause, this can be some of the first symptoms of perimenopause. You can use vaginal estrogen anytime of your life. Birth control pills, it causes GSM.

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Go on vaginal estrogen. It is the most benign medication. Remember, this is skincare. It's like a moisturizer.

Jenna:

If you did HRT for many years from the start of menopause, but then needed to stop due to cancer and aromatase inhibitor therapy, can you go back on HRT in your late 60s?

Rachel Frankenthal:

Yes, absolutely. So what I'll say is, let's say you were on hormone therapy, I'm just going to make this up, from 45 to 55, and then you are off of your hormones from 55 to 64. I would only count those nine years that you were off of hormones when we look at the timing theory, the window that I talked about, how starting hormones are safest within 10 years of menopause.

If you are on hormones starting from menopause for those 10 years, I wouldn't count that, if that makes sense. I would start counting from the time you stopped your hormones. The other thing I will say is that even though we have this timing hypothesis, we have so much data that supports the use of transdermal estradiol in older women. So even if we start our older women on transdermal estradiol preparations, the risk is incredibly low.

The thing we worry about when we start hormones after 10 years are thrombotic events, like heart attacks and stroke, things from blood clots. But when you give transdermal estradiol, there's no increased risk of blood clots and the risks are still very small. So this is where individualized conversations are important. And I have some older women who have osteopenia or osteoporosis. Estrogen is FDA-approved for osteopenia. Prevention of osteoporosis is very important for bones.

They say, "I want it for my bones." And so again, it's always these individualized conversations, but I personally believe you can start estrogen at any age, as long as you have a fully informed conversation.

Jenna:

Okay. Last question. I know there's so many more. What are the suggestions that you have for people finding a provider who can help them navigate this? Other than emailing you and asking for recommendations.

Rachel Frankenthal:

You can find me, by the way, I'm @RachelFrankenthal on Instagram, and I literally connect people with clinicians all around the world. So if you are struggling to find someone, please message me, I will find someone for you. I do this all the time. There are directories. The Menopause Society has a provider directory, the International Society for the Study of Women's Sexual Health... Maybe we can send out these resources. Heather Hirsch Academy has a provider directory. If anyone, and anyone in the Heather Hirsch directory that is in your state, they know what they're doing. So I would go to these directories. And again, I'm just @RachelFrankenthal on Instagram and message me and I will help find you someone.

Jenna:

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Thank you. And I'm going to ask my colleagues from Sharsheret to put that in the chat. So as we wrap up, I do want to thank you, first of all, Rachel, just fabulous. We're going to be putting our evaluation link in the chat so that you can evaluate this webinar. And I do want to remind everyone that if you are a member of our EMBRACE program, someone facing metastatic breast or advanced ovarian cancer, we invite you to stay on the Zoom for a more intimate breakout session with Rachel in a few minutes.

Again, please fill out our survey. We are here for you. If you have any questions, Sharsheret provides emotional support, mental health counseling, and financial assistance, as well as genetic counseling. We're here to help you navigate your journey. Our information is in the chat. I'm going to thank our wonderful sponsors one more time for supporting this and all of our webinars, Merck, Lilly, Novartis, and Pfizer.

Without their support, we wouldn't be able to bring you this important educational information. So again, thank you, Rachel, so much for this first part. And again, we're going to ask all of our EMBRACE program participants, those facing metastatic breast and advanced ovarian cancer, to take a deep breath, stay on and we'll be continuing the conversation with Rachel in just one minute. Thank you everyone, and have a good night.