Surgical Menopause

More than “a few hot flushes”

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Surgical Menopause

- **Ovarian pathology**
- Endometriosis
- Ovarian cysts, benign and malignant tumours
- Endometrial cancer
- **Non pathological-Risk reducing BSO**

Risk reducing bilateral salpingo-oophorectomy for BRCA 1 and 2 mutations

- BRCA mutations present in up to 0.3% population
- BRCA status may be suspected on family history
- Particularly where there are first degree family members with premenopausal breast cancer, ovarian cancer or male breast cancer
- OR following breast cancer detection particularly in triple negative tumours or bilateral cancers
- Thus a woman may be completely healthy at time of BRCA mutation detection
- OR have an existing cancer

Different risks for BRCA 1 and BRCA2 mutations for ovarian cancer

- BRCA1
- Ovarian cancer –lifetime risk 35-46% risk rises steadily from late 30s with average age of diagnosis 50
- BRCA2
- Ovarian cancer lifetime risk 11-23% from mid 40's average age of diagnosis 60
- Lynch syndrome (hereditary nonpolyposis colorectal cancer syndrome) 3-20% lifetime risk ovarian cancer, 60% risk endometrial cancer
- General population lifetime risk 1.5%

Breast cancer risk in BRCA 1 and 2

- BRCA1 risk of developing breast cancer 55-65%
- Starts to increase ages 36-39

- BRCA2 risk of developing breast cancer around 45%
- Starts to increase ages 44-46

- General population risk of breast cancer is 12%

Benefits of RRBSO are substantial for at risk women

- Quoted rates:reduces risk of dying of ovarian cancer risk by 80 %. Peritoneal cancer still a risk
- Reduced risk of breast cancer death by around 50%
- Now this is under review especially for BRCA2
- For women without breast cancer or other contraindication the use of hormone replacement until the predicted age of menopause (51) is recommended (Domchek et al 2016 NAMS). It does not increase the risk of breast cancer in BRCA carriers and is associated with decreased risk.
- However many women are reluctant to use hormone therapy or cannot due to pre-existing breast cancer

Effects of surgical menopause

Short term/ongoing

- VMS
- Sleep disturbance
- Aches and Pains
- Genitourinary Syndrome of Menopause
- Sexual dysfunction- lack of libido, dyspareunia, poor arousal, weak/infreq orgasm
- Mood changes, anxiety

Long term

- Osteoporosis
- Dementia/cognitive decline/ Parkinson’s disease
- CVD

Impact of surgical menopause

- Sudden decline in ovarian hormones-oestrogen by >80%; testosterone by 50% in premenopausal woman
- Loss of fertility
- Loss of energy and sexual desire
- “No longer a woman”-changes in female smell, taste, shape, skin
- Reduction in oxytocin receptors-reduced bonding response
- Changes in other oestrogen dependent brain signalling
- Dyspareunia, vaginal atrophy, reduced arousal, reduced vaginal acidity
- Decreased frequency and enjoyment of intercourse

Psychological and relationship changes

- Changes in self confidence, body image
- Depression and anxiety, irritability
- Poor sleep, hot flushes
- “Uncoupling” of relationship not infrequent. (Marriage breakdown is more common in female cw male patients)
- Problems pre-dating surgery often exacerbated
- Prior sex functioning and feelings for partner most important determinants of post menopausal sexual function

Clinical experience

- Women often unprepared for the dramatic change particularly in sexual function
- Often report that the doctor mentioned “a few hot flushes”
- Unaware of the functions of the ovary beyond periods and reproduction (unlike male castration anxiety)
- “I’ve finished my family and who wants more periods?”
- Partners included in pre and post op counselling helpful
- Issues of informed consent
- Discussion takes time

