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Commentary

# Vaginal Estrogen Therapy in Breast Cancer Patients

**Hsing-Yu Leee***

*Department of Chinese Pharmaceutical Sciences, China Medical University, Taichung, Taiwan*

## DESCRIPTION

The importance of enhancing or sustaining quality of life throughout the aftercare period is growing as a result of the favourable prognosis for breast cancer patients. With symptoms like vaginal dryness, petechial bleeding, dyspareunia, and recurrent cystitis, vaginal atrophy has become more common in recent years, in part due to the rising use of aromatase inhibitors. And merely these symptoms have a negative effect on the quality of life for those with breast cancer. The most efficient way to treat vaginal atrophy is by using a topical oestrogen therapy. However, patients with breast cancer should not take systemic or, respectively, topical hormone therapy. The safety of vaginal oestrogen treatment requires additional clinical trials. Breast cancer mortality has decreased as a result of improvements in detection and treatment during the past several years. Because the disease has a fair prognosis, many patients experience long-term adverse effects that might be brought on by surgeries, radiotherapy, chemotherapy, or endocrine therapy. As a result, maintaining or improving quality of life is becoming more crucial for breast cancer patients' ongoing care. In about 75% of climacteric patients, menopausal symptoms such hot flashes, insomnia, a decrease in libido, and vaginal shrinkage are present. Since breast cancer often develops after age 62, the majority of patients are postmenopausal when they receive their initial diagnosis. The majority of these patients have hormone receptor-positive breast cancer, thus they are given tamoxifen or aromatase inhibitors as part of adjuvant endocrine therapy. These treatment choices frequently result in an increase in the frequency of symptoms of oestrogen insufficiency. Simply using AIs more frequently causes vaginal atrophy in postmenopausal breast cancer patients, which manifests as symptoms including vaginal dryness, petechial bleeding, dyspareunia, and recurrent cystitis. In a retrospective analysis of the Swedish cancer register, users of AIs were much more likely to have severe vaginal atrophies than individuals receiving tamoxifen medication (33.3% vs. 5.95%).

### Identifying vaginal atrophy

Clinically significant vaginal atrophy can develop in postmenopausal patients when blood estradiol levels fall below 73 pmol/l. Making a quick and precise diagnosis of vaginal atrophy requires a precise understanding of its symptoms. Usually during a gynaecological checkup, the diagnosis of vaginal atrophy is made. In this case, dry vaginal mucous membranes and potential petechial haemorrhages or, correspondingly, bleeding on contact should be given priority. Patients frequently mention concomitant burning, itching, and dyspareunia. Additionally, the disappearance of vaginal membrane folds, or rugae of the vagina, can result from the breakdown of collagenous reinforcing fibres in the vaginal epithelium [1,2]. Many patients are unaware of the connection between vaginal shrinkage and postmenopausal oestrogen insufficiency. Only a small percentage of patients ask their gynaecologist for advice on possible treatments. Gynecologists should tell their patients about the symptoms and available treatments whenever vaginal atrophy is identified during gynaecological examinations. The severity of the patient's suffering determines when a local Hormone Therapy (HT) is started.

### Risk of breast cancer from hormone therapy

The likelihood of getting breast cancer rises with HT use. After using for at least five years, the risk is increasingly obvious. The association between HT and breast cancer has primarily been studied in observational trials during the past few years. These have arrived at varying conclusions about the dangers of either an Estrogen-only Therapy (ET) or, correspondingly, an Estrogen and Progesterone-combination Therapy (EPT) [3,4]. These investigations demonstrated that the risk is increased more by EPT than by ET. Additionally, the relatively small risk increase caused by ET is not noticeable until far extended periods of use (>7 to 10 years) [5].

### Hormone Therapy in breast cancer

In a comprehensive review, investigated the Relative Risk (RR) associated with a breast cancer recurrence due to the usage of HT. 669 breast cancer patients who had received HT in total across 11 trials were examined. Only 4 out of the 11 trials had a control group, and in those, there was no discernible increase in the recurrence rate [6]. After a 30 month observation period, the

**Correspondence to:** Hsing-Yu Leee, Department of Chinese Pharmaceutical Sciences, China Medical University, Taichung, Taiwan; E-mail: leeyu@hsing.tw

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annual recurrence rate was 4.2 percent. Compared to 66 patients (11%) without HT, 17 patients (8%) receiving HT had a breast cancer recurrence (RR 0.64). There was no appreciable increase in breast cancer recurrence overall, with an RR of 0.82 20, in a total of 11 examined studies (7 uncontrolled trials) on 669 breast cancer patients with HT [7,8]. However, the case numbers in these trials were insufficient to allow a clear conclusion to be made about the safety of HT in this patient group.

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