Ep #170: Hormone Therapy and Estrogen Post Breast Cancer with Dr. Corinne Menn, MD

Full Episode Transcript

With Your Host

Susi Hately

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Male Announcer: You're listening to *From Pain to Possibility* with Susi Hately. You will hear Susi's best ideas on how to reduce or even eradicate your pain and learn how to listen to your body when it whispers so you don't have to hear it scream. And now here's your host, Susi Hately.

Susi Hately: Welcome, and welcome back. I am so delighted that you're here because I am continuing my mini-series on recuperating post breast cancer treatment. And here today I've got Dr. Corinne Menn. And she is going to talk with me, or really I'm going to hand over the mic, frankly.

Because when I was emailing her I said, you know what? I have a lot of clientele who have questions about hormone post breast cancer, at many stages, but particularly post breast cancer. And I just wanted someone who knew what they were talking about to share what they know and what we all need to know. So I'm just going to pass it over to you, Dr. Corinne. Let's have it, let's do it.

Dr. Corinne Menn: Awesome. This is my favorite thing to talk about. So let me give you a little background on who I am because it really informs me of a doctor and, I think, it gives me a lot of credibility to talk about this, and you'll understand in a minute. So back in 2001 when I was 28 years old I was newly married and I was a second year OBGYN resident in New York City.

My mom suddenly passed away at the age of 54 of ovarian cancer. It was a shocking diagnosis, we didn't have anything to prepare for it. We had no other cancers in our family. So I felt a lump around the time that she was very ill, in my breast. And I kind of ignored it because I was a second year OBGYN resident and I was busy and my mom was dying.

So she dies and I think, "Oh, geez, she was 54. I've got this lump here." I'm like, I should probably get this checked out. Of course, my fellow physicians who I consulted with, my female OBGYN residents, they felt it and they were like it's a fibroadenoma, you're too young for breast cancer. That's the message I got. So I ignored it for a little bit.

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But once my mom's funeral was over, I was like, okay. December of 2001 I had it biopsied and sure enough, stage two ER PR positive, HER2 negative breast cancer with a little bit of spread to one lymph node. So, obviously, devastating. Newly married, young, premenopausal, OBGYN resident, delivering babies, kind of thinking that I was going to want to have a baby soon. All of a sudden I'm hit with this on the heels of my mom dying of ovarian cancer.

So kind of to make a long story short, I wound up having a bilateral mastectomy with implant reconstruction, went through six months of chemotherapy where I lost my periods due to the chemo toxic effect, temporarily. So that was menopause number one. Finished chemotherapy, started on Lupron and tamoxifen. So then the Lupron, boom, second experience with menopause from the Lupron shutting down my ovaries and then taking tamoxifen in addition.

And prior to chemotherapy I did save some eggs and sperm and we had some frozen embryos. So we had that as a little, you know, kind of we banked that in case I wasn't able to get pregnant in the future. So I stayed on tamoxifen for a couple of years, went off of it at the blessing of my wonderful oncologist. And he gave me their permission to get pregnant. And luckily I was able to get paid on my own.

So I took a pause from my endocrine therapy, got pregnant spontaneously, didn't need those embryos, and had a healthy baby girl who's 18 years old now. And then went right back on my Lupron and tamoxifen. Horrible hot flashes, horrible menopausal symptoms. A few years later we adopted our second daughter from Guatemala, because we decided that I wanted to not have to take a break from any medications and just wanted to grow our family with adoption.

So then at that point I decided, you know what? Let's take the ovaries out. So, bam, surgical menopause. So that was the permanent menopause. So that was like the third kind of experience of menopause and that was the most dramatic.

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So I really suffered through that whole time with this collateral damage of breast cancer, primarily being all of the effects of premature menopause, which we'll go through all that. And I found myself as an OBGYN utterly unprepared to not only help my own menopausal patients, certainly there was not much training at all. And there still isn't much training in OBGYN residencies.

But then I'm a breast cancer survivor with estrogen receptor positive breast cancer, so no one knew what to do with me. The OBGYNs were afraid of me, right? The oncologist just wanted to cure my cancer and keep it away, they weren't so concerned about the menopause and the sexual side effects, right? The internists don't know what to do. So basically I'm left on my own. And I'm a doctor, right?

So hence it brought me to really have to do a lot of self-educating, joining the North American Menopause Society, really leveling up my knowledge. But really understanding I needed to go even beyond that and had to do my own research and really figure out what was the best option for me. And I continue to learn.

So I think what I would have told a breast cancer survivor 10 years ago, I think my knowledge has grown a lot and I understand the nuances, and so that's evolving. And so it changed the course of my professional career and with time I just stopped doing obstetrics and only did office-based gynecology. And now I only do telehealth consults for menopause, perimenopause, as well as breast cancer survivorship, including menopause issues.

And I think it works really well because women don't have access, as you know, this is why we're talking about it, to this information. So that's kind of like my background, what brought me to be interested in this. So I tell patients I get it. I've experienced early menopause. I've experienced the fears of the loss of fertility. I've experienced the body image issues, the loss of function. My muscles, my chest muscles, all of that, I know all of the wonderful work that you do.

And so much of this stuff is not discussed with patients at the time of diagnosis, at the time of surgery, at the time of them initiating these hormonal treatments for their cancer. So patients are really left in the lurch trying to hobble their way through treatments, when, sadly, we actually have a ton of evidence-based medicine guidelines on things that we can do, hormonally and non-hormonally. Lifestyle, nutrition, exercise, all these things that could vastly improve this collateral damage and these side effects.

