

EPECTM-O

Education In **P**alliative And **E**nd-Of-Life **C**are For **O**ncology

Self-Study Module 3n:

Symptoms; Menopausal Symptoms

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Abstract

Many symptoms and syndromes are commonly encountered in patients with cancer. This module first presents general approaches to symptom management, followed by management of the specific symptoms and syndromes, including: anorexia/cachexia, anxiety, constipation, depression, diarrhea, fatigue, insomnia, menopausal symptoms and sexual health, mucositis, nausea and vomiting, and skin problems.

Any symptom can be debilitating and prevent the patient and family from achieving goals that are important to them. As with other aspects of medicine, tailored management is based on the underlying etiology and pathophysiology. When several symptoms occur together, they can be interrelated and management can be complex.

Introduction

Premature menopause is common in the setting of adjuvant therapy for breast cancer. (Ref. 1) (Ref. 2) (Ref. 3) (Ref. 4) This situation occurs in female patients with other cancer diagnoses who receive cancer treatment, especially with alkylating agents, prior to menopause, although limited data are available for nonbreast cancer sites. The primary treatment for breast cancer is already quite complex, and premature menopause imposes an additional burden on younger women. (Ref. 5) In addition, some women note important changes in libido and sexual functioning. (Ref. 6) (Ref. 7) (Ref. 8) Urinary incontinence can also occur. Women treated for breast cancer today can expect long-term survival, and it is important for clinicians to become familiar with common symptoms that are a result of cancer treatment and premature menopause, and to have strategies for their management.

Prevalence

Menopausal symptoms are less common in women older than 60 years. (Ref. 9) Menopausal symptoms are not commonly troublesome for women with breast cancer who are already postmenopausal when diagnosed. Rather, they usually occur in the setting of withdrawal of exogenous hormone therapy or in women who receive endocrine therapy (e.g., tamoxifen or aromatase inhibitors) and are within a few years of menopause.

Prognosis

The outlook for women with cancer treatment-induced menopause is generally good, in that symptoms associated with menopause, although sometimes abrupt in onset, will

eventually resolve in almost all cases. Sexual difficulties may worsen, but careful attention to maintaining a good relationship between partners, treatment of anxiety or depression if present, management of sex-related symptoms (e.g., dyspareunia), and education about normal age-related changes and sexual health can help women and their partners through this transition and maintain sexual functioning into the future.

Case

Review the case below, and keep it in mind as you progress through the module. How would you approach the assessment of this patient? What interventions might be appropriate?

F.A. is a 47-year-old married woman who comes to you for an outpatient consultation for advice related to menopausal symptoms that have troubled her since starting tamoxifen adjuvant therapy about 1 year ago. She was diagnosed with stage II breast cancer (ER/PR positive; 5 nodes positive) about 2 years ago and received a lumpectomy followed by four cycles of doxorubicin and cyclophosphamide and four cycles of paclitaxel adjuvant therapy. After completing her adjuvant chemotherapy, she received 6 weeks of radiation therapy to the breast and was subsequently started on tamoxifen 20 mg/day.

Prior to starting her chemotherapy, she had been menstruating regularly and had not had any perimenopausal symptoms. She stopped menstruating after two cycles of chemotherapy. She had moderately severe hot flashes and night sweats, as well as sleep disturbance, but these got better over the next 6 months. However, once she started the tamoxifen, the severity and frequency of the hot flashes increased and she is now considering discontinuing tamoxifen. She also reports vaginal dryness and pain with intercourse that began shortly after starting chemotherapy and has gotten worse over the past 2 years. She has tried using a lubricant, but still experiences discomfort. She also reports significant lack of interest in sex and difficulty with arousal. Her husband has been supportive, but she feels saddened by the changes in their intimate relationship.