Adjusting to change

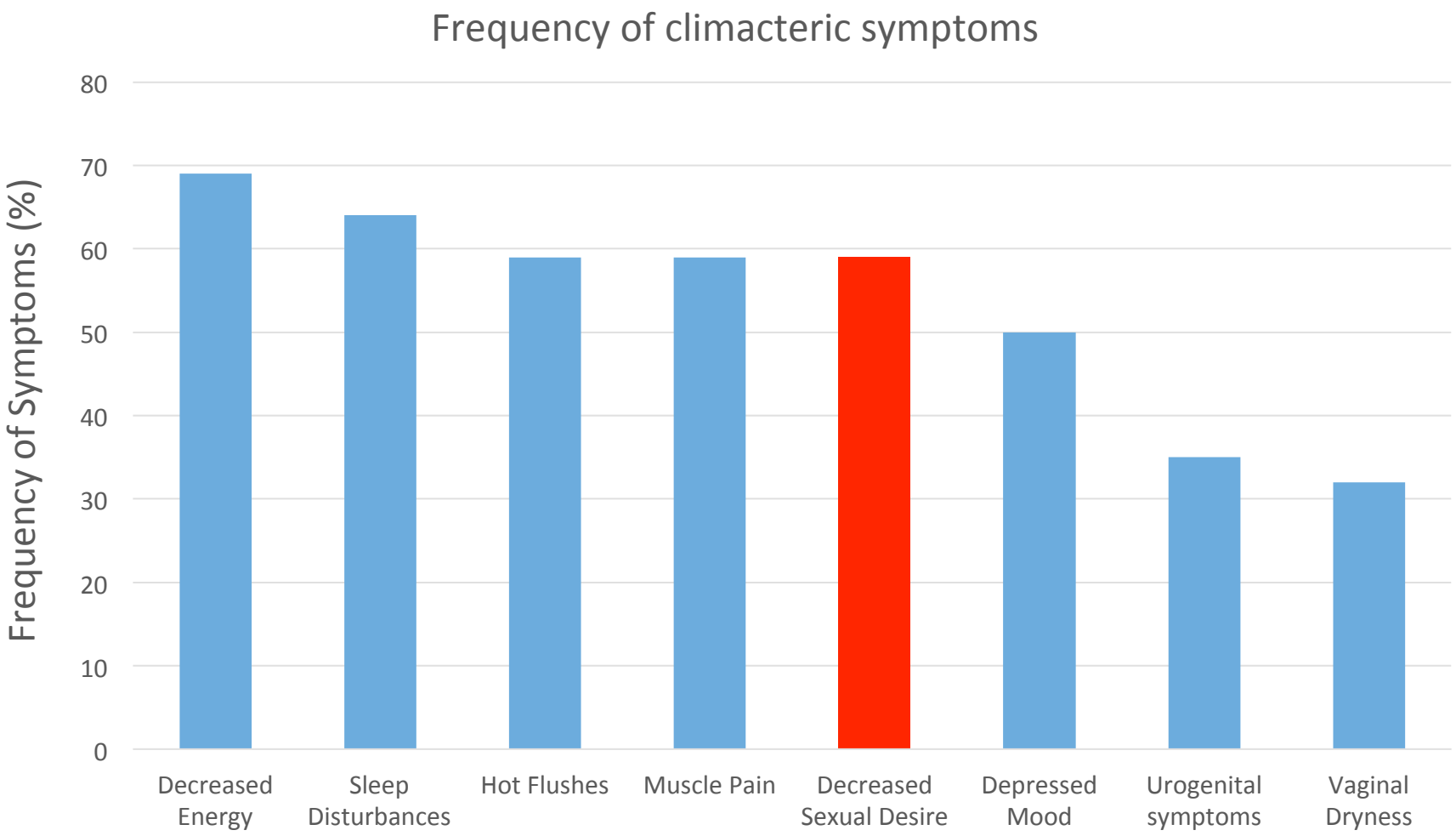
- Patients need to know that they will feel different after surgery. They and their partners need to adjust to “a new me” and “a new us”. Counselling before and after surgery recommended
- Evidence suggests women adjust better when prepared for changes even though this does not improve sexual function
- Hormone therapy when permitted will not usually completely ameliorate symptoms
- Non hormonal treatments for VMS all potentially worsen sexual dysfunction (antidepressants, gabapentin, clonidine) but can benefit wellbeing especially VMS and sleep

The emotional response determines outcome

- The woman will often be grieving the loss of a close female relative in the case of RRBSO for BRCA1/2. High levels of anxiety reduce capacity to absorb new information.

