

MHT AND GYNAECOLOGICAL CANCER

There are five main types of gynaecological cancer including uterine, ovarian, cervical, vaginal, and vulval cancers, each with unique risk factors and considerations regarding menopausal hormone therapy (MHT).

Uterus and Cervical Cancer

Of these cancers, only cervical cancer currently has a screening test that can detect abnormalities before they become cancer (Cervical Screening Test, CST), allowing for prevention and early treatment. Almost all cervical, vaginal, and vulval cancers are caused by the human papilloma virus (HPV), which is detected by the Cervical Screening Test. A vaccination is freely available for Australians aged 12 to 25, or for older individuals at high risk.

Endometrial cancer, primarily affecting postmenopausal individuals, has a diagnosis peak between ages 60–65, and affects up to 1 in 40 Australian women by the age of 85. Significant risk factors include overweight or obesity, Type 2 diabetes and in some cases genetic factors. Abnormal uterine bleeding, especially if it begins after a long time without bleeding or has a changed pattern, can signal endometrial cancer. Endometrial cancer can generally be treated if detected early, so any unusual bleeding should be assessed by your doctor.

Oestrogen-only MHT increases endometrial cancer risk in individuals with a uterus (i.e. those who have not had a hysterectomy), and for this reason it is essential to combine oestrogen with a progestogen as part of 'combined' MHT. Topical estrogen has not shown conclusive links to endometrial cancer risk.

Ovarian Cancer

Around 1 in 90 Australian women will be diagnosed with ovarian cancer by the age of 85. The early symptoms tend to be vague, and there is no effective screening program available. This means that ovarian cancer is often diagnosed at an advanced stage, earning it the moniker 'the silent killer'. In Australia, it is the ninth most common cancer among women, but the fifth leading cause of cancer-related death. It is important to be aware of any family history, and to make an appointment with your GP if you notice any unexpected changes in your body such as bloating, changes in weight or appetite, or changes in bowel or bladder habits.

The available data indicate that MHT does not elevate ovarian cancer risk substantially, with any additional risk being very low (approximately 1 in 2,000 individuals over five years of use.)

Considerations for MHT Use in Gynaecological Cancer

MHT presents varying degrees of risk and benefits across different gynaecological cancers, with the risk profile being influenced by tumour type and individual health factors. The decision to use MHT will vary from person to person depending on individual risks and the impact of menopausal symptoms on quality of life.

- **Endometrial cancer:** MHT, systemic or topical, may be considered after surgical treatment in early-stage cases with low recurrence risk. However, for advanced cases or those with high recurrence potential, non-hormonal options are generally recommended. Limited evidence exists for MHT safety in individuals with Lynch syndrome, a condition that increases overall cancer risk.
- **Uterine sarcomas:** These hormone-dependent tumours require oestrogen and progesterone receptor testing to guide MHT decisions. MHT's impact on non-hormone-dependent sarcomas remains unverified, though receptor testing aids in risk assessment.
- **Ovarian, fallopian tube and peritoneal cancers:** Evidence suggests that MHT, systemic or topical, does not negatively impact survival rates in non-serous ovarian cancers, germ cell tumours, or borderline malignancies. Treatment choice (oestrogen alone or combined) may depend on whether a hysterectomy has been performed. Special caution applies to serous and granulosa cell tumours due to their hormone sensitivity.
- **Cervical, vaginal, and vulvar cancers:** These cancers are generally not hormone-dependent, and MHT is not contraindicated. The decision between unopposed or combined MHT is based on hysterectomy status.

Comprehensive Cancer Management

An individualised approach, ideally managed by a multidisciplinary team, is essential for cancer management during menopause. Factors such as age, cancer stage and type, concurrent treatments, and personal health must guide decisions on MHT use and its duration. Reducing other cancer risk factors, including obesity, alcohol use, and inactivity, are equally important for overall health.

Worldwide, approximately 1.4 million new gynaecological cancers are diagnosed annually, underscoring the importance of informed, individualised menopause management based on cancer type and personal health status.

