Primary Care
Women's Health Society

Top tips

The menopause after gynaecological cancer, or in women at increased genetic risk of cancer – what do GPs need to know?

Dr. Kirsty Gillies
GPwER in women's health
BMS advanced menopause specialist

This resource has been produced on behalf of the PCWHS. It is for guidance only; healthcare professionals should use their own judgment when applying it to patient care.

For more resources, visit www.pcwhs.co.uk. Date of publication: May2025. Date of next review: May 2028.

1) Consider short and long-term issues.

- Menopausal symptoms may result from gynaecological cancer treatment (surgically induced or premature ovarian insufficiency, POI, from chemotherapy or radiotherapy).
- The specialist team should have discussed menopause treatment options– if this hasn't happened, ask the consultant why not, and consider referring to a menopause specialist.
- Long-term considerations include:
    - o Osteoporosis.
    - o Fertility.
    - o Increased heart disease risk.
    - o Bladder dysfunction.
    - o Neurocognitive impairment.
- With a palliative prognosis, long-term safety concerns aren't relevant; consider a lower threshold to use HRT for symptom control.

2) Have a different approach for systemic and vaginal HRT.

- Vaginal HRT is safe in most women after gynaecological cancer treatment and can help healing after surgery in vulval cancers[1].
- The safety of systemic HRT is discussed below in relation to specific cancers. If it is used, consider the following points:
    - Transdermal oestrogen should be first line - no added venous thromboembolism (VTE) risk[2].
    - Use the lowest dose of oestrogen which controls symptoms.
    - Progesterone dose should be proportionate to the oestrogen dose[3].
    - Tibolone is an option in post-menopausal women – it is neutral to the endometrium and reduces osteoporotic fractures. There are less breast cancers in women using tibolone compared to women on continuous combined HRT[1]. There is a small increased risk of stroke in older women with additional risk factors[4].
    - Review any HRT three months after starting, when needed due to a change in symptoms, and at least annually once stable.

For more resources, visit www.pcwhs.co.uk. Date of publication: May2025. Date of next review: May 2028.

For further information, or to leave any feedback, please contact admin@pcwhs.co.uk

3) Think about genetic risk.

- Use NICE guidance to assess the need for genetics clinic referral[5,6].
- HRT options should be explored by the specialist prior to risk reduction surgery. The potential for residual breast tissue left after mastectomy means that risk never reduces to zero.
- Consider the following when prescribing for women at increased genetic risk[1]:
    - If bilateral prophylactic oophorectomy/salpingo-oophorectomy takes place before 50, HRT should be offered unless there is a personal history of breast cancer.
    - HRT after the age of 50 years old lacks data for women with the BRCA genes.
- Women with Lynch syndrome or the BRIP1 mutation are not at increased risk of breast cancer. HRT use beyond 50 should be governed by the same principles as for the general population[1].

4) Don't forget to ask about sexual dysfunction.

- This is very common after gynaecological cancer treatment, but your patient may be embarrassed to mention it.
- Psycho-sexual support is recommended.
- Testosterone can be considered if oestrogen replacement is optimised and other causes for the dysfunction have been explored, but if oestrogen replacement is contraindicated, then do not offer testosterone[1]. This is because some of the testosterone will be metabolised to oestrogen in the body[7].

For more resources, visit www.pcwhs.co.uk. Date of publication: May2025. Date of next review: May 2028.

5) Be broadly aware of issues to do with specific cancers; always ask the woman's specialist if unsure[1].

a) Ovarian.

- Explore non-hormonal options first for all tumour types.
- HRT could be considered in FIGO Stage 1 low grade serous ovarian cancer, borderline ovarian tumours, germ cell tumours and high grade serous or endometrioid ovarian cancers.
- In epithelial ovarian cancers HRT is not usually contraindicated, but they are often diagnosed late so a discussion about quality vs quantity of life is useful.
- HRT not recommended in women with FIGO stage 2-4 low grade serous ovarian cancer as tumours are hormone sensitive and benefit from oestrogen suppressing treatment.

b) Cervical and vaginal.

- Women are often diagnosed young and have a good prognosis – treatment induced menopausal symptoms can be significant.
- HRT is not contraindicated after treatment of cervical or vaginal cancer.
- Cervical adenocarcinoma can express oestrogen receptors, but HRT use doesn't correlate with survival or recurrence.

c) Endometrial.

- Premenopausal women with low risk endometrial cancer, may have ovary sparing surgery.
- HRT may be discussed for low/medium risk cancer – no known increase in recurrence, but the data is limited.
- HRT is not recommended in women with high risk, advanced or metastatic disease with tumours expressing hormone receptors.

d) Uterine sarcoma.

- HRT is not advised; uterine leiomyosarcomas and endometrial stromal sarcoma are hormone sensitive.

For more resources, visit www.pcwhs.co.uk. Date of publication: May2025. Date of next review: May 2028.

e) Vulval.

- Systemic and vaginal HRT are not contraindicated after a squamous cell carcinoma, adenocarcinoma or adeno-squamous carcinoma; most of these women will be post-menopausal.
- Topical oestrogen to the vulva can support healing following surgery/resection.
- The limited evidence available for vulval melanoma does not support or contradict HRT use.

Resources

- British Gynaecological Cancer Society and British Menopause Society guidelines. Management of menopausal symptoms following treatment of gynaecological cancer. Aug 2024.
- Macmillan patient information. Menopausal symptoms and cancer treatment. Oct 2023.
- CRUK patient information. Menopausal symptoms and cancer treatment. Oct 2024.

References

1) BGCS and BMS. Management of menopausal symptoms following treatment of gynaecological cancer. August 2024.
2) BMS and WHC. BMS & WHC's 2020 recommendations on hormone replacement therapy in menopausal women. March 2021.
3) BMS. Management of unscheduled bleeding on hormone replacement therapy (HRT). April 2024.
4) SPC. Tibolone. Jan 2024.
5) NICE. NG241. Ovarian cancer: identifying and managing familial and genetic risk. March 2024.
6) NICE. CG164. Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer. Nov 2023.
7) Hammes SR, Levin ER. Impact of estrogens in males and androgens in females. J Clin Invest. 2019 May 1;129(5):1818-1826.

For more resources, visit www.pcwhs.co.uk. Date of publication: May2025. Date of next review: May 2028.