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Managing Menopausal Symptoms

August 13, 2008
Patricia A. Ganz, MD

OPERATOR:

I would like to welcome everyone to the Living Beyond Breast Cancer "Managing Menopausal Symptoms" conference call. It's now my pleasure to turn the floor over to your host, Miss Amy Grillo. Ma'am, you may begin your conference.

AMY GRILLO:

Thank you. Welcome to Living Beyond Breast Cancer's teleconference, "Managing Menopausal Symptoms." Today's program will educate you on the latest research in managing the symptoms of menopause on your body and mind that you may experience during or after treatment for breast cancer. Thanks to all of you who have taken the time out of a busy summer's day to join us for today's program. I'm Amy Grillo, LBBC's program manager, and I will serve as the moderator for today's program. Like all of our teleconferences, today's program will be interactive and will provide you with some of the latest information and breakthroughs in managing menopausal symptoms.

During the program, you will learn more about the latest research news, techniques for preventing or minimizing side effects, and strategies for improving quality of life. As many of you already know, LBBC offers an array of educational programs for women and families affected by breast cancer. Teleconferences are one way we are able to get information out to large groups of people across the country and around the world. For updated information on all of our education programs, publications and services, please visit us on the web [http://lbbc.org]….

…Feel free to share this information with others who may not have been able to join us live on the call today. Also, program evaluations will be e-mailed to you after today's program, and your feedback is very important to us. We use it to design ideas for future programs. We take your feedback very seriously, so we hope you'll take a few minutes to provide us with your ideas and your feedback about today's program, and future program ideas as well. Today's format will be a presentation by our featured guest speaker, Dr. Patricia Ganz, followed by the opportunity for participants to ask questions on today's topic.

To get us started, I would like to tell you a little bit about today's featured speaker. Dr. Patricia Ganz, a medical oncologist, is the director of the division of cancer prevention and control research at the Jonsson Comprehensive Cancer Center, where she directs the UCLA Family Cancer Registry and Genetic Evaluation Program. She is a professor at the UCLA Schools of Public Health and Medicine. In 1999, she was awarded an American Cancer Society clinical research professorship for enhancing patient outcomes across the cancer control continuum. She was awarded funding to lead UCLA's Cancer Survivorship Center of Excellence as part of the LIVESTRONG Survivorship Center of Excellence Network in 2006.

Dr. Ganz is a pioneer in the assessment of quality of life in people with cancer and is active in clinical trials research with the National Surgical Adjuvant Breast and Bowel Project. She has focused much of her clinical and research efforts in the areas of breast cancer and its prevention. She recently completed service on the National Cancer Institute Board of Scientific Advisors and the American Society of Clinical Oncology board of directors. She is an American Cancer Society clinical research professor and was named the Komen Foundation Professor of Survivorship in the past. In October 2007, she was elected to the Institute of Medicine. I am pleased to welcome Dr. Ganz.

PATRICIA A. GANZ, MD:

Thanks very much, Amy. It's a pleasure to be here today. I hope that in the next hour and a half that we have together, we'll be able to explore many of the common symptoms that women experience as they cross through menopause, whether or not they have had a cancer history. As you'll see, I'm going to try to frame my introductory remarks to relate to what's normal and what happens to women as they age, and then to how breast cancer and its treatment may affect the normal course of those kinds of symptoms.

First I'd like to go through the review of the natural history of menopause and aging and talk about what normally happens to women, and then spend a lot more time specifically talking about the effects of cancer therapy and its relationship to menopause. Of course the therapies women are commonly exposed to are chemotherapy and endocrine therapy, sometimes surgical therapy that's also directed at endocrine therapy. In terms of talking about what happens to women as they age, if we think back to 1900, the turn of the last century, the average age of death for women was 60 years. The average age of menopause is 51, and that has been very stable for a very long time. But if we think back over 100 years, women were living for a relatively short period of time past menopause.

As a result, many of the postmenopausal changes we see and the age-related changes we see in the normal population reflect the fact that women are now, on average, living into their late 70s and early 80s, and many are living to 100…

…Living many years past menopause and experiencing menopause the way women do today and their adaptations as they make this life transition are obviously quite different than over 100 years ago. The common symptoms that women experience often start before their last menstrual period. We say that somebody is in menopause if they haven't had a menstrual bleed in over a year, because women may have irregular periods as they approach menopause, but if they haven't had a bleed in over a year, they're likely not going to have another one.

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The average age at which that happens is 51 years, but in the decade before, in the 40s, women go through what we now call the perimenopausal transition, and that is a period of time in which the ovaries are not necessarily functioning regularly. They're not necessarily releasing an egg every month. Even though the woman may not actually bleed on a regular basis, she may not be ovulating. This is exactly the mirror image of puberty, where in puberty, many women – not all women, but many women – will not menstruate regularly. The relationship between the pituitary gland in the brain that regulates the ovaries, the cycling of that, may not become regularized until a woman is in her late teens.

In the wind-down of our ovarian lives in perimenopause, there may also be either irregularity that may be apparent in terms of irregular bleeding, or there may also be months when the estrogen levels are not as they should be. There may not be any progesterone secreted, because the ovary is not ovulating and an egg is not released. Women may have fairly significant fluctuations in their hormonal levels in their 40s, and there may be highs and lows of their estrogen levels. Women may begin to experience what we call vasomotor symptoms, or hot flashes and sweats, long before their last menstrual period occurs. This is kind of the buildup to the time in which the ovarian function ceases in terms of production of estrogen and progesterone.

During this same period of time, women may have some moodiness as a result of some fluctuations in their hormone levels. There may be breast tenderness and cystic changes, and ovarian cysts may also occur during this time. Some women may find that they have increases in their sexual desire. Their testosterone levels may go up and then gradually decline during this period of time. There are a lot of things going on even before menopause occurs, and then certainly after the hormones – estrogen and progesterone – drop off through the menopause transition, when there is no bleeding, there will be more significant fluctuations in these symptoms. Again, this is quite variable. Some women have never had a hot flash as they go through menopause, and others have many daily hot flashes. There is a great variation in normal behavior.

I also want to comment on a few other symptoms that are not always talked about in terms of menopause, and those sometimes include urinary incontinence, or losing urine. Women may find that they have trouble getting to the toilet on time. They may lose or leak urine. This may be related to physical changes after childbirth but also because the estrogen in our bodies is very important for the cells that line the urinary tract in the area of the vagina, so with loss of estrogen, these symptoms may occur. The other thing is that women may also, in this time, normally – we're not talking about women exposed to chemotherapy – start to complain of some difficulties with memory, word recall in particular, finding the words and the names for things.