But they're just simply not offered to people. I mean, I literally, I think after like eight years of dealing with premature menopause, struggling just trying to get by as a doctor, a young mom, a working woman, breast cancer survivor, just dealing with it, being told you don't have any real hormonal options. But finally a nurse practitioner was like, maybe you need a little Celexa. I think you're a little, that can help with your hot flashes and depression.

I mean, literally, no one gave me anything. And again, this was a while ago, it was 2001. I think things have evolved a bit, but I think they still are really problematic. Is that what you see in your own experiences with women?

Susi: Well, I find particularly, like they've come to me mostly because, especially when it's like a scar or there's tension in behind the breast area or where the breast was and they've got full range, but there's that ropey, sore feeling.

And then as we are working together, then oftentimes there's the question of hormone, or the question of they're considering what they should do for themselves separate from the breast cancer diagnosis and whether they're doing tamoxifen or whether it's using hormone replacement therapy and what they're getting from one medical practitioner versus another medical practitioner.

And, of course, as you made very clear, different specialists have their different focus. And so like the oncologists just want the cancer gone, but

aren't seeing the rest of the picture. And so it can be really tricky for someone when they're listening to an authority speak about hormones, what decision to make, because they're just trying to figure it out themselves.

Corinne: Yeah, and I wish there was a good solution for this. And sadly, in our disjointed medical system, especially in the US, I think it's kind of this problem everywhere. Especially when you're dealing with specialty care, specialists live in their silos. They don't really see the big picture, unfortunately. And in this kind of field of breast cancer survivorship, a lot of cancer centers now have survivorship programs, which is great, and they can be very helpful, and some are better than others.

I still feel most of them, and I'm in New York City, so I see like the "best" access here, supposedly. They're really lacking. They're still very conservative in their approach, right? So the way I like to talk about it, when I think about it for myself and I think about it for patients, is, one, I always want patients to understand actually what's happened to them hormonally.

Because I find a lot of women don't really even understand menopause in the general population, much less breast cancer survivors. So today I'll go over, like let's just understand some nuts and bolts, some basic terms and some basics like what's happening from a biological sense.

And then number two, just understanding that there's something called patient autonomy and shared decision making, and it's sorely lacking in breast cancer survivorship, right? I think these women, me included, we're tough cookies. We've been through a lot, we've had to learn how to deal with lots of medical terms and navigating a complex system and we can handle the information.

We understand there's no absolute guarantees in life, there's no 100%, nothing in breast cancer care is black and white. Nothing is, including survivorship care, including the risks and benefits of hormone therapy for your symptoms.

And so I really believe in just providing women with education and understanding we have to look, just like your breast cancer is literally like a unique fingerprint, every one of our breast cancers are different. So is your risk of recurrence and your risk and benefit kind of profile for hormone therapy.

There's some women who are much better candidates for systemic therapy, and some who are probably not great candidates at this point in time. And then I like to explain that to them. And then I think women, when given the information, they can make a decision that sits best for them. And this idea of we tell women you can't do something or no, you don't have access, or I don't believe in that. Women are not children.

We're survivors. We're breast cancer survivors and we deserve to have options. And also not be made to feel guilty that I want to address my sleep dysfunction, my hot flashes, my sexual dysfunction, the impact on my relationships, and to insinuate that I'm going to cause my premature death and that I have to choose between not having severe sexual pain or severe dysfunction in my life over not surviving my cancer, like how dare people insinuate that.

I think it's a false choice. You don't have to do it, it's not either or. You can find something where you can live a long life and you can have a good quality of life. And I'm really passionate about giving women that information.

Susi: Mm-hmm, because ultimately, if we give and provide the education, like I always say, it's like people know the truth for themselves.

Corinne: Yes.

Susi: They can determine the way their truth is. And I think about a client recently, and she actually said to me when I asked her, I mean, how are you doing with all this? She's just over a year out and she's doing really, really well. And she says, most days I'm doing great until I have to go get

my checkup. And on my chart it says I'm high risk, because she's chosen to do an aspect of hormone replacement therapy. And the oncologist said no hormone replacement therapy.

And she's like, I've done my research. I know, this is good for my bones. I know this is good for this. I know this is good for this. And she's like, I totally understand why they're saying that, but it's like they also have to get that it messes with your mind.

Corinne: Yeah, there's so much psychological trauma surrounding survivorship and going back to your doctor. To this day, I'm 22 years out from my cancer diagnosis, and to this day I don't really like it when a doctor calls me with any blood results or anything. I always think that they're going to tell me some other bad news. You know, I think we're all traumatized.

And it's actually really paternalistic to be labeling people like that. And I think one of the biggest things that gets missing in this picture is, ooh, you're high risk because you're taking hormone therapy. But what is not addressed is you're actually high risk if you don't take it in some cases. You're high risk for cardiac disease, dementia, bone loss, hip fracture, cardiac dysfunction, increased diabetes risk, sexual dysfunction, relationship issues, depression, anxiety.

So are those labels on her chart? No, no. And in fact, most breast cancer survivors will die of heart disease, not breast cancer. And many of them are at a higher risk of heart disease due to their breast cancer treatments and their premature menopause. And no one's addressing that. Are they looking at their cardiac markers? Are they getting a calcium score, a coronary calcium score? Are they addressing things that they can do for their heart health?

