European Menopause and Andropause Society

EMAS

Gynecological cancer: all cancers are not the same

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All gynecological cancers are not the same

- Worldwide 1.3 million new gynecological cancer cases are diagnosed each year.
- Different types, stages, hormone dependence
- Different treatments: hysterectomy with or without bilateral salpingo-oophorectomy, radiotherapy, chemotherapy, anti-estrogens
- Menopause management needs to be individualized

Gynecological cancer: endometrial

- Most cancers diagnosed at an early stage (FIGO stage I–II) after menopause and have a good overall prognosis, with a 5-year survival rate of over 85%.
- Treated with TAH/BSO
- MHT is a reasonable option for patients who are at low risk of tumor recurrence eg early stage but evidence limited
- No evidence about higher stage disease
- No studies are available for women with Lynch syndrome, who are also at increased risk of other cancers.

Gynecological cancer: sarcomas

- May be hormone dependent, estrogen and progesterone receptor testing should be undertaken to guide decisions as to whether MHT can be used.
- No data regarding MHT in non-hormone-dependent tumors.
- No data in Smooth uterine muscle tumors of uncertain malignant potential (STUMPs)

Ovarian, fallopian tube and peritoneal cancers 1

- Three major types of ovarian cancer are:

- epithelial accounting for 90% of cases
- germ cell (3%)
- sex cord-stromal (2%)

- Fallopian tube cancer, primary peritoneal cancer and epithelial ovarian cancer are indistinguishable and share the same genomic signature.

Ovarian, fallopian tube and peritoneal cancers 2

- Epithelial cancers five histotypes:

- high (aggressive)-grade serous carcinoma
- low-grade serous carcinoma
- endometrioid carcinoma
- clear cell carcinoma
- mucinous carcinoma

- The different histotypes are now considered to be different diseases.

MHT in low and high grade serous carcinomas

- Low-grade serous
- MHT, currently not recommended for low-grade serous cancer of the ovary or peritoneum in advanced disease

- Letrozole, anastrozole, tamoxifen and leuprolide acetate used after primary cytoreductive surgery and platinum-based chemotherapy for stage II to IV low-grade serous carcinoma of the ovary or peritoneum

- High-grade serous
- No evidence to inform practice

MHT: non-serous and germ cell tumors

- MHT, either systemic or topical, does not appear to be associated with harm and does not appear to decrease overall or disease-free survival.

- Regimen (estrogen alone or combined with a progestogen) depends on whether hysterectomy undertaken

MHT: granulosa cell tumors

- Most common sex cord stromal tumors
- Affect young women
- May secrete sex steroids
- Can recur up to 20 years after diagnosis
- Hormone dependent: recurrence therapy includes aromatase inhibitors
- But no studies with MHT show harm

Cervical, vaginal and vulvar cancers

- Not hormone dependent
- Regimen (estrogen alone or combined with a progestogen) depends on whether hysterectomy performed
- In utero diiethylstilbestrol-exposure associated tumors: no evidence regarding MHT use

Further reading

- European Menopause and Andropause Society (EMAS) and International Gynecologic Cancer Society (IGCS) position statement on managing the menopause after gynecological cancer: focus on menopausal symptoms and osteoporosis. Rees M, et al. Maturitas. 2020;134: 56–61.