We do know that there are a complex set of things going on during this time. If you're having hot flashes and sweats at night, you may not be sleeping, so your alertness and sharpness during the day may change. Your ability to concentrate and focus on things may change. Again, this is just a normal menopausal change. Specifically, in some experiments or studies that have been done where women have had their ovaries removed at a younger age or had their ovaries suppressed, it turns out that what we call verbal word fluency, which is coming up with the word and naming things, is particularly affected by changes in estrogen. Drops in estrogen as women go through menopause do not globally affect cognitive functioning but may be more specific for this word-finding kind of cognitive skill.

This is what's going on with women normally. In the ten years or so after the woman has her last menstrual period, she's going to still be making some estrogen, because even though she's not ovulating and eggs are not being produced and released, and those cells that make estrogen are on the wane, there are still cells in the ovaries that make androgens, or the male hormones, and they still provide a source of estrogen, because those male hormones get converted to estrogen in the fat tissue. Those are going to be on the decline as well, and, again, may affect sexual interest as testosterone levels decline. That's what's going on for women who haven't had cancer, women going through natural menopause.

If you add onto this what happens to women when they have cancer, we may see substantial worsening or exacerbation of all of these symptoms. I'd like to spend time specifically talking about chemotherapy and its effects and then endocrine therapy and its effects and how that relates to menopausal symptoms. The audience is probably familiar with chemotherapy being used in the adjuvant treatment of breast cancer – that is, for women who have newly diagnosed breast cancer where we want to prevent its recurrence for a long time. It's obviously used for women with metastatic or recurrent disease as well.

In the adjuvant setting, where most women are exposed to this, there is a relationship between the development of menopause as a result of chemotherapy and age. ... Amenorrhea and cessation of menstrual periods can occur at any age, [but] it's most likely to be permanent or where menstrual periods will not return over the age of 40. ... Women who are treated in their 30s or 20s with standard, adjuvant chemotherapy may have some temporary cessation of menstrual periods but usually will have a return of function.

If you're older, if you're closer to menopause, if you're in that perimenopausal window, 40 to 50, you're more likely to have permanent discontinuation of menstrual periods. That's because the cells of the ovary are rapidly growing and dividing cells, just like the cells of your bone marrow and the cells of your intestinal tract, and they are very sensitive to being injured as a result of the chemotherapy treatment. When they are injured, they do not reproduce, and the ovary then loses egg follicles, and it loses the cells that make hormones. As a result, women may very abruptly begin to experience menopausal symptoms of hot flashes and sweats as part of their chemotherapy treatment very shortly after their breast cancer diagnosis.

You have, in many younger women, the collision of the stress and the anxiety and the challenges of the breast cancer diagnosis with the onset of unexpected menopause or menopausal symptoms. That's a very challenging thing for the woman to endure while she's going through the side effects of chemotherapy. Very often, even if chemotherapy suppresses menstrual periods during its course, for younger women there may be a gradual return of menstrual periods. That may take a year or two or three. Particularly if a younger woman gets put on tamoxifen following chemotherapy, that may suppress the resurgence of her menstrual periods, although she still may be making estrogen, so it's a complicated situation.

We have women who, as part of their chemotherapy, may become acutely menopausal. Let's take a 45-year-old woman whose menstrual periods stop and do not resume. The intensity of the menopausal symptoms can be quite severe and very significantly greater than if you compared her

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to a 45-year-old woman who had not had chemotherapy and didn't have breast cancer. That's because, as I've already mentioned, the chemotherapy damages the ovarian cells. It's almost like having your ovaries removed because of the dramatic shutdown of hormones that occurs with chemotherapy-induced menopause. That's very different from having the ten years from age 40 to 50 of your body gradually getting used to having somewhat lower levels of estrogen over this period of time. When it happens, it's very dramatically. It can be very difficult, and the hot flashes and sweats and vaginal dryness that are often part of this may be very troublesome to women, and that's what we're going to be talking about managing.

In addition, in some of the studies we've done where we were looking at the effects of breast cancer treatment and cancer itself on women's lives, subsequently, as survivors, we did see effects of chemotherapy even in the postmenopausal women in terms of sexual functioning. While those women may be well beyond menopause and have already made that normal life transition, we did find that having had chemotherapy contributed to worse vaginal dryness, even in older women who were already postmenopausal.

As I'll talk about later, in terms of sexual functioning, women who have vaginal dryness and pain with sexual intercourse are less likely to have a satisfying and functioning sexual repertoire post-cancer treatment. That's also true for healthy women who have not had breast cancer. Vaginal dryness may be very problematic for them as well, but this occurs at a much higher rate in women who have had chemotherapy. I'll speak to that shortly.

We have a group of women who may be prematurely forced into menopause as a result of cancer therapy at a younger age. We have older women who may get chemotherapy and may not necessarily have any changes in their hot flashes or sweats or other vasomotor symptoms but may have worsening of sexual functioning as a result of the chemotherapy treatment. I'm now going to talk about endocrine therapy separately, and then later I'll talk about what happens when you have chemotherapy and endocrine therapy.

As you know, the major types of endocrine therapy are the selective estrogen receptor modulators, specifically tamoxifen, which up until 2000 had been the standard adjuvant therapy for both pre- and postmenopausal women, but the aromatase inhibitors, which are a different class of drugs, were introduced in the early part of this century and now, in addition to being used in metastatic breast cancer, are used for the adjuvant treatment of postmenopausal women. A third type of therapy that may be used is ovarian suppressive therapy, which is with a drug that shuts down the ovaries in younger women. Again, that will lead to very significant menopausal symptoms. Then, rarely, women may have their ovaries removed, which obviously at a younger age leads to very severe menopausal symptoms.

The endocrine therapies that we use: Tamoxifen is a drug that's been in use for many, many years – 35, 40 years. We have a lot of experience with it. I'll speak a bit to the risks for hot flashes with this particular drug. It's primarily used in premenopausal women today because the aromatase inhibitors cannot be used in premenopausal women. It doesn't work. It's not effective in women who still have hormones from their ovaries. For older women, where aromatase inhibitors are used, the mechanism of action for that particular drug is to take the estrogen level – which may be, say, at 15 or 20 in a postmenopausal woman – down to zero by blocking the production of estrogen in the postmenopausal woman's body.

Even though, postmenopausally, the hormone levels have fallen, when we take a woman's blood level of estradiol down from 15 or 20 to zero, she may often feel very deficient in estrogen. She may not have so many problems with hot flashes and sweats, but very severe vaginal dryness and sexual dysfunction have been reported with this, and very significant joint pains are also noted. Joint pains are something that begin to occur in healthy women in their 40s and then get worse as women get older. The mechanism for joint pains and arthritis – that actually are very common in women as they age – is not clear, but it does seem to be related to estrogen levels and its role in inflammation.

What we're seeing in women who are on aromatase inhibitors is that by dropping the estrogen levels we're seeing, for some women, very significant joint pains and symptoms. While that's not the specific focus of this talk, I wanted to basically speak to that, because that's one of the reasons women who are taking aromatase inhibitors often stop that therapy. I want to say that tamoxifen is a very good alternative in postmenopausal women. Although there are some risks of blood clots and uterine cancer, it's still a very effective therapy. Tamoxifen works by telling cells in the body that would normally be taking up estrogen that there's no estrogen around, by blocking the uptake of estrogen.