No, no. They're just like, are you still taking your tamoxifen? Or, oh, no hormones for you. Don't worry about it. You've got to just do lube for your dry vagina. I mean, that is literally the disconnect. It's actually disgusting,

don't get me started. Actually, you got me started, that's why I'm on this podcast.

Susi: There you go, yeah.

Corinne: So if you want, I'll jump into just kind of going over some basic things so your listeners really understand what's happening to their bodies. And for some people, they already get this. I think others it's, I think, important for women to kind of realize because understanding that breast cancer survivors, when we talk about the collateral damage of premature menopause, they can arrive at that premature menopause or menopause in various ways.

So I think it's important for women to understand you can have early menopause from the toxic nature of the chemotherapy. So the older you are when you get your chemotherapy, the more likely it's going to put you into permanent menopause. The younger you are, the more likely those ovaries will be resilient enough that they can recover, as happened in my case. So I temporarily had my ovaries shut down, but then they kind of popped back and came to life about nine months later.

You can have premature menopause iatrogenic from the doctor giving you medication. Like the most common in a breast cancer survivor is Lupron, so a medication that kind of chemically stops your ovaries from working to lower your estrogen levels. This is most commonly done in women who their ideal course is to be on, they choose to be on an aromatase inhibitor. In order for an aromatase inhibitor to work, you've got to have menopausal levels of hormones.

So if you're premenopausal and you're estrogen receptor positive and they deem you to be on the higher risk side, generally speaking from an endocrine standpoint, they're going to offer you an aromatase inhibitor along with shutting down your ovaries with Lupron. If you're already menopausal because you've had your ovaries removed or you're an older

woman, then they're going to go right to an aromatase inhibitor, they don't need to give the Lupron.

But Lupron has its own side effects. I find a lot of women who are dealing with menopause due to Lupron. That is particularly rough on them. And when you pair that with an aromatase inhibitor, I think it's really important for women to understand this, it's like super duper menopause. Because the Lupron is shutting down the ovaries, not allowing estrogen to be produced.

The aromatase inhibitor is then making your hormone levels even lower than a natural menopause. Because in natural menopause, let's say in a non-breast cancer survivor, or non-breast cancer patient who went through natural menopause at 52, their ovaries still produce a little bit of estrone, they produce testosterone. That testosterone and then estrone, which is a form of estrogen, it's converted in your fat cells to low levels of estrogen.

So women who go through natural menopause, yes, can suffer from menopausal symptoms and, yes we can give them hormone therapy. But the symptom severity could be much worse with an aromatase inhibitor because it's extra low, extra low hormones.

And so in particular with the aromatase inhibitors, in addition to the typical classic menopausal symptoms of hot flashes, night sweats, insomnia, I find their genitourinary symptoms, so GSM, genitourinary syndrome and menopause can be quite severe. And we're going to talk about how to treat all these things.

But then, obviously, the other kind of way to get to menopause is to have your ovaries taken out. So some breast cancer survivors, their ovaries are removed because they carry breast cancer, BRCA 1 and 2 gene or other gene or maybe their ovaries were out for some other reason.

These days, this is super interesting getting into whether hormone therapy after breast cancer diagnosis, you know, does it worsen prognosis? The

answer is no. But it's really interesting, and we'll circle back to this, but there was a trial called the soft trial that looked at women taking tamoxifen who were premenopausal, so still getting periods.

So understanding that for women who receive endocrine therapy, some women who are premenopausal, because you have to separate these out right? Premenopausal women who were still getting periods and having estrogen around, some women who are lower risk might be given tamoxifen only and still allowed to have their menstrual cycles. Other women who want a little bit more aggressive treatment are given Lupron, an aromatase inhibitor to really shut their estrogen levels down. So those women are in menopause.

When women are taking tamoxifen, this is something that I want women to understand. When you take tamoxifen and you are still getting your menstrual period, your ovaries are still producing estrogen. Tamoxifen does not put you in menopause, okay? I hear it all the time, "I'm going to be on tamoxifen, Dr. Menn is going to put me into menopause." No. In fact, women who take tamoxifen have higher circulating levels of estrogen.

What people don't know is tamoxifen is a cousin of Clomid. Clomid is the medication that we give women to make them produce eggs. It's a fertility treatment. When I was getting my eggs harvested before chemotherapy, they didn't give me Clomid, they gave me high doses of tamoxifen for a couple of weeks. And my ovaries produced all these extra follicles. I had all these extra eggs and my estrogen levels were high.

So that's an important thing. If you're premenopausal and you're on tamoxifen, you're not in menopause. Your estrogen levels are not low. So anybody who tells you that you can't take vaginal estrogen or you can't take something if you're having hot flashes is just, it's like upside down thinking. And we'll talk about that more.

But they did look at women taking tamoxifen, would it improve their prognosis, decrease the risk of recurrence and decrease their mortality risk,

if in addition to tamoxifen they also gave them Lupron and shut their ovaries down or remove their ovaries? So if they were put into menopause permanently. And the study was like, no, there was no increased benefit.

We know tamoxifen is a powerful medication for decreasing recurrence, but it's not improved by blocking your estrogen levels. So that should raise some, like that should get you thinking a little bit, right? Tamoxifen works by blocking estrogen receptors in certain tissues, including circulating rogue breast cancer cells that may still be floating out there. Or if you still have an intact breast, it will block the receptors in that breast, right?

So those are the ways women get into menopause. I think the menopausal symptoms that most people think about, I want your audience to know, obviously, hot flashes and night sweats. But a lot of women don't realize all the other symptoms of menopause. So genitourinary syndrome and menopause, I mentioned it, we're going to dive into that next.