- Women unprepared for these changes may be so devastated they opt out of further recommended surgery such as RRBM

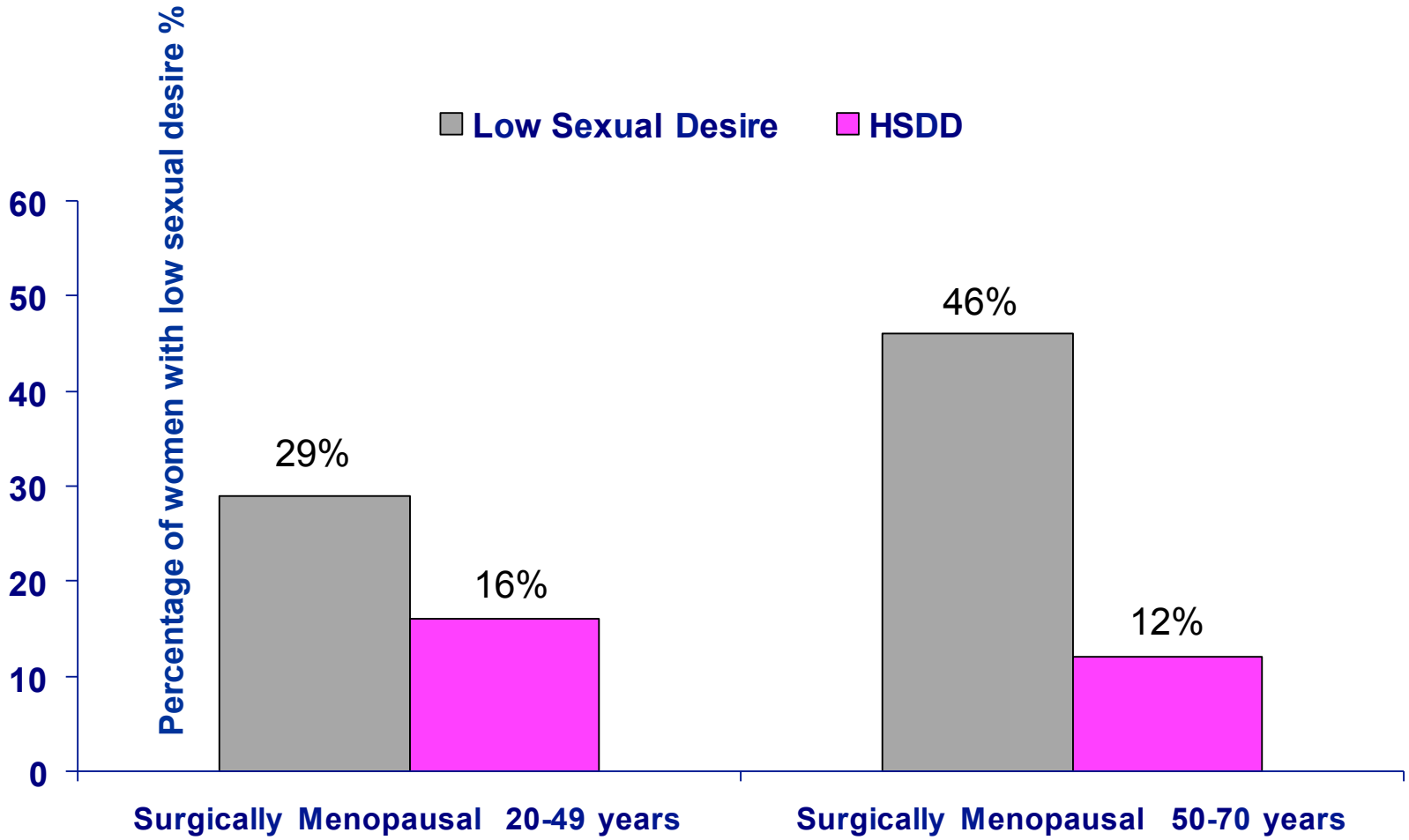
Low sexual desire is a key symptom of menopause



n = 603 menopausal women aged 49-59 years (MRS-Rating)