In breast tissue and in any metastatic sites, the tamoxifen blocks any stimulation that the premenopausal woman's ovaries – the estrogen she may be making in her body would be stimulating those cells. At the same time, the brain, the hypothalamic cells of the brain sense that there's no estrogen around, and the temperature-regulating system that leads to hot flashes and sweats gets out of shape as a result of the tamoxifen being present. Again, that's most common in women who are in the early postmenopausal years – say, in their early 50s – or women who may have recently had chemotherapy and have become amenorrheic, or not menstruating. Their ovaries have been shut down, and then you add tamoxifen to this, and it may make those symptoms worse.

I think that if you have this background about what's going on normally and how these drugs may be working, you may have a sense of how these symptoms are common in healthy, aging women but are then made worse by the cancer treatment exposures that women have had. I want to spend a little time talking about how frequent some of these menopausal symptoms are and then speak more directly to how we might begin to manage and treat them in the setting of both healthy women without cancer and women who have had a cancer history.

In a recent study that we did as part of the Breast Cancer Prevention Trial [visit http://www.cancer.gov/clinicaltrials/digestpage/BCPT to read about different aspects of this clinical trial], which was the tamoxifen prevention trial, we collected information on women's daily symptoms related to menopause and other kinds of symptoms. These were women we assessed before they ever took tamoxifen. Just to let you know, in healthy women without cancer, about 25 percent of women ages 35 to 49 are already reporting hot flashes. About 55 percent of women 50 to 59 are going to be reporting hot flashes. That drops down to about 25 percent over age 60. I like to say that you don't see too many 65-year-old women fanning themselves in their hot flashes, because there is just a natural accommodation that the body has over time. But if you're in a room of women, with or without cancer, in their 50s, there are going to be a lot of them who are just opening up their clothes, taking out something to fan, as they break out in a sweat.

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This is very common, and, again, it can be made worse by our cancer treatments.

Similarly, night sweats have that same pattern where they tend to peak in women in their 50s and then decline some in women over age 60. Vaginal dryness is somewhat different. When women are still having hormone functioning from their ovaries in their 40s, vaginal dryness is pretty infrequent, although about 10 percent to 15 percent of women will report it. But in women over age 50, about 30 percent of women who have not had any cancer treatment report vaginal dryness. This is a direct response of the vagina to having low levels of estrogen postmenopausally. Then, as I've already mentioned, joint pains go up dramatically. Women over age 60 in the healthy sample that I described, 60 percent of them report joint pain. This is very common.

If we then look at some of the data we collected in breast cancer survivors who were between one and five years out after their treatment – they may have still been on their endocrine therapy but finished their chemotherapy – we see that compared with younger women without cancer, there is about twice the rate of hot flashes. About 50 percent of women younger than 50 who are breast cancer survivors report hot flashes. In women ages 50 to 59, about 78 percent report hot flashes, compared with about 54 percent in the healthy comparison group. Over age 60, there's still an increased rate of hot flashes in women who have had breast cancer treatment. About 42 percent of them report hot flashes. Parallel pattern for night sweats: They're not quite as common as hot flashes but, again, a parallel pattern.

I want to talk a bit about vaginal dryness now, and this is one of the major problems that breast cancer treatment does induce. It isn't talked about, but because we did this very comprehensive study on sexuality and intimacy after breast cancer, we collected this information. About 42 percent of women younger than [age] 50 who have had breast cancer treatment report vaginal dryness – this is women who are disease free after their adjuvant therapy – [along with] 47 percent [of women ages] 50 to 59, and 44 percent [of women age 60 and over]. Again, across the board, very increased rates of vaginal dryness. Pain with intercourse mimics this. A woman may not be sexually active with a partner, but about 30 percent of the women younger than [age] 50 in our breast cancer sample reported pain with intercourse, [along with] 31 percent [of those] ages 50 to 59 and 21 percent [of those] over age 60. Again, there is a decline with sexual activity and having a partner as women get older.

Another problem that I want to spend a couple of seconds on is weight gain. That is not always talked about as a menopause issue, but it is directly related to menopause. Women tend to begin gaining weight – healthy women making their normal menopausal transition – in their 40s. They may gain a pound or two a year, and over the course of that transition time have 20 pounds that they've gained. This is because the ovaries are our major source of the androgen testosterone. Testosterone leads to muscle mass, and as women transit that period and their testosterone levels are falling, if they don't do something to maintain their muscle mass, if they don't eat less, they're going to gain weight.

What we see among the breast cancer survivors whom we've studied is very significant problems with weight gain, about 50 percent of them reporting this in [the] less than 50 and the 50-to-59 age group[s] compared with only about 21 or 25 percent of women who have not had cancer. This is, again, directly related, and this has been shown in other studies by Dr. Goodwin, that if you go into menopause as a result of chemotherapy premenopausally or even in your 50s that this will, again, dramatically shut down your ovaries, change your metabolic situation so that you're not burning as many calories. You may wind up not exercising as much because of your cancer treatment, and weight gain becomes an important problem.

I want to talk a bit about how, within the breast cancer patient population, the different combinations of chemotherapy and hormonal therapy may affect things. If women haven't had any endocrine or chemotherapy treatment, they're still going to have these symptoms. In our studies, we've shown that hot flashes and night sweats are still common in those women, because they're just like everyone else transiting the menopause normally, where they're going to have these symptoms. The challenge up until recently had been that the community of women without cancer were taking estrogen for these symptoms, whereas this was prohibited, if you will, or very strongly discouraged in women with a breast cancer history.

We now know since the 2003 results of the Women's Health Initiative trial that hormone replacement therapy at menopause does not have health benefits in terms of heart disease prevention or other major health benefits. It is good for symptomatic relief of hot flashes and other symptoms, but we only recommend or prescribe it if necessary for women without cancer for a very, very short time, because long-term, there may be complications like blood clots, gall bladder disease, stroke and heart disease. There also was a randomized trial in women with breast cancer, randomly assigning them to hormone replacement therapy or not, and there was a higher rate of death and recurrence in breast cancer survivors who took hormone replacement therapy. We strongly discourage its use in women with a cancer history and women without a cancer history.

But if we look at how these symptoms play out across the use of endocrine therapy alone with, say, tamoxifen or chemotherapy or chemotherapy and tamoxifen, women with more intensive treatment – that is, the women who get chemotherapy and endocrine therapy – are likely to have the most severe symptoms, such as hot flashes and night sweats. Vaginal discharge is a symptom that we see primarily associated with tamoxifen. Some women find it annoying. Other women find that it may actually help them with some vaginal lubrication, so it's kind of a double-edged sword.

