# MHT AND GYNAECOLOGICAL CANCER

## There are five main types of gynaecological cancer: uterine, ovarian, cervical, vaginal and vulval.

Of all the gynaecological cancers, only cervical cancer has a screening test (CST) that can detect it in a pre-malignant form, when treatment can be most effective. In most cases, cervical, vaginal and vulval cancer risk is related to exposure to the human papilloma virus (HPV). Cervical cancer is almost exclusively due to the persistence of the high-risk form of HPV.

Cancer of the uterus (endometrial cancer) occurs mainly in postmenopausal women; the average age at diagnosis is 60–65 years. The life-time risk for uterine cancer is 1 in 44, or 2.3%, by the age of 85. The incidence of uterine cancer in younger women is increasing, possibly due to obesity or genetic factors. Abnormal uterine bleeding (new onset after years of no bleeding or a change in the pattern or flow) may be the first sign of uterine cancer and should be investigated promptly. Oestrogen-only menopausal hormone therapy (MHT) increases the risk of endometrial cancer in women who still have their uterus, and the risk persists for years after stopping medication. The addition of progesterone counteracts this. For this reason, it is important to take a combined preparation when the uterus is present. It is estimated that about 3% of cases of endometrial cancer in Australia are due to women using oestrogen-only MHT. There is no conclusive evidence that topical (vaginal) oestrogen affects the risk of endometrial cancer.

The lifetime risk of ovarian cancer is about 1.5% overall, although there are regional and ethnic differences. Unlike endometrial cancer, the majority of ovarian cancers present at a later stage (75% at stage 3 or greater), hence the 'silent killer'. Ovarian cancer is the seventh most common female cancer worldwide and the eighth most common cause of cancer death. There is no acceptable screening test yet. The only good quality evidence available regarding MHT and ovarian cancer does not show any increased risk with MHT use. It has been suggested that the effect of MHT on ovarian cancer risk is about 1/2000 women over five years.
In conclusion, MHT can increase the risk of uterine cancer, but the **increased risk is small**. It may be safe to take MHT for early-stage or graded uterine cancer following discussion with your specialist.

The risk-benefit profile of MHT is favourable for most ovarian cancers. MHT can be safely taken with cervical cancer if it is clinically indicated. Vulval and vaginal cancers are relatively uncommon and unaffected by MHT, however, it is not recommended in women with advanced gynaecological cancer. In most cases, an individualised, common-sense approach will safely guide you regarding MHT. Reducing other risk factors for cancer, such as alcohol, obesity, and inactivity, is very important.