HRT and Breast Cancer in Perspective

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Introduction

Ovarian failure with associated oestrogen deficiency is the commonest, potentially serious endocrine disorder. It affects, to a variable degree, most women over 50 and its effects are usually reversible with hormone replacement therapy (HRT). The suggestion that HRT may be associated with an increase in the incidence of breast cancer has resulted in widespread fear of its use and considerable, probably unnecessary suffering. The recent Lancet publication [1], again suggesting a link between HRT and breast cancer, has stimulated this author to audit HRT users in his private gynaecology practice. This experience based study is presented with the intention of alleviating some of the anxiety surrounding HRT.

The practice study

- One hundred randomly selected, consecutive HRT users were reviewed between September and December 2019. Their ages ranged from 40 to 93 with a mean of 66.95 years. Years of supervised HRT usage ranged from 1-45 with a mean of 9.08 years. All patients underwent clinical breast examination at the review unless this had been done within 3 months prior. Some had had mammography performed within the previous year as well. All patients have been taught breast self-examination.

- The commonest indication was hot flushes and sweats with or without sleep disturbance and malaise. Twenty five patients had been referred with chronic vulvovaginal disorders, mostly lichen sclerosus, lichen planus or desquamative inflammatory vaginitis. This author has found that the treatment of these conditions is more successful with the prescription of systemic HRT when atrophy is also present[2]. Symptomatic vaginal atrophy and sexual disorders affected 39. Other indications were recurrent urinary tract infections, osteopenia and osteoporosis, urinary incontinence, to help with healing following vaginal repair, other vulval dermatoses and mild to moderate vaginal prolapse.

- For at least the last decade, oestradiol was the only oestrogen used and medroxyprogesterone acetate (MPA) the only progestogen. Thirty five of the women had undergone hysterectomy and therefore did not require progestogen. A small minority had used other medication, such as conjugated equine oestrogens and tibolone, when treatment was started and before referral. Dosage was kept to a minimum and determined by relief of symptoms and/or a serum oestradiol and FSH and/or vaginal cytology[2]. Oestrogen administration was oral (the majority) or transdermal and 9 cases were by oestradiol implant. Thirty patients changed their mode of administration during the time of the study.

- There were two breast cancer survivors in the series. They were commenced on HRT (with their surgeons' consent) 21 and 5 years after the cancer diagnosis. Both required the HRT for vulval dermatoses and severe vaginal atrophy. The first, aged 78 , had been on HRT 3 years and the second, aged 72, had been on HRT for 30 years.

- One (only) of the patients reviewed was diagnosed with breast neoplasia. The lesion was detected by mammography. It was an 8cm ductal carcinoma in situ treated by mastectomy. Lymph nodes were negative. She was aged 55 at the time of diagnosis and had been on oestradiol and MPA for 4.5 years for vulval eczema and insomnia until their cessation with the diagnosis of the carcinoma.

Discussion and Conclusion

There is nothing in this series to suggest an increase in breast cancer incidence in HRT users, although its small size precludes the assessment of a very small increase. The findings of this study support the views expressed by Rymer et al [3]. Manson et al[4] found 'Menopausal hormone therapy for 5 to 7 years was not associated with risk of long-term all-cause mortality' . The numbers in this author's series are small compared with those in the Lancet article, but the lack of quantity is made up for by the quality of the information about each of these private specialist practice patients. It is difficult to accept the suggestion that oestrogen, a naturally occurring hormone like insulin and thyroxine, could be carcinogenic, especially when one considers the oestrogen levels pregnant women endure - approximately 10 times the serum oestradiol required to relieve a post-menopausal woman's symptoms. The risk, if any, associated with the progestogen component of HRT is beyond the scope of this study, but once again there is nothing in this series to suggest it is significant.

In conclusion, the fear associated with HRT is not justified and women complaining of disorders due to oestrogen lack deserve the management of any patient with an endocrine deficiency. Many symptomatic women chose an obvious large improvement in quality of life over a theoretical small risk of break cancer.

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