Adapted from Schultz-Zahden (2003) *Der Gynakologie*

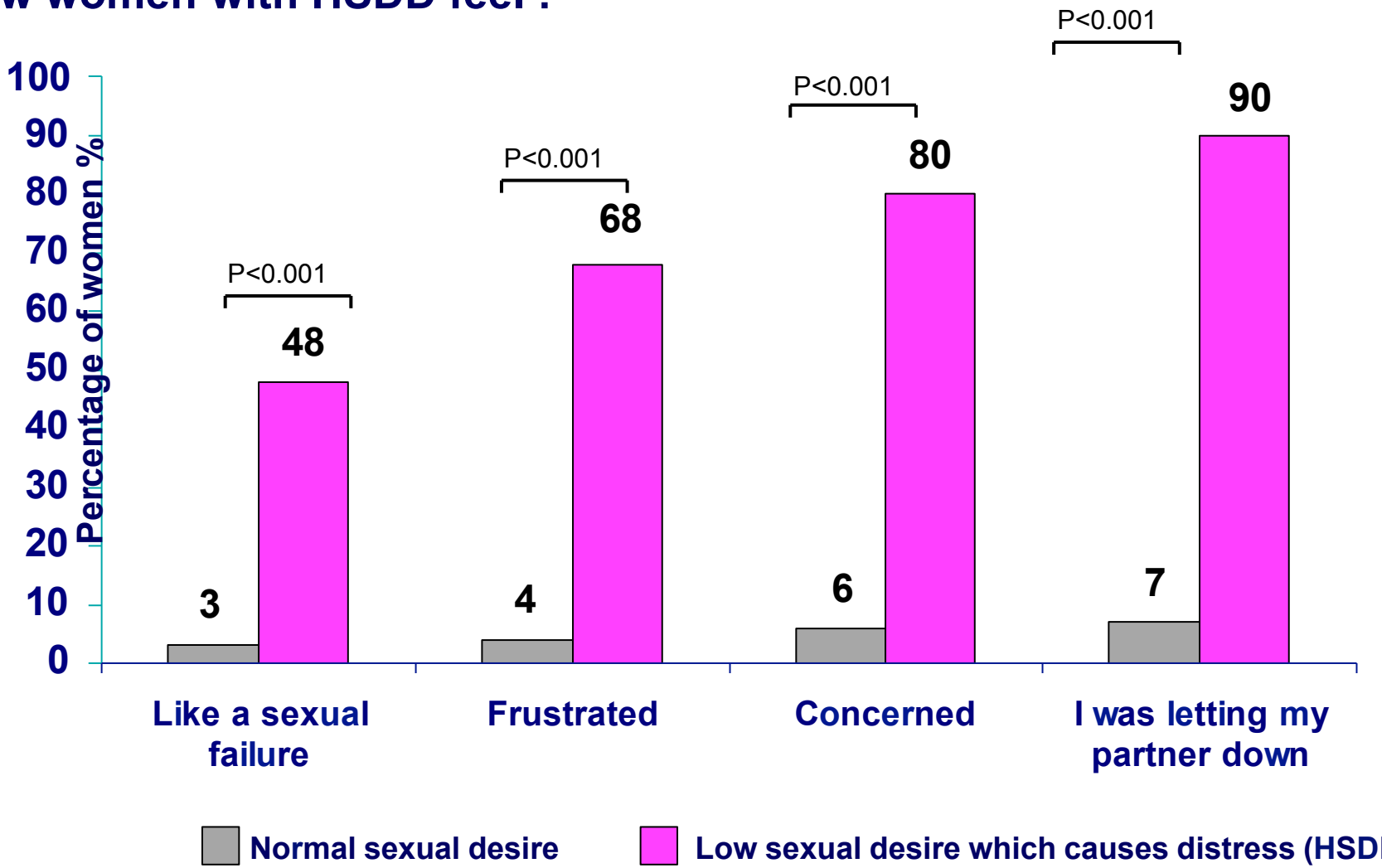
Amongst surgically menopausal women with low sexual desire, 1 in 3 reports being distressed about it and are classified as having Hypoactive Sexual Desire Disorder (HSDD)



Adapted from Dennerstein L, *et al.* (2006) *Journal of Sexual Medicine;* 3: 212-222

Low sexual desire which causes distress strongly impacts on women's well-being and relationship

How women with HSDD feel :