It's not just vaginal dryness, it's decreased arousal, decreased lubrication, urinary frequency, urinary urgency, increase in urinary tract infections, obviously painful sex. And that's due to the dramatic loss of estrogen causing the tissue to thin, not have a good blood supply, less lubrication, less collagen, less healthy tissue. And it dramatically changes the vaginal microbiome so that they're more prone to yeast infections and BV.

But everything that's happening with the thinness and the dryness of the vagina, I want women to understand it's also happening in their bladder and the urethra. And so their bladder has really declined. I truly believe there's just a generation of women sitting in nursing homes incontinent, in diapers, suffering from ulcers on the outside of their vulvas, recurrent urinary tract infections, kidney infections, sepsis. A common cause of sepsis is from a UTI.

We could be preventing all of this in the breast cancer survivor or the non-breast cancer survivor with vaginal estrogen. So that's a huge symptom that is really not met in the breast cancer community. I think there's like 2

million current survivors of breast cancer living in the United States alone, and really, hardly any of them are getting treated for their severe genitourinary syndrome and menopause with hormones. So we'll talk about that next.

The other symptoms that people don't think about are also the mental health symptoms. Increased anxiety, increased depression, brain fog, the sleep changes, dizzy spells, heart palpitations, joint pain. Big, big problem. You probably see that a lot. Muscle pain and joint pain. And all of these things are like a vicious cycle and really impact quality of life.

So, what do women offer, what are they offered to treat these things? I'd say I think, probably this is what you've seen, is that most women first are told first try non-hormonal options, right? Sigh, right? So, when I talk about hormonal options for these things, I like to separate it in the local vaginal estrogen and hormones, which somehow is really provocative for many oncologists, and I want to dispel some myths there. And then let's talk about the systemic use of hormones because they're two separate things.

So I was recently at the Young Survival Coalition, anybody listening please check out youngsurvival.org. It's like the premier organization for women diagnosed with breast cancer in their 40s and younger. And I was talking to a room of like 400 women and I brought up genitourinary syndrome in menopause and I said, "How many of you know about the guidelines? Not only from the North American menopause society, but from every major women's health organization in the world, including American college of OBGYN, the oncology professional societies."

There's very, very clear guidelines that vaginal hormones are very, very safe in breast cancer survivors and are extremely underutilized. And there's a lot of lumping together the risks of vaginal estrogen with the risks of systemic hormone therapy, and we need to separate them out.

So this is an easy thing to deal with, vaginal estrogen, vaginal hormones – I say vaginal hormones because these days we have vaginal estrogen, but

we also have medications, like one called Intrarosa approved in the US. It's vaginal DHEA and we know that those vaginal hormones have never been associated with increase in recurrence, they're not systemically absorbed, they're locally absorbed, locally applied and locally absorbed and are game changers.

And when I see a new diagnosis, a patient who is newly diagnosed with breast cancer and they're being told by their oncologist, well start with a vaginal moisturizer. People have to understand vaginal moisturizers are temporary relief, will just help moisturize and make things feel a little bit more comfortable temporarily. They do not inherently change anything in this tissue structure. Vaginal lubricants are only to decrease friction during intercourse. And vaginal hormones are the only thing that is FDA approved to treat and prevent the genitourinary syndrome of menopause.

So what I wish more breast cancer patients were told is that you don't need to start with just a moisturizer. Start with that, fantastic. But I would much rather start somebody on vaginal estrogen proactively before they even start that damn aromatase inhibitor. Because guess what? If we do the wait and see approach, I know what's going to happen in three or six months. She's going to have severe dryness and symptoms. And we can restore things. Why should women suffer?

But for whatever reason, even though we've got super clear guidelines, and I'll give you a link, I have a document that lists literally every guideline out there. I cannot tell you how many women are being told you have estrogen positive breast cancer, you cannot take any hormones including vaginal hormones.

So to me, the vaginal estrogen thing, this isn't anything that's controversial, like there's real clear guidelines. And even with these super clear guidelines on the safety of vaginal estrogen, women are denied all the time. I recently had to fight for a patient who has metastatic breast cancer, is in remission for metastatic breast cancer, and she's doing well.

She's getting married, and she's going on her honeymoon and the oncologist and the OBGYN will not prescribe her vaginal estrogen because she's got metastatic disease. But I'm like, it's actually nonsensical and it's actually just cruel, you know? It's just cruel. So that really bothers me.

Have you seen women complaining about that? Or have you seen – What's the access like in Canada? Just curious.

Susi: Well what's interesting is most of my clients aren't actually based in Canada, even though I am in Canada.

Corinne: Oh, that's right because you're doing online.

Susi: Yeah, and so I'm hearing it from a variety of different places in the world. And it's, I mean, everything you're saying, I'm just sort of nodding over here. I mean you're putting a finer tooth on it, right, which is important. And I think the piece that's so vital is it can sometimes be really scary making a choice, especially when we hear about you have this percentage risk and this percentage risk. And if you don't do this, then the risk goes this way or this way.

And then you're kind of left with risk. And how do you navigate that? And the thing is, we look to our physicians, as an authority figure, as knowing something. And so what I often see are people, no matter what the scenario is, whether it's related to cancer or whether it's related to anything else, where a physician has weighed in and said, that won't make a difference, that will make a difference, and there's an authority figure that they know stuff, or are supposed to know stuff and they do know stuff.