In the Breast Cancer Prevention Trial, we did not find that tamoxifen significantly led to deterioration in sexual functioning, but that was tamoxifen alone. If you combine it with chemotherapy, you get increased vaginal dryness and problems associated with that. That may be the driver of sexual dysfunction in women who take chemotherapy and tamoxifen.

In the work that we've done where we asked women who had had cancer treatments whether they had difficulty concentrating or had forgetfulness, we didn't see any difference between the women who had had no chemotherapy or endocrine therapy and those who had had treatment. While my research group is intensively looking at issues of cognitive function in breast cancer survivors, it's not clear what the relationship is to treatment and whether this does relate to menopause.

I want to now move to strategies to potentially treat some of these symptoms. I'm sure as we discuss this in the next hour, you'll have questions that will explore this in more detail. Because women with a breast cancer history could not be safely prescribed estrogen because it may stimulate tumor cells to grow or lead to the development of new cancers, there have been very good

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randomized, controlled trials done for the past 15 or 20 years looking at ways, particularly, to manage hot flashes.

Dr. [Charles] Loprinzi and the North Central Cancer Treatment Group have pioneered a number of studies. They've looked at strategies such as vitamin E [http://jco.ascopubs.org/cgi/content/abstract/16/2/495], and antidepressants, specifically Effexor [http://jco.ascopubs.org/cgi/content/abstract/16/7/2377]. Other groups have looked at Paxil and, more recently, drugs like gabapentin to see if they would be helpful in a placebo-controlled strategy to relieve symptoms. These drugs do work. The drug Megace, which is a progestational agent, is also very effective in managing these symptoms. These particular drug strategies can be used.

For women who are on tamoxifen, we have to be careful about which antidepressant regimen is used, because some of them may interfere with the metabolism of tamoxifen. The preferred drug for those women is Effexor, but if you are not on tamoxifen, a wide variety of these drugs can be tried. There are also over-the-counter remedies such as Peridin-C. Some women that I've seen have had relief from this. Vitamin E has also had a modest effect. Many drugs and remedies actually have a placebo effect, with about 25 percent of women given a placebo having benefit.

Other herbal strategies and remedies have been tried. There's an herb called black cohosh. It's commercially sold as Remifemin and other forms. Randomized, controlled trials with it have not shown much benefit. I just was reading some literature last night cautioning against the use of black cohosh because of liver toxicity. This is one of the concerns we have with herbal remedies. There have also been some trials looking at soy to manage hot flashes. These have not been very effective in managing this. A lot of women will resort to behavioral strategies – having a fan, wearing light, layered clothing and being able to control their body temperature in this way. If you are having difficulty, talking to your physician about this is very important, because this is a big issue not just for women who have had breast cancer but for the whole world of menopausal women who are now experiencing hot flashes, and estrogen is not our first choice.

For the vaginal dryness that I talked about as being an important problem, vaginal lubricants can be very, very effective in terms of helping women, particularly who are having pain with intercourse. A number of them are over-the-counter and non-estrogen containing and, if used prior to intercourse, are very effective. Vaginal estrogen can also be used. There are two low-dose vaginal estrogen preparations. One is Estring, a low-dose estradiol that is slowly released in the vagina over a three-month period of time. It doesn't get absorbed into the bloodstream. It is not safe to use – nor is the other preparation, Vagifem, which is inserted vaginally twice a month – with aromatase inhibitors because of the fact that the aromatase inhibitors drop the estradiol level to zero or near zero, and that is their mechanism of action.

The modest absorption that would occur with these vaginal estrogen preparations would counteract the benefits expected, and there have been some studies where women taking an aromatase inhibitor and also using an intravaginal preparation have very high levels of estrogen. In contrast, if you're on tamoxifen and use a vaginal estrogen preparation, there's no problem because tamoxifen works even in premenopausal women who have very high levels of estrogen, in the 200 range. It can still be effective.

Non-estrogen vaginal preparations such as Replens that can be used topically have been shown to improve the vaginal moisture. This can be used in women who are not sexually active but who are symptomatic from the vaginal dryness. In studies that we and other people have done, we've seen improvement in symptoms and in sexual functioning. This is very important to think about if you're having these symptoms or if sexual functioning is an issue. I think it's important to know that the normal sexual response changes with age – that women, as they age, are having a decline in their testosterone that leads to a lack of interest in sexual activity.

If you are having difficulties in your sexual life, treating the vaginal dryness is an important first step. Then couples counseling may be very effective, and there are a lot of strategies that can be used. In some women, we give low doses of testosterone. Particularly, if we measure their blood level and they are testosterone deficient, we can give some of this back, and that may improve their functioning. A few other things that may result from the symptoms that I've described are insomnia and cognitive problems, and if you are having sleep difficulties, it could be, in part, from being awakened at night because of your vasomotor symptoms. There could be other things that are going on in your life.

There have been excellent randomized, controlled trials showing that something called cognitive behavioral therapy, which really gives you very structured advice about how to change your sleep hygiene and behaviors related to this, is very effective. Midlife women have a lot of troubles with sleeping, and it's complicated, the reasons why. Their habits that lead to these problems are varied. This is something that has been shown to be very important. In terms of the cognitive problems, getting a good night's sleep is the key. That's very important, but treating underlying depression and anxiety may also be very important in managing any of the cognitive or thinking problems that you're having.

I think I will close there and turn it over to Amy.

AMY GRILLO:

Thank you, Dr. Ganz. It was a very comprehensive presentation here on many of the common problems we hear about at Living Beyond Breast Cancer. I have a follow-up question for you concerning the use of vitamin E for hot flashes. I was wondering if you knew how much was recommended to have that modest effect you talked about.

PATRICIA A. GANZ, MD:

Vitamin E is not something I recommend regularly because there are controversies about its safety and the dose. I would not go above 400 units, because there are some health risks associated with higher levels. If you look at Dr. Loprinzi's trial [http://jco.ascopubs.org/cgi/content/abstract/16/2/495] where he did this head-to-head comparison of placebo and vitamin E, the vitamin E wasn't a lot better than the placebo. [Inaudible] a few percentage points, but occasionally women will find it beneficial, and who knows? They may be having that 25 percent placebo response, which is a good thing.

AMY GRILLO:

Great. Then you mentioned the cognitive behavioral therapy for insomnia or some cognitive problems. Is that a type of psychological counseling women can request from their practitioner? Should they talk about that with their oncologist or internist? What would you recommend?

PATRICIA A. GANZ, MD:

You could start with your internist or family doctor. As I mentioned, sleep problems are very,

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very common. [Inaudible] women, 50, 60 percent of them will complain of sleep difficulties. It's becoming more and more common in the general population of women to be referred to this. I've seen this happen with family physicians in my UCLA community actually actively referring [inaudible]. I think women can ask this of their primary care physicians or their oncologists. One of the randomized trials that was effective was published in the *Journal of Clinical Oncology*. It doesn't always get the oncologists' attention, but there are more and more therapists who are providing this in the community.