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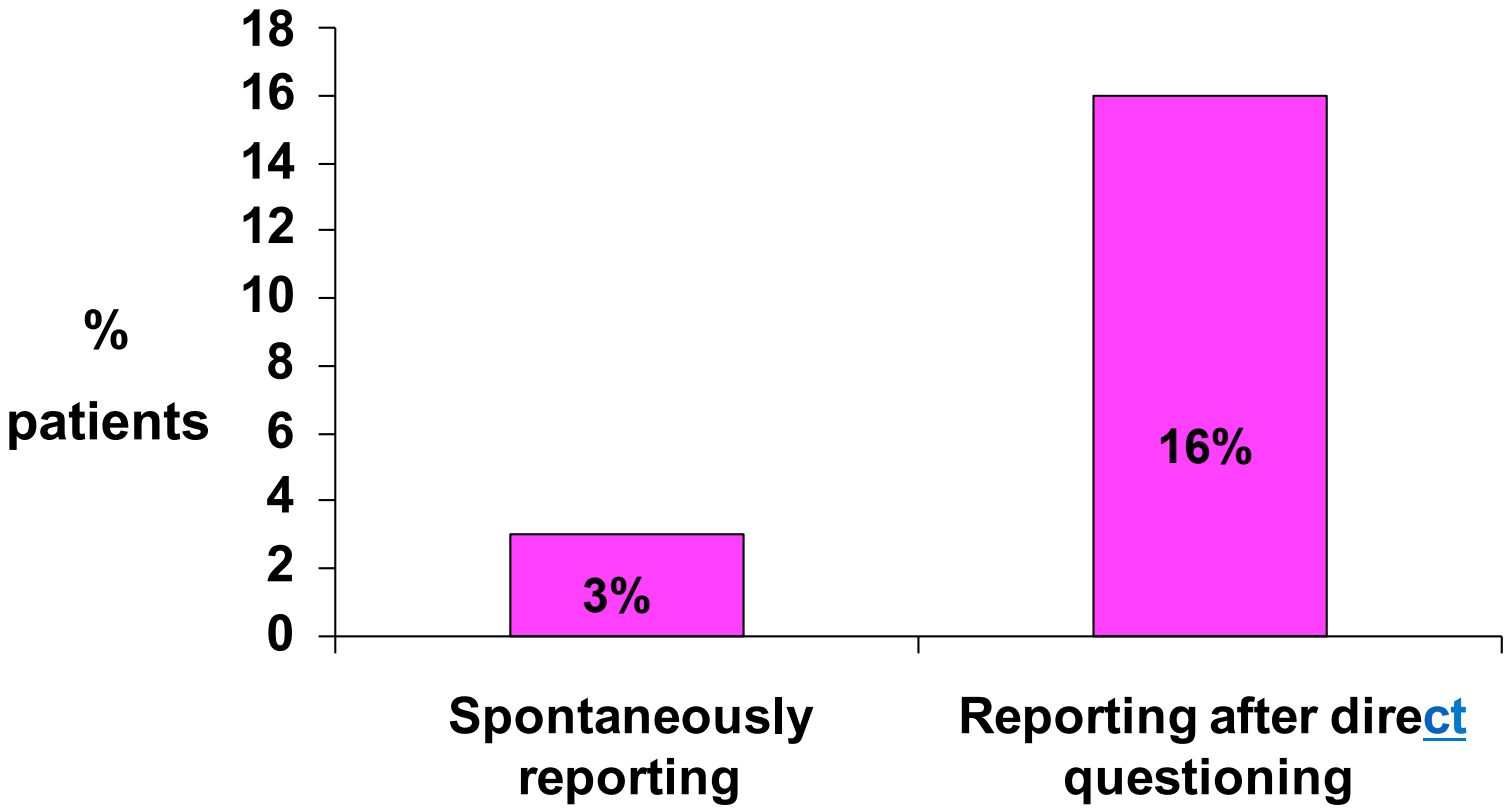
Physician questioning helps the patient talk about sexual problems



* Patients screened for sexual complaints by inclusion of two medical history questions (n=887)

Sexual counselling

- Individual and relationship counselling-reducing unresolved tensions, building goodwill, better communication, acceptance of change
- Remember the partner may also have problems
- Other sensory modalities can enhance intimacy
- Good conditions for sex, lubricants, replens, acijel-sense of humour!
- Use of vaginal oestrogen when permitted (Consult with oncologist)