And all those other things you've mentioned throughout this is there's an individual nature to this for one. You've said there's a fingerprint piece of it too, like every breast cancer is unique to the woman who has it. And so there's this piece of it that I hope as people are listening to this, and it kind of frees them up a bit because related and not related, one thing I see over

and over again is that cancer treatment can really hammer away one's own inner sense of knowing.

And part of my job, I feel, is as someone kind of reconnects with themselves with breath, movement and stillness, they can tap back into that intuitive wisdom and that ability to make that choice based off of what feels right in addition to intellectually processing by bringing that data in and kind of like this is right for me. And that is the process they have to do for themselves because it's not something that most offer in the medical world because of the way that medicine is done, really.

Corinne: I hear you. I think what you said is so interesting because women who have been through cancer, they've lost so much. But you pointed out they also lose this, one, they stop trusting their body because their body kind of turned on them, right?

And you're right, they put all this trust in someone and once that person says, it only takes one doctor, one oncologist or one GYN or whatever says you can't have any of that, that's going to increase your risk of breast cancer. Even if it's completely misinformation, totally ill informed, not based on any guidelines, it's always going to sit back in their brain and the fear is there.

So that's why I like to separate out when I see a new survivor come in and say, okay, so here. Here's a list of literally like the guidelines tell you vaginal estrogen is safe. You don't even have to double – This is something you don't have to think about. We're going to think about in a minute more deeply and more nuanced systemic hormone therapy. But I'm telling you, vaginal hormones are safe for all including aromatase inhibitors.

There was one study that came out recently, this Danish study that everybody talks about and everyone is scared of. But it was a deeply flawed study, and even the North American Menopause Society made a statement that said this is not practice changing. Because basically, every study out there, every book of data says that locally applied estrogen is not

systemic and is extremely, extremely safe if you are using an aromatase inhibitor.

When we want your hormone levels to be exceedingly low and you want to be extra, extra careful, and you don't want to have any theoretical absorption of any extra estrogen, guess what? We've got vaginal options for you too. All vaginal options are considered systemic. Some of the vaginal options have a theoretical, you know, a tiny, tiny amount of maybe theoretically being absorbed. So you can avoid those and you can use, they have very, very low dose vaginal tablets.

Imvexxy is a brand named in the US that comes in a four microgram option, which is really, really low dose and super effective. You can use the vaginal estrogen cream, just cut down the amount. One thing I like about the vaginal estrogen cream is you could apply some on the outside as well as putting a little bit up on the inside. So if you're on an aromatase inhibitor, that would be the one scenario where I guess I can theoretically see that someone would be somewhat concerned, but we actually have studies showing that there are no elevated estrone levels of the estrogen.

And then remember that if you're taking tamoxifen, tamoxifen works by blocking estrogen receptors. So even if you're overdosing on vaginal estrogen and you're getting tons of absorption, you're taking tamoxifen, it blocks estrogen receptors. Women on tamoxifen are allowed to still continue to get their periods. It's okay, that's totally safe.

So I think when you're talking about the sexual side effects and the genitourinary side effects, it's kind of like a slam dunk case, print out the guidelines. You bring it into your oncologist and be like, "You're giving me misinformation. I know I can have this," and demand the prescription. Because it can be incredibly life changing for sexual and urinary symptoms.

And really, I would rather you do it proactively so that you don't get to a bad point. Because what we see is when women get to a very bad point with severe vaginal dryness and atrophy is that, and you'll understand this as a

physical therapist and dealing with this, you get tons of pelvic floor dysfunction and muscle dysfunction. And then you start to have other sexual pain syndromes that go beyond just the loss of estrogen. So that's why I'm very passionate about dealing with that.

So then we get to, okay, the systemic hormone therapy, this is that big elephant in the room. So I think we have to think about things very individualized. And when I've got a new breast cancer survivor who is talking about how am I dealing with the systemic symptoms of hot flashes, night sweats, insomnia, brain fog, bone loss, all of the classic menopause stuff.

They're hearing in the media, at least here in the US, I think around the world there's a new focus on menopause. There's a big cover story in the New York Times, women have been misled on menopause. There's a new interest in menopausal hormone therapy. We're understanding that we're like decades behind because of the Women's Health Initiative. And that hormone therapy for the vast majority of women is extremely beneficial and safe.

And breast cancer survivors feel totally left out of the conversation. They're like, great, I survived breast cancer, now I'm going to get dementia and heart disease and all this stuff and I can't take estrogen to help me. And they feel really, I say it's like a loss upon loss, right? And they're first offered non hormonal options.

And we can talk about those non hormonal options, and I think they can work well enough for some women. But when we're talking about when to go to systemic hormone therapy as an option for a breast cancer survivor, I think first the message has to be you have to treat your primary breast cancer first.

Whatever surgery is recommended, you have to do. Whatever your chemotherapy, Herceptin, if you're told to be on an endocrine therapy like tamoxifen and aromatase inhibitor, you should complete that. But we'll talk

about how to look at that, because there's obviously different degrees of hormone therapy.

But once you've completed your primary treatment for your breast cancer and now you're going into your post survivorship phase or your long term survivorship phase, that's when you should be able to sit down with an oncologist or a menopause specialist and look, okay, this was your breast cancer diagnosis. This is your cell type. This is how many nodes you had. This is your risk of recurrence. These are your symptoms that you're dealing with, okay?

