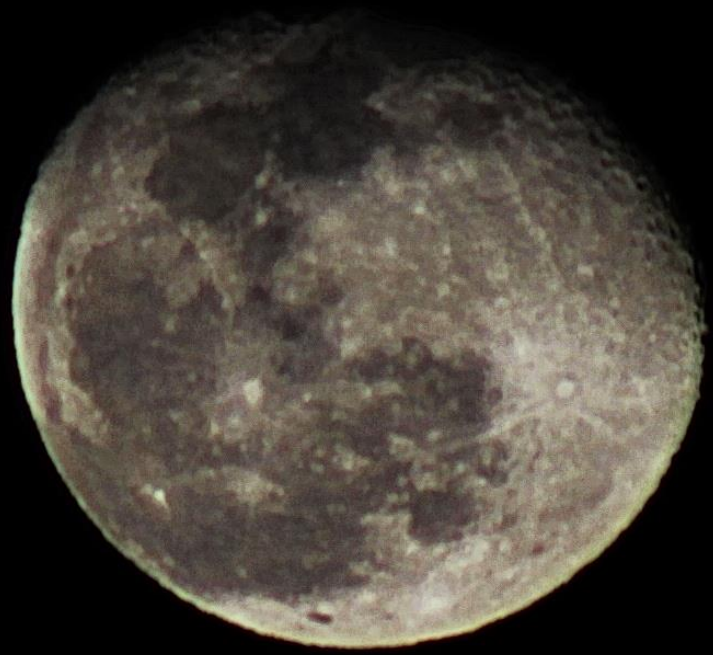
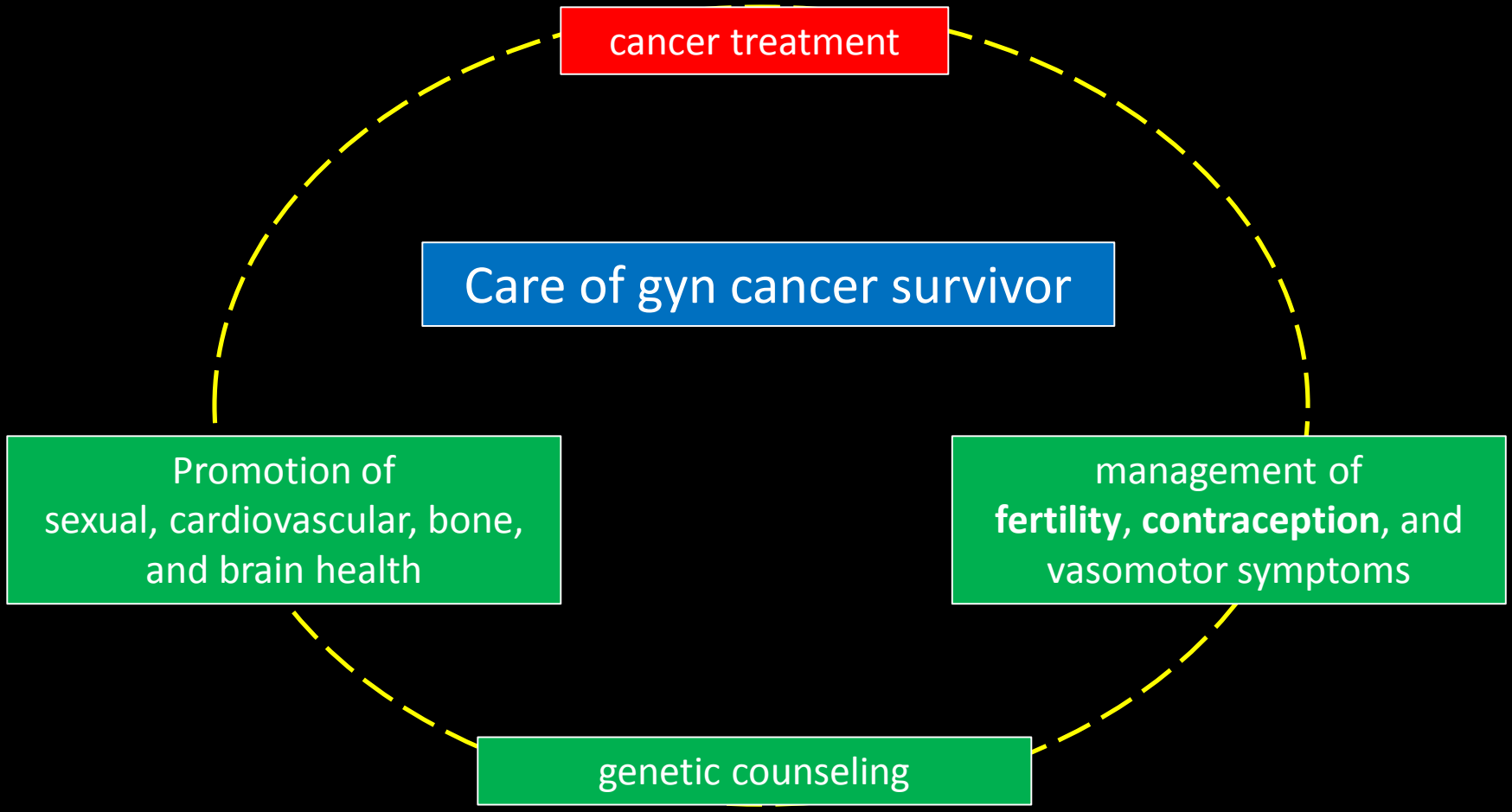