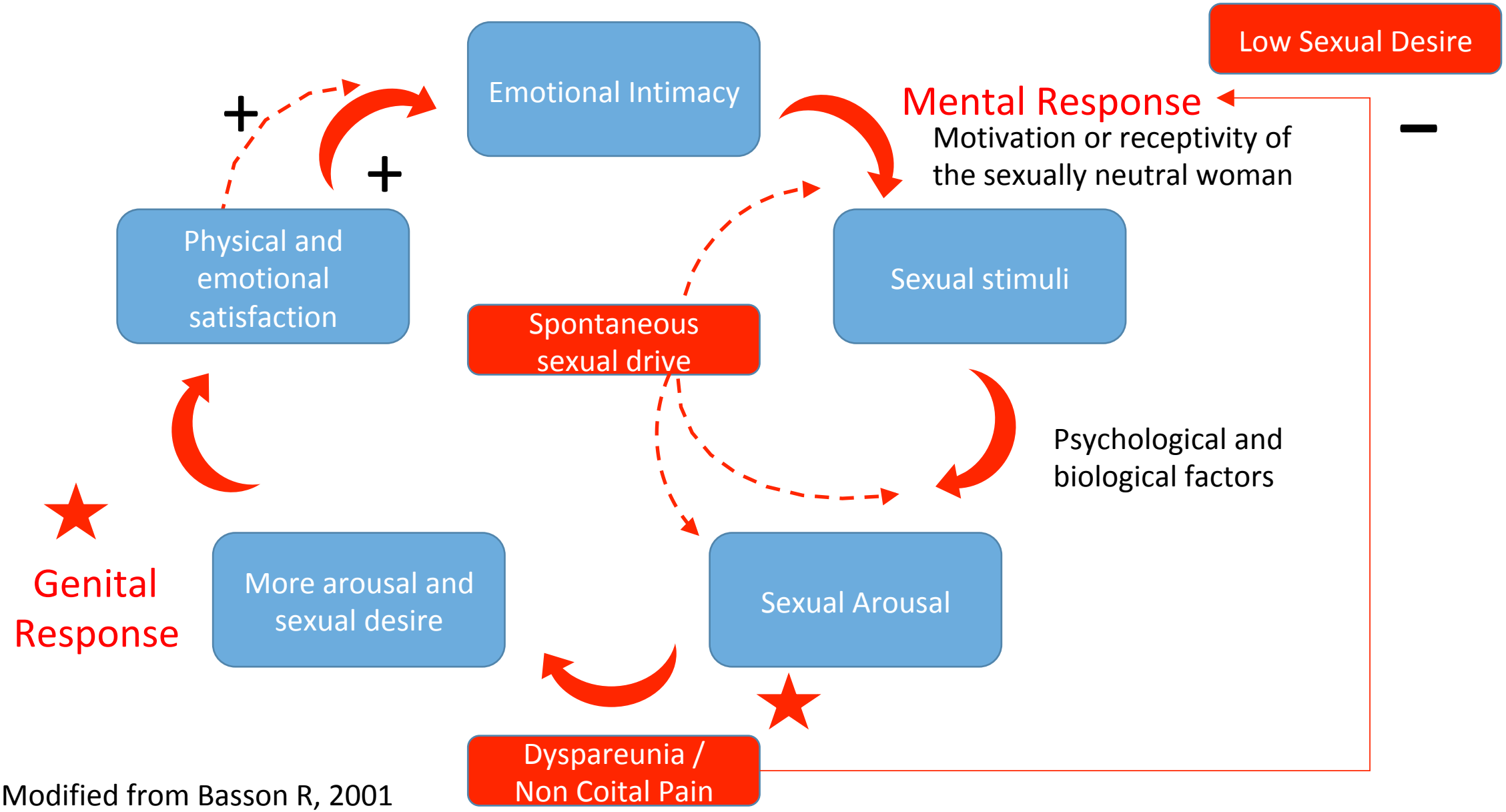
The importance of oestrogen for the female urogenital tract

- Rebuilding the vaginal epithelial thickness up to 5 times
- Improving elasticity and blood supply
- Returning capacity for lubrication
- Increase sensation and contact
- Improving bladder supports
- Future possibilities for women needing to avoid oestrogen
- Topical SERM only activating vulvovaginal oestrogen receptors
- Laser treatments (as yet unproven)

Receptive interest-building arousal

- In face of systemic reduction of oestrogen, local oestrogen may enhance arousability by increasing epithelial thickness, elasticity, blood flow and lubrication. Using Basson's model of circularity of sexual response-focus on gradual arousal to build desire

Circular model of female sexual response



Modified from Basson R, 2001

New medical interventions

- Low dose vagifem 10mg available on PBS
- Ospemifene SERM- oral T-sec FDA approved
- Sildenafil-Animal studies show sildenafil significantly increases genital blood flow and irrespective of hormonal status. Estradiol not testosterone increases blood flow and lubrication
- Laser-Mona Lisa Touch re-epithelialisation of vagina
- Still in research phase

Controversies

- Oestrogen appears to be more important than testosterone for female sexual function
- Better screening techniques eventually may preclude risk reduction surgeries
- The whole person, her quality of life and her relationships need to be considered
- The notion of risk is complex-life is never without risk.
- Existential issues important “how do I want to live my life?”
- Informed consent should include information on sexual function