AMY GRILLO:

Great. The last follow-up I have is if you could spend just a few minutes – and I'm sure it might come up in the questions as well – on the impact of menopause or taking the AIs on bone health. What's your recommendation for getting a baseline reading?

PATRICIA A. GANZ, MD:

That's a very important question. I didn't talk about that particular outcome. All of us reach our maximum bone density around age 35. How dense our bones are is really related more to what our diet, nutrition, physical activity might have been when we were teenagers. If you weren't drinking milk or taking dairy products, your bone development may have been more modest. If vitamin D hasn't been part of your diet, or sun exposure, there could be issues there.

The bone mass that a woman has at age 35 is really determined by what went on earlier in life. Then there is a 1 percent decline per year. If you had a high bone density to begin with and you start on that decline, you're not going to necessarily be at high risk for menopausal exacerbation, if you will, of that bone loss. But if you had a low-range bone mass at age 35, then 15 years later at menopause, you may already be in a risk range.

The bone density numbers that we get with DEXA scans are just numbers. It doesn't mean you're going to have a fracture. It's just like measuring your cholesterol and finding it a little high doesn't mean you're going to have a heart attack. It's a risk factor. We need to have this done on women before they start an aromatase inhibitor to know where they are, because medications to stabilize the bones may be very important to give along with the aromatase inhibitors. For women who have normal bone density at the start of an aromatase inhibitor, it should be checked every 18 months to two years.

AMY GRILLO:

Eighteen months to two years. Great. What we'll do now is move into our questions and answers with the audience. I have a few reminders for those of you who have questions. Frame your questions in general terms to help maximize Dr. Ganz's response for the help of others who are listening. Also, try to focus your questions on today's topic or on those closely related.

OPERATOR:

Our first question is from Bridgewater, [Inaudible].

CALLER:

My question is about weight gain. You mentioned that if a woman has had chemotherapy and the chemo has pushed her into menopause, she's more likely to gain weight. Do you have any suggestions, other than the usual diet and exercise, as a way to deal with that?

PATRICIA A. GANZ, MD:

Yes. Being aware of this is half the battle. I'm still trying to lose the ten pounds I gained during that time of my life, and I wasn't so smart and wasn't aware of it. Many oncologists do try to make their patients aware of this, but it can creep up on you. Clearly, weight training is something that isn't always included in women's exercise regimens. Women tend to do a lot of walking or aerobic exercise, but you want to build up that muscle mass so your baseline caloric expenditure is increased. Obviously, decreasing portion size and eating a healthy diet is very, very important. I find a lot of my patients say, "Oh, I'm eating healthy," and they are. It's just that the quantities are much greater than what's necessary.

The other thing we are focusing on in our younger patients is stress management, because in our research we have found that, for younger women, cancer comes at a time when it's least expected, and if you don't deal with that, very often eating is a way of dealing with stress. It's a very individual thing, but these are some general guidelines.

CALLER:

So weight training as opposed to even running?

PATRICIA A. GANZ, MD:

Running doesn't do much for your upper body.

CALLER:

That's true.

PATRICIA A. GANZ, MD:

Women in the general population lose upper-body strength as they age.

CALLER:

This is obviously a personal situation for me, and I'm not finding I'm eating any more than I ever have, but the weight is continuously creeping up.

PATRICIA A. GANZ, MD:

Yes, and, again, it hasn't been studied as well as we would like. Tamoxifen has been around for a long time. I can tell you in the Breast Cancer Prevention Trial with healthy, high-risk women, we did not see weight gain with tamoxifen alone. It's really the menopause transition that does this. We don't know enough about the AIs, but I have a clinical guess that when you lower the estrogen as low as it is, there does seem to be some body fat distribution change. Whatever a woman can do to try to build muscle mass – and it's just not in the lower body; it's throughout the body – you increase your caloric expenditure and it may help with that.

CALLER:

Thank you.

OPERATOR:

Thank you. Our next question is from Miami, Florida.

CALLER:

Hello. I'm interested in the alternative for managing hot flashes and night sweats of acupuncture. Also, is there a difference between a hot flash and a night sweat?

PATRICIA A. GANZ, MD:

Let's start with what those are. They are both manifestations of the temperature-regulating center in the brain being aware that there's been some change in the estrogen level. We don't know exactly how these get triggered, but the zone of comfort that a woman may have, as she's in this unstable period, is much smaller. A half-degree difference in temperature may trigger either sweating or a hot flash, whereas if she were ten years before or after that point in time or before or after cancer treatment, it might be a two-degree temperature [difference] that would trigger a sweat, if you will. Why some women have the hot flash and why others have the sweat is not clear. It is a way for the body to cool itself down when it feels that it's getting a little too warm. That's the physiology of what's going on. Many young people, or men, will sweat obviously if they're too warm. We don't really know why some people are more vulnerable to one or the other.

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The studies that I know of that have looked at acupuncture in a randomized, controlled trial where you give sham acupuncture treatment – in other words, you don't treat the purported effective sites but do that in one group versus another – have not been successful in alleviation of symptoms. But with all of these particular strategies, as I've said, if you do anything to someone – give them a sugar pill or perhaps do acupuncture – you can get about a 25 percent improvement in symptoms. The mind-body connection, how the mind perceives the activity that's being given as a treatment, may have a powerful effect on that temperature-regulating center.

CALLER:

Thank you.

OPERATOR:

Thank you. Our next question is from Donalsonville, Georgia.

CALLER:

Yes, I've been off the aromatase inhibitors now for almost six months. I had all of the side effects quite severely. Are they going to go away? Also, I've had vaginal atrophy; will a vaginal dilator help in that situation?

PATRICIA A. GANZ, MD:

It's very hard to speak to your personal situation, since I have not met you and I can't evaluate exactly what's going on. In general, the symptoms that women experience, in terms of the achiness and sometimes loss of well-being, on aromatase inhibitors do seem to improve when they stop. Again, I don't know how old you are and what your vaginal health was before you started the aromatase inhibitor, but certainly over time there can be substantial atrophic changes. It sounds like that wasn't attended to while you were on your therapy. That's why a lot of what I do is encouraging doctors and patients to talk about these issues so that the symptom can be managed earlier on. You can use vaginal lubricants. You can use over-the-counter medications like Replens to try to improve the vaginal health. I would try to do that first before using a dilator.

CALLER:

I have done all that, and as a matter of fact, for two years my husband and I have not had vaginal sex because of the pain involved.

PATRICIA A. GANZ, MD:

Were you doing it while you were on the aromatase inhibitor?

CALLER:

Yes.

PATRICIA A. GANZ, MD:

You may, again, talk to your doctor about whether it is safe for you to use a low-dose vaginal estrogen preparation. That's the other thing to discuss.

CALLER:

I have done that also.