Pathophysiology

Menopause occurs when a previously menstruating woman with an intact uterus and ovaries has had amenorrhea for at least 12 months. The average age of menopause in North American women is 51 years. (Ref. 10) Endocrine disorders or conditions can lead to secondary amenorrhea. Cancer treatment-induced secondary amenorrhea is the most relevant consideration in this setting. The menopausal transition is characterized by decreased responsiveness of the ovaries to luteinizing hormone (LH) and follicle-stimulating hormone (FSH). Gradually, over time, the estradiol levels fall as the ovarian

follicles are depleted and there is no further response to LH and FSH. Clinical symptoms of estrogen deficiency begin to occur with these changes. Lowered levels of estradiol affect various target tissues, including the vagina, skin, bone, vascular endothelium, and smooth muscle, as well as the hypothalamic temperature-regulating centers. (Ref. 11) The ovaries are the primary source of androgens in women, persisting into postmenopause, and decreased production of ovarian androgens may account for changes in libido during this time. (Ref. 12) Symptoms associated with estrogen deficiency include vasomotor symptoms (hot flashes, sweats, palpitations), urinary incontinence, and vaginal dryness. Vasomotor symptoms are most frequent (up to 75% of menopausal women) and are among the earliest symptoms of menopause, with the more gradual onset of urinary incontinence and vaginal dryness in the later postmenopausal years. (Ref. 11)

The impact of menopause on sexual health is controversial because many women remain sexually active into old age. Several population-based studies of perimenopausal and menopausal women have documented that most women who have partners are sexually active; (Ref. 13) however, changes can occur in sexual functioning (desire, arousal, orgasm) that are age related and to which menopause may contribute. (Ref. 11) (Ref. 14) (Ref. 15) Research suggests that in postmenopausal women, a variety of factors are potential moderators of the components of sexual functioning (e.g., psychological distress, quality of the partner relationship, physical activity, body mass index). (Ref. 13) Without sufficient levels of endogenous estrogen, the vaginal epithelium becomes atrophic, leading to clinical symptoms of vaginal dryness and dyspareunia. With chronic or untreated symptoms of vaginal dryness, postmenopausal women often choose to avoid sexual intercourse completely. Hormone replacement therapy is effective in managing menopausal symptoms such as hot flashes and vaginal dryness, but does not appear to improve sexual functioning. (Ref. 16) (Ref. 17) Untreated vaginal dryness can contribute to dyspareunia, thus affecting both desire and arousal in women with cancer. The variety of physical, psychosocial, and treatment-related factors associated with cancer treatment may also cause or exacerbate sexual dysfunction. Menopause per se may not be the culprit.

Tamoxifen and aromatase inhibitors are associated with vasomotor symptoms. Tamoxifen can also cause vaginal discharge in 10 to 20% of women due to its estrogenic effects on the vagina, while the aromatase inhibitors are associated with vaginal dryness.

Assessment

The hot flash or flush is the hallmark menopausal symptom. It is usually described as the sudden sensation of warmth over the face, neck, and upper trunk. It is often associated with sweating and palpitations. Hot flashes may occur infrequently throughout the day or night, or occur nearly continuously in some circumstances. Night sweats, a parallel symptom, are also common in association with menopause.

Sometimes women will also experience nighttime awakening, without a hot flash. These symptoms often appear within a year or two before the last menstrual period and then gradually resolve over several years after the last menstrual period. In women who become acutely menopausal as a result of chemotherapy or the use of ovarian suppression therapy, the intensity and frequency of these vasomotor symptoms can be extreme. In addition, women receiving endocrine therapies at the time of the perimenopause or early menopause will usually have exaggerated vasomotor symptoms.

Most women understand what a hot flash is or feels like. One can ask:

- “Are you having hot flashes or sweats? How frequently?”
- “Do you need to change clothing or bed sheets?”
- “Do your hot flashes interfere with your activities?”
- “Do they awaken you at night?”

For sexual difficulties, it is important to take a brief history to determine the pattern of sexual difficulties and whether they are related to the breast cancer treatment or menopause. Changes in sexual frequency and patterns are a normal part of aging, although many individuals have an active sex life into old age.

Vaginal examination may show evidence of irritation and friable tissue, and vaginal cytology may show an absence of estrogen effect. While these clinical signs are valuable, their absence does not preclude substantial clinical symptomatology. (Ref. 18)

The laboratory diagnosis of menopause is usually made with low levels of estradiol in the face of elevated levels of gonadotropins. For women who complain of lack of sexual interest or decreased libido, causes may include: testosterone deficiency, fatigue, anxiety, and depression. Consider ordering a serum-free testosterone level as part of the evaluation of sexual dysfunction. In women who have had an oophorectomy, and some women who have had chemotherapy, the levels will be exceedingly low and may warrant testosterone supplementation.