And you should be able to have a review of the literature and understand that there's actually over 25 studies done in the past decades that have looked at this very question of hormone therapy in a breast cancer survivor. Women are blown away when I'm like, "Did you know there's 25 studies or more out there?" They're like, "No, I didn't know there was any data." Or I thought it was just dangerous.

I'm like, "No, we actually have data." And in all of those studies, except for one which we're going to talk about, in all of those studies they showed either no risk of recurrence, or in the majority of the studies a lower risk of recurrence and a lower risk of mortality. And certainly an improved quality of life and treatment, obviously, they benefited just the same way as a non-breast cancer survivor would benefit.

These studies varied. Some are small, some are large, most are not randomized controlled trials, most of them are observational studies. Some are better quality than others. But the preponderance, they all point in one direction.

And there's one study called the habit study that looked at hormone therapy after breast cancer. And in that study it was stopped early because they saw a slight increase in recurrence risk in women who were breast cancer survivors who were being given hormone therapy. It was a very small number, but as in all studies the devil is in the details.

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So in this one study they did not do screening mammograms on women who entered the study. Women who had a recurrence on hormone therapy had only a local recurrence in either the same breast that they had their initial breast cancer in, or in the contralateral breast. These are women who had intact breasts.

Nobody had a recurrence distant, no distant metastasis. There was no increased risk in mortality. And in fact, the study showed women who were taking the hormone therapy had a lower risk of death from breast cancer. But there was an increase, there were 22 more patients who got a breast cancer recurrence in the local tissue versus women who were not taking hormone therapy.

But guess what? They never did mammograms on these women before they entered the study. The recurrence happened in the first two years of being on hormone therapy. We have no idea of whether these women actually had breast cancer sitting in those breasts and not that the hormone therapy caused the breast cancer to grow, but they already had breast cancer in those breasts.

And so they were found to have this recurrence. And many, many critics of the study say that this study is uninformative, it is fatally flawed and really does not inform us because that's a fatal flaw right there. I mean, you can't randomize people and not know who's entering the study who may already have a local recurrence. They didn't check their breasts.

And it's fascinating that neither group, ones who were on hormone therapy or ones who were not on hormone therapy, they had no distant recurrence, adverse risk of death, or adverse breast cancer risk. So you've got this one study, and that one study was published in an oncology journal. We've got over 25 other studies and more, over 25 that show that there's no increased risk of recurrence. So what is a woman to do?

I mean, the reality is nobody tells a woman that there's even those studies out there. They just say estrogen is bad. And that's it, end of discussion.

And so I think that's where I start with patients. I say, listen, we've got some data out here. If you are really suffering, you've done all you could, you did your treatment, you were the good patient, you did what you needed to do and you're really suffering now. And you have either tried non hormonal or don't want non hormonal options, or tried the non-hormonal and they weren't working, they weren't helping you.

And remember, non-hormone medications are only going to help your hot flashes. They're only going to help your hot flashes and night sweats and hopefully if you're having trouble sleeping. Non hormonal medications aren't helping your heart, your brain, your bones, your sex life, right? Those are big things. So I think that's the first thing. I think it's important for women to understand there is data out there and you deserve to know what the science says, right?

And we should also explain to women that we've got some very clear science on pregnancy after breast cancer. So, when you're pregnant your estrogen levels are astronomically high. At the last San Antonio Breast Cancer conference just this past December they released a very important trial called the positive trial.

And it looked at could women who had hormone sensitive breast cancer stop their endocrine therapy to get pregnant? So they were allowed to stop it for up to two years, get pregnant, go off all their medications, have their hormone levels sky high, and then afterwards they went back on their tamoxifen or on their aromatase inhibitor

Women who took a pause in those two years and had these sky high levels of estrogen had no increased risk of recurrence, no local recurrence, distant recurrence, no increased risk of death. And that was a very important randomized controlled study, but that data exists for decades. We have lots of other studies supporting those findings.

So the preponderance of evidence tells us that pregnancy with sky high levels of hormone therapy does not increase recurrence. We've got a

preponderance of evidence in observational studies that show, again, not perfect studies, but a lot of data out there showing that women do not have an increased risk of recurrence if they use hormone therapy after breast cancer.

We have this one poorly designed study that basically actually had a lot of positive findings, and then this one blip of local recurrence. We've got tons of data on vaginal estrogen and clear guidelines on that. We've got the soft trial that showed that suppressing your estrogen and hormone levels while on tamoxifen didn't make any difference, it didn't help, it wasn't beneficial.

So that's a lot of data showing that low dose, tiny amounts of hormone therapy so that you're not suffering, there's a lot of data there to say, yeah, you should have the right to have that discussion and have that be an option.

In addition, we have data in, not in breast cancer survivors, but we have data from the Women's Health Initiative which is a problematic study mainly due to the messaging. But we have a lot of data now and the North American Menopause Society's statement is that women who have not had breast cancer, giving them hormone therapy to treat their menopausal symptoms does not increase their risk of breast cancer over their baseline risk, right?

In BRCA 1 and 2 mutation carriers who are previvors, who have not cancer yet, and BRCA 1 and 2 women are at risk also for not only breast cancer, but ovarian cancer. So they have their ovaries removed to prevent ovarian cancer. We don't have good screening tests for ovarian cancer, that's a wise move, right? You're done with your childbearing, you carry the BRCA gene, get those ovaries out.

But some women will choose to have their ovaries out and they maintain their breasts and they just do increased surveillance on their breasts and they don't have prophylactic mastectomy. North American Menopause Society made a specific practice pearl statement on this, saying that the

preponderance of observational data that we have shows that even in those very high risk women for breast cancer, that the addition of menopausal hormone therapy to treat their symptoms did not further increase their risk.