OPERATOR:

Thank you. Our next question is from Philadelphia, Pennsylvania.

CALLER:

Good afternoon. Thank you very much for your very fine presentation, but I have some questions. I am on an aromatase inhibitor after tamoxifen. I find, having hen sessions with many of my normal friends and other friends, that these products tend to carry us to some extreme of the menopausal symptoms. I don't know how you would measure levels, but it's sometimes very unlivable. As the previous caller stated with the AI, although minus the sweats and the moods and all kinds of other things, and the joint things, I am not inclined to say, "Oh, it's all age." I think there is an extreme that these adjuvant things carry you to. I just wonder why they aren't addressed in the community.

PATRICIA A. GANZ, MD:

That's what I tried to tell you. I told you there is a substantial increase in vaginal dryness and hot flashes and other symptoms with these. It's an exaggeration of what is normal because, again, your friends have estradiol levels that are 15 or 20 and yours may be zero. It's just a difference. That difference starves the breast cancer, but it also exacerbates and worsens the menopausal symptoms. The problem with the aromatase inhibitors is that in order for them to work, they have to take away whatever little estrogen is left. Again, speaking to your doctor about this is indicated; I don't think you should go off your cancer therapy.

But sometimes women are treated aggressively for very tiny tumors when they may or may not need it. I'm not saying that that's the case. For some women I've seen – not in your situation; you've had five years of tamoxifen, but in women who are approaching their first endocrine therapy – if they cannot tolerate an aromatase inhibitor, they can certainly be treated with tamoxifen.

CALLER:

I see. I've had the ten years, five years of one and five years of the other, and I'm almost near the end of the five years of the AI, but I'm just finding that it doesn't seem to contain the symptoms at all.

PATRICIA A. GANZ, MD:

Again, you'll probably feel a lot better when you get off [the drug].

AMY GRILLO:

Are you currently off [the drug]?

CALLER:

Thank you.

AMY GRILLO:

We'll take the next question.

OPERATOR:

Thank you. Our next question is from New York, New York.

CALLER:

Hi. My question is related to supplements for both the hot flashes and also – I also look at the bone support kind of supplements, and I notice that many of them have soy in them. I have been hesitant to take anything with soy, given things that I've read about soy acting as an estrogen. I've been trying to avoid any of those. I wonder whether that's overdoing it, and whether I should not be avoiding supplements that have soy, and whether that could actually be helpful – in other words, that it's not enough soy to be concerned about.

PATRICIA A. GANZ, MD:

First of all, if you're eating soy in your diet, if you're eating tofu, miso, edamame, tofu burgers or whatever it is, it's not a problem. What we are very concerned about, though, is when you eat a supplement that's just isolated compounds. Mother Nature packages these as multiple forms of the soy and balances things out, but when you have an isolated chemical – and this was seen very nicely in the beta carotene lung cancer prevention trials [http://www.cancer.gov/clinicaltrials/results/final-CARET1204], where we thought people who got lung cancer were deficient in carotinoids, found in carrot and red and green fruits and vegetables, but when they gave the beta carotene, it actually caused a higher risk of getting cancer. It wasn't the way Mother Nature packaged it.

The studies that have been done looking at soy supplementation for management of hot flashes have not shown that it's effective. That's one

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thing. The other thing is there's no evidence that I know of that you should be using this for bone health. The best things that we know about are having an adequate diet in terms of calcium and supplementing yourself if necessary, making sure that you have adequate intake of vitamin D and sunlight. One of the things that's very interesting now – I can't remember if you're from New York – is that many people, because of wanting to avoid sun exposure and skin cancer, are not getting enough exposure to convert vitamin D from its inactive form to its active form. You can get your vitamin D level checked to be sure it's in the normal range and [inaudible] physical activity.

CALLER:

Yes, the only problem I've been having is when I go to a lot of the supplement stores and look for, let's say, a bone [inaudible] – you read things like you need calcium, but you need certain vitamins with it for it to absorb. Almost all of them have soy in there, and the same thing for – it's not the main ingredient, but it's one of many. Then I feel like I can't find any supplements that don't have it.

PATRICIA A. GANZ, MD:

Avoid the supplements, because they are not regulated. I would just take calcium. You can take Tums. You can take calcium [carbonate]. It doesn't matter. Again, in your diet, have enough milk or dairy products.

CALLER:

Thank you.

PATRICIA A. GANZ, MD:

There's nothing magic about supplements. Even if you worry about food safety, foods in general are very safe and are really your best source of all of these micronutrients.

CALLER:

Thank you.

OPERATOR:

Our next question is from Chesterfield, New Jersey.

CALLER:

Thank you. We're a group of nine, and we actually have two questions. The first one is related to joint pain. Do you have medications or recommendations for people when they're taking the aromatase inhibitor, or afterward if they still have the joint pain persisting? The second question is related to sleep deprivation and what kind of therapist and what kind of blood tests might be given or taken in helping to determine the problem.

PATRICIA A. GANZ, MD:

Joint pains are a really, really big problem. As I mentioned, about 60 percent of women without a cancer diagnosis who are completely healthy will complain of joint pains into their 60s, and we have not yet found a miracle drug for them. Most of them are treated symptomatically with Tylenol, acetaminophen. But in the women who are taking aromatase inhibitors for whom we are now seeing these as a clinical symptom that often is preventing them from staying on – and, as one of the earlier callers said, she has these symptoms at a greater magnitude than her friends – there are active clinical trials that are now going on.

Some studies have shown that there's increased inflammation in the joints. I think we're going to begin to see some treatments being studied in the cancer community because, as you know, many hundreds of thousands of women are on aromatase inhibitors. I don't have a magic solution for you at this time. Some women find that regular physical activity is helpful to them. Along with the weight gain/physical activities that are very, very important, they find that if they can stay active, some of the joint pains and symptoms are less for them. I don't have a remedy, and I think we are, in the next year or two, going to be able to see some clinical trials focused on breast cancer patients who are taking these drugs testing some strategies.

As far as the sleep, I used the term "cognitive behavioral therapy" and "sleep hygiene." Typically a doctor such as myself may interview the patient and say, "What time are you going to bed? What are you drinking before you go to bed?" Some people will get up to go to the bathroom in the middle of the night. You really have to have, with your doctor, a conversation about your sleep habits and your patterns and what's waking you up at night. Very often, just kind of regularizing, going to bed at the same time every night, [helps]. If it's urination that's waking you up, make sure you don't drink everything after 6 or 7 in the evening.

I have interviewed many survivors who have said they kind of fall asleep at the TV after dinner and then wake up out of their lounge chair and try to go to sleep. Some women have told me the only quiet time they have after they've taken care of everybody else in the house is 11:00, and they're on the Internet until 1. These are all very bad habits and are very disruptive. In addition, not using your bed for anything other than sleeping – many people watch TV in their bed, read books in their bed. The bed should be a place where you sleep and have sex, and that's it. Going to bed at the same time and having a regular time to get up in the morning is very important. This is what a cognitive behavioral therapist would do in trying to change your behavior to try to make sure you can get a good night's sleep.

