Menopausal hormone therapy in patients with a history of gynecologic cancer

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1 Menopausal systemic and local hormone therapy can be considered after a gynecologic malignancy based on hormonal receptivity of the cancer[1,2]

Loss of ovarian function due to treatment of gynecologic cancers can result in severe and abrupt vasomotor symptoms, and increased risk of cardiovascular disease, osteoporosis, and mood and cognition difficulties. Hormone therapy with systemic estrogen, using oral or transdermal formulations, is the recommended treatment for vasomotor symptoms in patients with cancers that are not hormone-sensitive, with consultation with the patient's oncology team.[1,2] Local hormone therapy options using ring, cream and tablet formulations can be considered in select patients.

2 Systemic hormone treatment can be prescribed safely in patients with an ovarian cancer that is not hormone-sensitive,[3] such as high-grade epithelial ovarian cancer

Hormone therapy should not be prescribed in patients with hormone-sensitive cancers, such as low-grade serous, endometrioid or granulosa cell cancers.[1,2]

3 Hormone therapy can be used safely in patients with a history of cervical cancer[1,2]

Estrogen receptor positivity has no prognostic impact on cervical cancer. Progesterone should be used for endometrial protection if the uterus is intact, as endometrial tissue can persist despite pelvic radiation or chemotherapy.

4 Hormone therapy can be considered after early-stage (I-II) endometrial cancer,[1,2] as it does not appear to increase the risk of recurrence[4,5]

Data regarding safety of hormone therapy in advanced-stage (III-IV) endometrial cancer or uterine sarcoma are insufficient and, therefore, hormone therapy is not recommended.[1,2]

5 Duration of therapy should be individualized

For younger patients, treatment should generally continue until the average age of natural menopause (52 yr).[1] After this age, titrating to the lowest effective dose, changing to a nonoral route or stopping treatment can be discussed based on symptom severity, effectiveness of nonhormonal treatments and risks of cardiac disease and osteoporosis.[1]

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