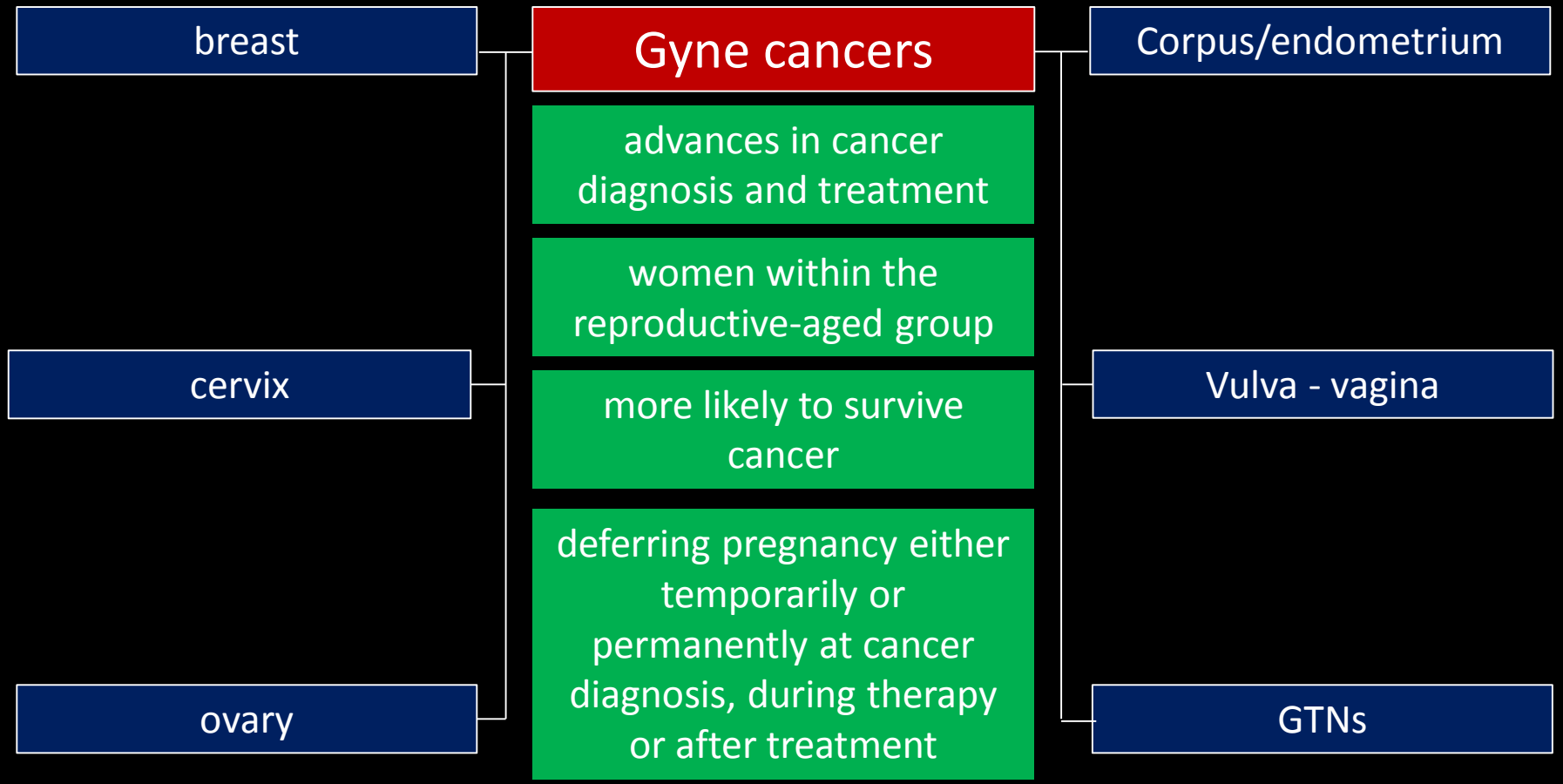
Ardhanu Kusumanto – Oktober 2017

Contraception methods for gyne cancer survivors

Background

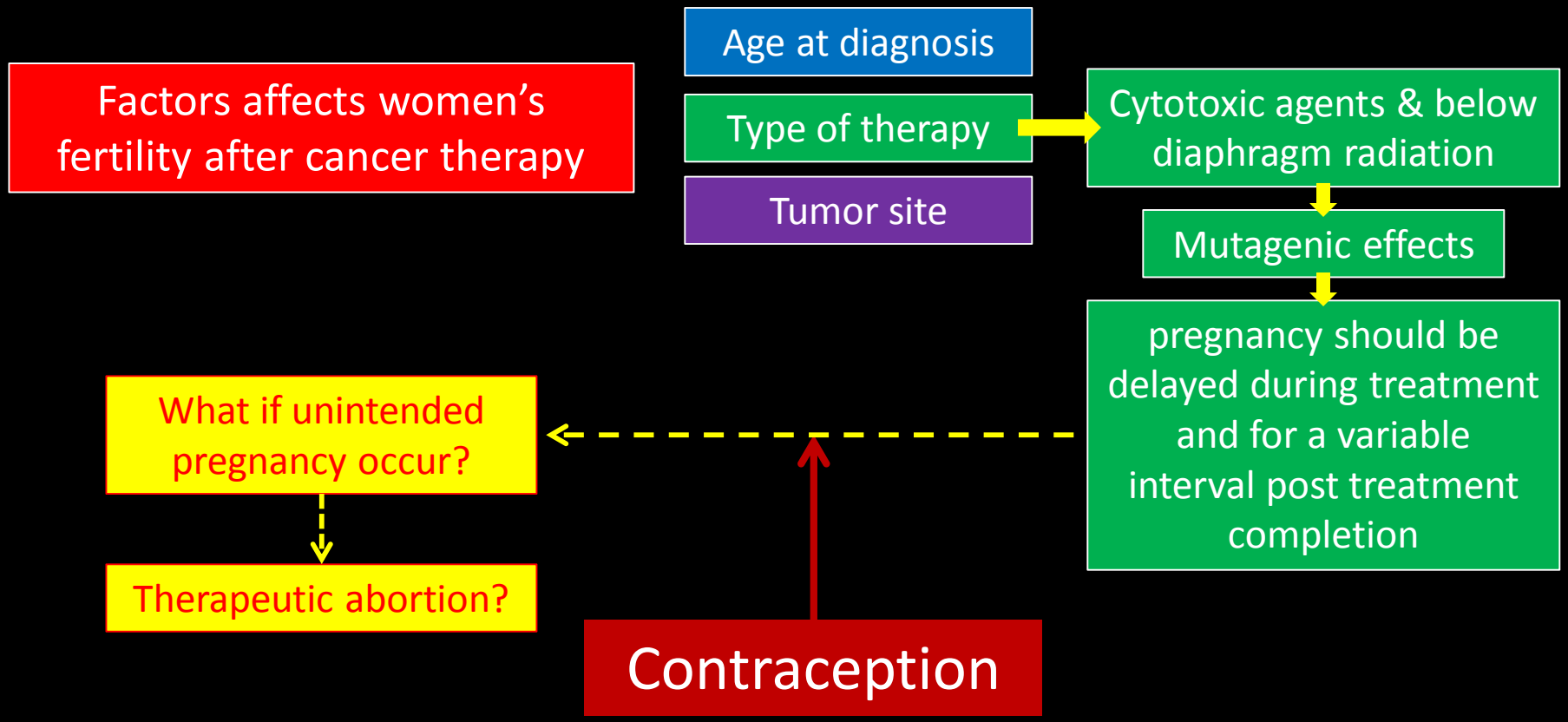

cancer treatment
Care of gyn cancer survivor
Promotion of
sexual, cardiovascular, bone,
and brain health
management of
fertility, **contraception**, and
vasomotor symptoms
genetic counseling

Background



Although cancer treatments increase risks of infertility and premature ovarian aging, most survivors retain ovarian function and potential fertility after cancer treatment

Background



Long-acting contraceptive methods including sterilization, implants and intrauterine devices (IUDs)

Short-term contraceptive methods, which include combined estrogen and progestin methods with various delivery systems and barrier and behavioral methods

Breast

- breast tissue is a target for female steroidal hormones --> response to oestrogen and progesterone depends on the presence of their corresponding receptors