CALLER:

One other question, a clarification: On the medications for joint pain, things for arthritis, anti-inflammatories – would they be considered something that a woman might take?

PATRICIA A. GANZ, MD:

Yes, I suggested acetaminophen, which is Tylenol, or you can use the nonsteroidal medications like Motrin. Again, you can talk to your family doctor and your oncologist about it. We would recommend symptomatic management with those – similar drugs to what the general population of women are using.

CALLER:

If the cancer was in the joint, would that be more of an intense pain control or what?

PATRICIA A. GANZ, MD:

You're worried that your symptoms may be reflecting recurrence of cancer?

CALLER:

Correct.

PATRICIA A. GANZ, MD:

Any persistent pain in one location should be brought to your doctor's attention, but usually the kinds of aches and pains that women have either after the taxanes or with the aromatase inhibitors tend to be traveling from one place to the other.

CALLER:

Thank you.

OPERATOR:

Our next question is from Sun City, Arizona.

CALLER:

Hello. I've really enjoyed the conference so far. I am on aromatase therapy for about six months and have noticed a significant increase in constipation. I added Citrucel and stool softeners, and it doesn't seem to really help that much. I wondered if I'm missing something here.

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PATRICIA A. GANZ, MD:

It certainly could be a change in your physiology from that. There are hormone receptors in many different parts of the body. There are actually hormone receptors for estrogen and progesterone in the colon. You may be one of those people who is very sensitive to the change in your hormone level. I would work with your primary care doctor and your oncologist. Also, I would make sure there's nothing else going on with your uterus and ovaries, to make sure nothing new has cropped up there that might cause a bowel change or, remotely, a colon cancer. Telling your doctor about the change in your bowel habits is very important.

CALLER:

Okay, thank you very much.

OPERATOR:

Thank you. Our next question is from Las Vegas, Nevada.

CALLER:

Hi. I'm an unusual case because I have basal-like breast cancer, but my estrogen is a little bit expression – I'm an ER six. I've been on the aromatase inhibitors and tried both – I'm on Femara now, but I've been on a different one prior to that because I've been having severe stiffness and joint pain and hot flashes like 12 to 24 times a day, with dripping. I'm only 54. The osteoporosis is pretty severe also. I don't know what to do as far as whether I should stay on it with an estrogen being only six. I'm getting a total mixed review out here. I just want to know what your impression would be if someone is basal and they are a low expressor with estrogen. Is it even worth it as far as the benefit to be on the aromatase inhibitors?

PATRICIA A. GANZ, MD:

When did you stop menstruating?

CALLER:

At 42, and that was natural. I've never had children or anything. I stopped early on. I was diagnosed with HER2 positive breast cancer, which was incorrect, and I went through 52 weeks straight of Herceptin.

PATRICIA A. GANZ, MD:

We don't need to go through all of your therapy. I just wanted to know if you weren't recently menopausal.

CALLER:

I had all that, too, which I shouldn't have.

PATRICIA A. GANZ, MD:

I can't really give you a medical opinion. I would suggest getting a consultation from a university cancer center, from a breast center, to discuss it because in general with basal or the triple-negative cancers, chemotherapy is the mainstay of that therapy. Somebody would need to really review your case, look at the slides, etc.

CALLER:

It's a tough call because of being so low on estrogen, only a six, whether I'm really going to get any benefit.

PATRICIA A. GANZ, MD:

That's what you need to decide with whomever, and I would really get a second opinion.

CALLER:

Yeah, I'm getting mixed reviews from everybody.

PATRICIA A. GANZ, MD:

I would get a second opinion from someone outside of your community.

CALLER:

Thank you very much.

AMY GRILLO:

Thanks for your question.

OPERATOR:

Our next question is from Ann Arbor, Michigan.

CALLER:

Hi. I just want to ask about anxiety and tearfulness. I know, of course, with the breast cancer diagnosis and issues of middle age, we have reasons to be anxious. But can menopause in and of itself cause this anxiety and tearfulness?

PATRICIA A. GANZ, MD:

You're raising very good questions. And how much is the cancer adding to what would be in the background already normally? Many of the people who had focused on menopause and its effects on women's health were worried about depression as a major issue and whether depression was increased as a result of menopause. Most of those studies do not show that, but there haven't been as many good studies on anxiety, tearfulness, less serious mood changes. Most women who go through menopause will tell you – and this is with or without cancer – that they have what we would call emotional lability, swings in mood, being one minute very happy, one minute tearful.

It is part of that constellation of transition that we are all wired differently. We may all have the same levels of estrogen in our body when we are 40 years of age, whether or not we have cancer. One person can just have terrible mood swings with her menstrual periods, and for the other, it's no big deal. The interactions of the mind and the body are incredibly intertwined. The hormones play a very, very important role. This fluctuation of hormones, particularly at menopause, may bring out those kinds of changes and symptoms; it just may be made somewhat worse by the cancer experience.

My experience taking care of a lot of breast cancer patients and survivors, as well as our research, suggests that overall they function at a very high level, and they tend to recover and are pretty resilient. That doesn't mean they don't have moments when they just really feel out of control. That can happen to any woman, but it certainly can be worse for somebody with cancer.

CALLER:

I must be the only woman in America who can't wait to turn 60. Thank you.

OPERATOR:

Thank you. Our question is from Woodbridge, Virginia.

CALLER:

I have a question regarding taking the vaginal lubricants. Anyone except for those that are on AIs should be able to take it if they are either ER positive or ER negative?

PATRICIA A. GANZ, MD:

The lubricants that I spoke about are non-estrogen containing. Replens, which is a moisturizer that you use preventively – and I don't have stock in any of these. Astroglide is a common over-the-counter lubricant that's used with intercourse. None of those contain estrogen, and they're perfectly safe in any woman. We recommend them, obviously, for healthy women who don't have cancer as well as for women with cancer. This is a big business, because we just have a lot of women who are aging and having these symptoms.

If you have breast cancer and these kind of simple lubricants that don't contain estrogen are not helping you, or you need some additional symptomatic relief, you can use the low-dose estrogen preparations Vagifem and Estring. Estring is preferred because it has probably a bit lower

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levels than Vagifem. These two will, if you measure estrogen levels – if you put the Estring into a woman, her estradiol level might bump, say, from 13 or 14 to 18 or something like that – some small, modest amount. That's not enough, if you're not on an AI, to be an issue.

But if your main treatment for the breast cancer – if you've just had breast cancer, you're postmenopausal, and your doctor recommends, as your endocrine therapy, an aromatase inhibitor, we want to take your level of 13 down to about zero, because that's how the aromatase inhibitor is going to work for you. It's going to starve any breast cancer cells in your breast, or any that may have escaped the breast, by removing the estrogen that's in the circulation. So, that's a no-no. We can't use that.