And they urge women that they should not postpone lifesaving removal of their ovaries to prevent ovarian cancer out of the fear that they will not be able to treat their menopausal symptoms. So I think that's really powerful data too.

So, to me, there's just all these talking points and all these data points, I should say, not talking points. All these data points out there that tell us like this black and white thinking, this very like gatekeeping thinking on giving women access to low dose, FDA approved, safe hormone therapy is really unreasonable. It's unscientific, it's paternalistic. It's cruel, I think, in some ways. And women deserve the right to have that option, right?

So I think that's kind of like my sales pitch and the data. And I think that it's really naive for doctors to think that we're going to deny millions of women around the world access to hormone therapy that for millions of other women we're telling them it's going to lower all these chronic medical conditions.

And we're telling these breast cancer survivors no. But after listening to what I just said, I would find it hard for someone to like, what's your counter argument of not even allowing a discussion, right?

Susi: So interesting, isn't it?

Corinne: And it's maddening because I feel like there's a lot of gatekeeping there, right? And I think that quality of life really, really matters, and so when I tell a breast cancer patient like, listen, I've got lots of observational data. I can summarize everything I just told you. But in the end, I can't promise you your breast cancer is not going to come back. I know that breast cancer will always be a diagnosis for me.

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We know breast cancer is a systemic disease and it can come back at five years, at 10 years, at 15, at 20, at 25 and beyond, sadly. If you look at the recurrence rates over time, they slowly do creep up. It's a scary fact. So your breast cancer may come back. Do I think it's going to come back because of hormone therapy? In most cases, no.

Now if there was a patient who was on an aromatase inhibitor and she had stage three disease with multiple lymph nodes and a very aggressive cell type and it's very important for her to stay on that aromatase inhibitor, obviously, I can't give her hormone therapy. But you know what I can do for her? I can proactively treat her hot flashes with non-hormonal options. I can give her vaginal estrogen safely. We can offer her lots of other support so that she doesn't get that heart disease.

And guess what? When she's done with that aromatase inhibitor, when she's completed that five to 10 years, she deserves a conversation as well. Sometimes I do tell patients, we're going to start non-hormonal, we're going to get you through this part of your life and then we'll consider this. And different women have different values, right? Some women have a lower tolerance for risk, some women have a higher tolerance. Those are decisions they have to make for themselves.

And just like hormone endocrine therapy for your breast cancer, aromatase versus tamoxifen. I see a lot of women suffer on aromatase inhibitors and some women need to stick to those aromatase inhibitors because they have a very high risk disease and that aromatase inhibitor in studies has been shown to be a bit more powerful than tamoxifen.

But then I've got other patients who are being thrown on aromatase inhibitors and, frankly, if they're really suffering, and this is a generalization, there's about a 4% benefit difference between tamoxifen and an aromatase inhibitor. And tamoxifen can be much more tolerated. So I think there's also nuances there and that you should be able to advocate for even an adjustment in your endocrine therapy if you're really suffering.

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Susi: All right, so now we are here, there's been an amazing amount of information that you've provided. Really, really, really great information. So a woman is listening to this, what would be the next steps for her in terms of making a decision advocating for herself?

Corinne: So I think the very first thing is, I really think that I think patients can be surprised that even the most kind of stringent doctor who's not being that open-minded, I think the first thing you should do is I want you to try to work with your healthcare team, right? We want your oncologist to be on board. We want your GYN to be on board. We don't want an antagonistic relationship, this is your care team.

I do think if you make an appointment and that appointment time, and it might be an additional copay, you may have to go back and pay for an additional appointment because they can't do everything at once. But if you say, hey, I want to set aside a time, I want to talk about menopausal hormone therapy. I want to know about my menopause symptoms. I know you're busy, can we carve out time? Fine, do that.

Come prepared. You should come with a list of your symptoms, a list of what you're interested in discussing. And in addition, and I'll provide this to your listeners, I can give you guys a couple of things that you can print out and bring with you to arm yourself. You should come out with, certainly a list, if you're talking about the genitourinary syndrome in menopause and vaginal hormones, that's easy. You can obviously print up the guidelines from ASCO, from ACOG, from NAMS. Super easy peasy.

And then say I want vaginal estrogen and this is what I want and I want it now. Okay, that should be a no brainer. If you're on an aromatase inhibitor, within that vaginal estrogen recommendations I'm going to give you this link. There's the North American Menopause Society's statement on that one fringe study about women on an AI with the counterpoints of why that study was really flawed. So I think that's an easier thing to address.

Then when you want to address menopausal hormone therapy, I think, again, arming yourself with information is really important. If you've not already shared with your listeners this book, it's called Estrogen Matters. It's written by Dr. Avrum Bluming and Dr. Carol Tavris. Dr. Bluming is a renowned breast oncologist who just kind of saw the collateral damage he was causing himself and his patients who were breast cancer survivors, and is just an incredibly astute and thoughtful physician leader who just did a deep dive and said let's reexamine this. What does the data show us?

And so he wrote this wonderful book called Estrogen Matters. It's very patient friendly and it will explain the benefits of hormone therapy for the average woman. But he has a chapter on the breast cancer survivors where he goes in, he basically explains all the studies in a very easy to understand way and he lists all the studies. And to make it even easier for you, so you can read that book. So you should read that book and bring that with you.

