

RGH Pharmacy E-Bulletin

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A joint initiative of the Patient Services Section and the Drug and Therapeutics Information Service of the Pharmacy Department, Repatriation General Hospital, Daw Park, South Australia. The RGH Pharmacy E-Bulletin is distributed in electronic format on a weekly basis, and aims to present concise, factual information on issues of current interest in therapeutics, drug safety and cost-effective use of medications.

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Menopausal symptoms in women with history of breast cancer

Women with a history of breast cancer can have more frequent and severe vasomotor symptoms than the general population of women. This is due in part to the use of tamoxifen and aromatase inhibitors. As with all women, the management of vasomotor symptoms and symptoms of vaginal atrophy in women with a history of breast cancer requires an individualised, patient centred multidisciplinary approach, based upon the woman's expectations and goals of therapy.

If drug therapy is required for vasomotor symptoms, national and international guidelines recommend non-hormonal treatment is the first choice. Randomised controlled trials (RCT) involving women with a history of breast cancer demonstrate a significant reduction in the frequency of hot flushes with venlafaxine (initially 37.5 mg XR daily increased to 75 mg XR daily if needed) and paroxetine (10 mg daily). Higher doses of venlafaxine and paroxetine are associated with a greater adverse effect burden without further improvement in hot flush frequency. Caution is recommended with the combined use of paroxetine and tamoxifen as paroxetine may inhibit the metabolic activation of tamoxifen.

Gabapentin (up to 300 mg three times/day) has also been shown to reduce hot flush frequency in women with a history of breast cancer. However, poor tolerability (somnolence, dizziness, peripheral oedema) may limit its use. There appears to be no benefit upon vasomotor symptoms from combining antidepressants with gabapentin.

Clonidine (up to 0.1 mg/day) may modestly decrease hot flush frequency in women with a history of breast cancer. Potential adverse effects include drowsiness, headache and dry mouth. To minimise these effects, the dose should be slowly increased, and slowly decreased on withdrawal.

Tibolone may increase breast cancer risk in women with a history of breast cancer and should be avoided.

If the above mentioned options do not provide adequate relief and the woman wishes to pursue further therapy for vasomotor symptoms, a cautious trial of systemic hormone replacement therapy may be trialled under the guidance of an oncologist, only following a full discussion of the potential risks associated with such therapy. Compounded bio-identical hormones should be avoided in women with a history of breast cancer.

If vaginal symptoms predominate, vaginal moisturisers and lubricants are first line. If these are inadequate, vaginal oestrogen therapy may be trialled, however the hazards of such treatment is unknown and the woman should be warned of the potential risks.

This E-Bulletin is based on work by Joy Gailer, Senior Pharmacist, DATIS, RGH.

FOR FURTHER INFORMATION CONTACT THE PHARMACY DEPARTMENT ON 82751763 or email: chris.alderman@health.sa.gov.au
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