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Hormone substitution in patients treated for breast cancer
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Patients with breast cancer have been denied subsequent exposure to increased levels of estrogen (endogenous or exogenous) based on the belief that exacerbation of the cancer would occur. This issue is of critical concern in postmenopausal breast cancer patients where hormone replacement therapy (HRT) was demonstrated improvement in quality of life and survival of menopausal women as a result of the prevention of osteoporosis and cardiovascular disease. A re-examination of the foundation of this traditional denial based on the poor outcome of pregnant breast cancer patients has demonstrated that youth and not pregnancy predicts for poor outcome. Examination of other situations in which breast cancer occurs coincidentally with high levels of estrogen (women receiving oral contraceptives of HRT) has not demonstrated an adverse outcome with respect to breast cancer. Furthermore, current understanding of breast carcinogenesis suggests that HRT may have a protective (anti-promoter) effect on breast cancer recurrence or the development of second primary breast cancers. Based on our understanding of the interaction of HRT and breast cancer we have allowed occasional patients to receive HRT. To the present we have managed 77 previously treated breast cancer patients who have been given HRT. The median age of this group is 50 years and stage of disease range from 0 to III. Median follow up after initiation of HRT is 27.0 months with median period of observation from diagnosis being 59 months. Ninety-two % of patients are alive without evidence of breast cancer while 3% are alive with recurrence. Three patients have died because of recurrent breast cancer. Although the power of this study is not sufficient to ensure absolute safety of HRT in breast cancer patients, it strongly suggests that renewed hormonal exposure does not cause excessive and uncontrolled recurrence as was feared. Prospective studies are imperative to resolve this important question that will face ever increasing numbers of women.

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The risk for breast cancer: Various forms of hormone substitution therapy inducing different effects on important biological parameters

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Epidemiologic data on breast cancer risk in menopausal women treated with oral estrogen alone show no risk modification with 'conjugated estrogens' 0.625 mg/day, and only a slight risk increase with long term use at generally higher doses. Contrarily to parenteral estrogens, oral estrogens produce marked hepatocellular effects. Some of these effects, for example increased sex hormone binding globulin (SHBG) level and reduced circulating insulin-like growth factor-I (IGF-I) level,

might offer protection to the breast. Epidemiologic data on breast cancer risk following the addition of progestogen to estrogen are not consistent: overall, American studies suggest no risk modification; on the contrary, two European studies show that the progestogen addition increases the risk. Most women in both the worrying epidemiologic studies from Europe received 19-nortestosterone derivatives, with strong androgenic hepatocellular effects opposite to those, potentially protective to the breast, induced by oral estrogens. It is possible that these progestogens were more dangerous for the breast through their androgenic hepatocellular effect than through their direct progestogenic effect. If this is the case, the progestogens with scanty androgenic action might be less hazardous.

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Screening for ovarian cancer

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Purpose: To critically review the available evidence for screening asymptomatic women for ovarian cancer with ultrasonography or the CA 125 radioimmunoassay (CA 125) or both. Data Sources: A MEDLINE search of the English-language literature and bibliographies of published studies providing estimates of ovarian cancer risk and test operating characteristics (based on observational studies and meta-analyses) and effectiveness of treatment according to stage of disease (based on randomized trials). Published mathematical models simulating screening for ovarian cancer in specific populations were also included. Death from ovarian cancer and morbidity from surgical procedures were the principal outcomes considered. Results: Age and family history are the most important risk factors for ovarian cancer. Annual screening with CA 125 or ultrasound in women older than 50 years without a family history of ovarian cancer would result in more than 30 false-positive results for every ovarian cancer detected. False-positive tests are likely to require invasive testing, often including laparotomy. There is currently no direct evidence that mortality from ovarian cancer would be decreased by screening. Conclusions: Available evidence does not support either screening of pre- or postmenopausal women without a family history of ovarian cancer or routine screening in women with a family history of ovarian cancer in one or more relatives (without evidence of a hereditary cancer syndrome). Women from a family with the rare hereditary ovarian cancer syndrome are at high risk for the disease and should be referred to a gynecologic oncologist.

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The incidence of vaginal bleeding with tibolone treatment

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Objective: To determine the incidence of breakthrough bleeding and its significance in recently postmenopausal