But he was also in the Cancer Journal, the major cancer journal in the United States, the May 2022 issue was dedicated to these very questions and there's a review article called Hormone Replacement Therapy After Breast Cancer: It Is Time. It's not very long, it's really well summarized. So I really encourage women to print this article out, to read it yourself, it's not hard to understand. It basically summarizes a lot of what he talks about in the book, and come armed.

And you should come armed with what you want. If you are met with incredible resistance, then you've tried that approach, you can ask, write down what the resistance is, what are their concerns? And then if you're in the United States, or even I think they have listings throughout the world, but menopause.org lists certified North American Menopause Society certified practitioners.

Most, not all, most of them should be knowledgeable on this. I will say there's still even in the menopause expert world, some of them aren't as up-to-date on breast cancer. But that can be a really good place to start.

The other good place to start to find a physician or clinician who's knowledgeable is International Society for the Study of Women's Sexual Health, ISSWSH, which they also have a listing. So those two places tend to have clinicians who are following evidence-based guidelines, not wacky stuff, and will work with you to access that.

So I think those are some good tools because sometimes, when you place a paper like this over the desk of a physician and say, "Read it over, I'll come back for another appointment," you very well might change their mind. You'll get their respect, and if not, at the very least, you've educated them, right? And then, unfortunately, sometimes it's not easy and you've got to go on to somebody else.

But I think that's like the first approach, and sometimes you have to know when to go elsewhere. I tell women it's okay that your breast oncologist is nervous. I don't want my neurologist delivering my baby, okay? Sometimes I don't need my oncologist taking care of my hormone therapy. It's okay to outsource. But when people have a label on their chart –

Someone told me recently, she is taking menopausal hormone therapy after breast cancer and they have like this disclaimer in her chart. She goes to a big cancer center in the United States. And she says every time I see my electronic medical record on my patient portal I see that patient has been informed increasing her risk of death and all this.

And it's upsetting to her. And I think, a lot of hospital systems from a medical legal standpoint, they've got administrators and lawyers telling them they have to put this in their medical records. It's gross. It's mean. It's unscientific. It happens. But center, take a deep breath and know that you're doing what you feel is best for you. But it sucks when you see that, I get it.

Susi: Yes.

Corinne: But you got to just move on from it, you know?

Susi: Yes. And I sort of kind of slid in there. I love it because this is just another voice in the wilderness, so to speak, that's just helping people make the best decision for themselves. Because ultimately, like anything, there is no black and white. There is no black and white. There is no cookie cutter. There is nothing binary about any of it, right?

Corinne: No. If you don't want menopausal hormone therapy, if you're very risk averse and if you look me in the eye and say, "Dr. Menn, you know what? Unless you can show me there is a huge, randomized control study that absolutely definitively tells me this is totally safe, then I'm not doing this." And I'll say, okay, then, you know what? I don't want to make you feel more stressed, then let's try some great –

There's all these different non hormone medications out there. I'll treat your hot flashes, we'll work on non-medication options for sleep and your bones and other stuff. We're going to give you a vaginal estrogen because I'm going to really push that one. And we're going to make you feel better, we're going to restore your quality of life.

But even those things, even the non-hormonal things, the exercise, the nutrition guidance, all these things, even those things are not well addressed with these women. They are really left on their own to flounder and piecemeal it together. Versus, listen, you're about to go on an AI, you better get prepared. Let's start lifting weights. Let's eat an anti-inflammatory diet. Let's start the vaginal estrogen. Let's really up your cardiac exercise, let's do these things.

But unfortunately, that's not done either. But you shouldn't feel guilty if you don't want the hormones.

Susi: I love it. Love it.

Corinne: It's okay. It's okay.

Susi: If people want to reach out to you, do you accept like DMs of just questions? Do you do that?

Corinne: Yes. So you can DM me, I can't answer personal medical advice. But if there's a theme, if you're like, "Hey, I'm really curious about this, will you do a reel on this?" I'll do that. If you want to do a patient education consult where I'm not your physician because I'm not licensed either in your country or your state, you could do a patient education only consult if you want. If you want actually to be a patient I'm licensed in many states but obviously only in the US.

I'm always happy for breast cancer survivors if they want me to help connect them with a resource that's local to them. I've got a great network, I'm always happy to, without charge, just point them in the right direction.

Susi: Love it. All right, so the best way to reach you then on Instagram, is that the best?

Corinne: Yes, @DrMennOBGYN or they can just go to my website, drmenn.com, D-R-M-E-N-N.com. And I'm always doing Instagram reels about breast cancer survivors. And I'm also doing stuff about the regular woman. The regular woman, the non-survivor. And sometimes the survivors are like, "Hey, Dr. Menn, that makes me feel alone and I can't do that." I'm like, I know, but I can't be everything to everybody.

So I put tons of information out there, some is breast cancer specific, some is more general menopause. But DM me there, do the contact form on my website and I promise I'll get back to you.

Susi: Love it. Thank you so much. All those links, by the way, are going to be in the show notes along with the resources you mentioned. Do check those out on the website. And thank you so much for being here.

Corinne: Thank you for having me and all the work that you do.

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If this episode has resonated and you're looking to deepen this idea of getting your body back on board, of listening deeply to your symptoms, of listening to the whispers so you don't have to hear the screams and you're looking for one to one support or professional training, then reach out to us at health@functionalsynergy.com where we can customize your learning path. That's health@functionalsynergy.com. Looking forward to hearing from you.