Management

There are a variety of hormonal and nonhormonal approaches to the management of menopausal symptoms in cancer survivors. (Ref. 19) (Ref. 20) (Ref. 21) (Ref. 22) (Ref. 23)

Hormonal therapy

For those women who do not have an estrogen-associated cancer (e.g., patients with leukemia, lymphoma, etc.), systemic hormone therapy can be considered. Give it for as short a period as possible, given the modest level of other benefits and presence of some significant risks from such therapy, as found in the Women's Health Initiative Study. (Ref. 24) Alternatives to hormonal therapy should be considered as well. In women with a history of breast cancer, consider a range of hormonal and nonhormonal therapies, but it is probably best to avoid estrogen alone/estrogen plus progestin supplementation.

Megestrol acetate is usually quite effective. Its use is limited by theoretical concerns of patients and physicians about the potential risk of a progestational agent in the initiation and promotion of primary breast cancer.

- **Megestrol acetate**, 20 mg PO bid

Nonhormonal therapy

Various SSRI antidepressants have also been found to be useful, although recent studies have raised concerns about drug interactions with tamoxifen. (Ref. 25) (Ref. 26) (Ref. 27)

- **Venlafaxine**, 37.5mg PO daily for 1 wk then escalate to 75 mg PO daily.
- **Fluoxetine**, 20 mg PO daily.

Gabapentin has also recently been found to be effective for management of hot flashes.

- **Gabapentin**, 300 mg PO nightly. Titrate to effect, maximum of 900 mg PO q 8 h.

Sleep disturbances

For women with only nocturnal difficulties, either a sleeping medication or a combination with phenobarbital and ergotamine (Bellergal) is sometimes useful.

- **Bellergal**, 1 tablet PO q 12 h.

Most women, however, are reluctant to try medication unless their symptoms are quite severe, and for that reason practical interventions, including avoiding hot liquids or stimulants (coffee, alcohol), layering clothing to keep cool, and having a fan available are usually helpful. (Ref. 22) (Ref. 23)

Vaginal dryness

Vaginal dryness may be a problem with or without adjuvant treatment for breast cancer, as the frequency of this symptom increases with age. (Ref. 14) The nonhormonal vaginal lubricants (e.g., K-Y jelly, Astroglide, and Replens) have been found to be helpful in several studies. More recently, topical estrogen therapy utilizing a silastic ring

implanted with estradiol has become popular because of the lack of systemic absorption and good relief over a 3-month period of time. Other vaginal estrogen preparations can be considered; however, these may lead to systemic estrogen absorption, which may have adverse consequences in terms of breast cancer recurrence.

Vaginal dryness and pain with intercourse may indirectly affect sexual interest, for if coitus is painful, it can lead to avoidance. If the patient has a good partner relationship, some simple suggestions are often helpful in refreshing the relationship and improving the situation. However, it is often useful to refer the couple for sex therapy counseling to address specific issues that may be impairing a satisfying sexual relationship.

Summary

Menopausal symptoms are often quite troublesome and add to other symptoms experienced by patients in relationship to the cancer or its treatment. The satisfactory control of these symptoms can improve quality of life and sexual functioning (e.g., management of vaginal dryness). Often, patients will be reluctant to ask for help with these symptoms, so it is important for the clinician to directly inquire about them to determine whether or not they are a problem.

Key Take-Home Points

1. Ask about menopausal symptoms.
2. Treat hot flashes aggressively if the patient finds them disturbing.
3. Ask about vaginal dryness and sexual dysfunction.

Pearls

1. Sexual function in women with breast cancer is improved when menopausal symptoms are decreased.
2. Therapy for some target menopausal symptoms (hot flashes, vaginal dryness) is effective for the majority of symptomatic women.
3. Make a partnership with your patient and the family caregiver; draw them into the interdisciplinary team and foster their active participation in the care plan.

Pitfall

1. Avoiding discussing sexual function out of a sense of modesty.

References

Module 3n: Symptoms - Menopausal Symptoms

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