If you are on tamoxifen, because tamoxifen blocks any uptake of estrogen into the cancer cell, it doesn't matter whether your level is 13 or 18. It doesn't matter if your level is 200 and you're premenopausal. Tamoxifen works. It's a very good drug in this situation. I've had challenges. One of the patients in my practice, in her late 60s, I actually treated with tamoxifen. She started when that was the main therapy. We didn't stop her before five years and switch to an aromatase inhibitor because vaginal dryness was a big problem for her, and it wasn't safe. Now that she's done on an AI, it's been much more difficult for her. Those are kind of the nuances.

Now, if you've finished all of your endocrine therapy and you're many years out after your breast cancer, whether it's safe to use estrogen is something you have to discuss with your doctor because, again, one way to look at it is if you measure the estradiol level we can see how high it's moving with the vaginal estrogen.

CALLER:

Even with the hormone receptor-negative ...

PATRICIA A. GANZ, MD:

With hormone receptor-negative, I wouldn't worry. The only issue is if you still have your breasts preserved, you could get a second breast cancer. Increasing the estrogen level is not something we want to do, but if your estradiol level is measured and it goes from ten to 15, I'm not worrying. Some women will be put on, by their gynecologist, an estrogen cream, which is not used in the breast cancer situation but can be used in healthy women. Those women may have levels of estrogen from an estrogen cream – say, Estrace cream or some other vaginal estrogen cream. Their levels might be 75 or 100 because the vaginal tissue, when it's rehabilitated, if you will, can absorb that, and you get high levels. That's why we only use the low-dose estrogen preparations.

CALLER:

So, testing after you use some of these vaginal estrogens [inaudible].

PATRICIA A. GANZ, MD:

Yes, if there was any question about what it's doing in you personally. The reason those low-dose preparations are safe for women even without cancer – we worry about giving unopposed estrogen and its effect on the uterus because unopposed estrogen can cause uterine cancer. The way they tested these low-dose regimens, the Estring and the Vagifem, is they actually did endometrial biopsies in women who were using them, and they didn't see stimulation of the lining of the uterus. Therefore, not enough is getting absorbed to cause biological changes.

CALLER:

Thank you very much.

AMY GRILLO:

I think this will be our last question for the day.

OPERATOR:

Thank you. Our next question is from Wausau, Florida.

CALLER:

Hi, Dr. Ganz. I've really enjoyed the conference. I have a question. It's nice to hear all these comments, because I took tamoxifen and had very few symptoms. Now, with the AI, I have almost every symptom that all of these women have mentioned. My question is, I don't believe anyone is checking my estrogen level. I go for my oncology checkup every six months. Should we have that checked every six months?

PATRICIA A. GANZ, MD:

No. The assumption – at least from the early development of these drugs – is that they're doing what they're supposed to do in terms of lowering your levels. Clearly, if you're having symptoms, you're getting a biological effect.

CALLER:

Oh, yes.

PATRICIA A. GANZ, MD:

I'm just saying in the case of where we're giving vaginal estrogen back, then it's a problem.

CALLER:

Okay, and I want to add that what has helped me is the weight training, and I've gone to Curves. I'm not plugging it, but it's 30 minutes, and it has helped immensely in relieving my symptoms.

PATRICIA A. GANZ, MD:

That's great to hear, because I've heard that from other patients. I think we have to be very practical. Physical activity is just a wonderful thing for us to do for all aspects of our health: for diabetes, heart disease, Alzheimer's. Physical activity is being shown to be very important. It's critical in terms of bone health as well as maintaining your weight after breast cancer, so I'm glad to hear you've had a positive experience.

CALLER:

I gained weight, and it's not really ever stressed that you are going to gain weight. Now, I've been able to lose a few pounds, and I know it's just due to increasing the muscle, the strength training. Thank you.

AMY GRILLO:

Thank you. Since her question was a shorter one, we'll take one more question.

OPERATOR:

Thank you. Our next question is from [inaudible].

CALLER:

Yes. I'm asking if there have been previous health conditions, like a stroke a couple of years before the cancer and mastectomy, and then AI therapy, which would cause more of the lack of sex interest and the consequent fallout that goes with that?

PATRICIA A. GANZ, MD:

That's a really tough question. Obviously, it relates to you personally. It really depends on what kind of residual side effects you had from the stroke. The biological effects of the aromatase inhibitors are quite profound. They do lead to vaginal dryness; if people are older, they may have vaginal dryness to begin with, and it can certainly get worse. If you're having achiness and not feeling well, that can also detract from your interest in sex. It's hard to say if you've had other health problems as well.

CALLER:

Yes, okay. Would any of those vaginal enhancers be of any help to increase the interest, do you think?

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PATRICIA A. GANZ, MD:

It may not increase your interest, but it can certainly deal with any pain or discomfort. The Astroglide, which is a lubricant, and the Replens, which is a moisturizer – that's safe to use a couple of times a week. Those are both really good starting places. The other thing is to try to be physically active. Usually if people's energy is good, they feel a little bit better about themselves, and that can also enhance the interest.

CALLER:

With the AI, I'm soon to be off of that. Would using any of the estrogen therapies be of any help? Or should I not even consider any more estrogen?

PATRICIA A. GANZ, MD:

I would start with the non-estrogen preparations. If you do not get relief, particularly when you're off the AI, then it's something you have to discuss with your doctor, about the risks and benefits.

CALLER:

Mm-hm. So, it's probably more the AI than the stroke that ...

PATRICIA A. GANZ, MD:

If you're going to be going off of it soon, you'll have a way of telling.

CALLER:

True, true.

AMY GRILLO:

Thank you so much for your question.

CALLER:

Thank you.

AMY GRILLO:

That's going to do it for our questions today. I want to ask Dr. Ganz if she has any closing remarks before we wrap up.

PATRICIA A. GANZ, MD:

No, you've been a great audience with really good questions, and I know you're going to be empowered and prepared to take care of yourself, because doctors and medications can only do part of the job, and you are really able, by taking good care of yourself, to do a lot that will enhance both the quality and the quantity of your survival.

AMY GRILLO:

Thank you, Dr. Ganz. We here at Living Beyond Breast Cancer appreciate your time and expertise in joining us today. We've learned a great deal from you to empower ourselves forward and get some relief from so many of these issues. We really appreciate your time. I also want to thank, like you mentioned, all of the callers who had such great questions, for helping each other and joining us today on the program. You can always continue your [conversations] with each other online [http://lbbc.org/] through our interactive message boards. Help each other by talking with each other. I think that's an important piece of connection – like Dr. Ganz said, opening up the lines of communication with your physicians. Thanks so much for joining us today, and we hope you have a great day.

[END OF TRANSCRIPT]

A nonprofit organization dedicated to empowering all women affected by breast cancer to live as long as possible with the best quality of life.