- exogenous estrogen and progestins → may increase the risk of cancer recurrence
- oral medroxyprogesterone acetate → benefit as a chemotherapeutic agent

Breast

- progestin-only contraceptives **have been (have not been???)** associated with an increased risk of breast cancer
- Tamoxifen → endometrial proliferation - even endometrial cancer → levonorgestrel-containing intrauterine system (IUS) may be optimal for both contraceptive and endometrial effects, as it decreases both endometrial proliferation and the need for investigation of vaginal bleeding
- copper T380A, the most effective hormone-free and reversible contraceptive

Breast

- contraception --> breast cancer?
  - combined hormonal contraceptives containing higher doses of estrogen (or who had used such oral contraceptivesin the prior 10 years) had a relative risk of breast cancer of 1.24????
  - recent studies found no association between use of modern oral contraceptives and an increase risk of breast cancer development
  - levonorgestrel IUS has not been shown to increase the risk of breast cancer
  - injectable and implantable progestin-only contraceptives has not been associated with an increased risk of breast cancer

Endometrium

- Contraception → Endometrial cancer?
  - COC --> lower risk (56%, 67%, 72% with the use in 4, 8, 12 years)
  - after stopping 20 years --> 50% below women never use OC
  - taken > 12 months --> protection againts adenocarcinoma, adesquamous carcinoma, adenoacanthoma

Ovarium

- Contraception → Ovarian cancer?
  - OC --> lower risk (41%, 54%, 61% with the use in 4, 8, 12 years)
  - Reduced 4 main histologic subtypes: serous, endometrioid, mucinous, clear cell)
  - DMPA decrease risk 80%, protective effect 8 years
  - Protective benefit for hereditary ovarian cancer

Cervix

- Contraception - cervical cancer?
  - The use of OCs has been associated with an increased risk of CIN and cervical cancer
  - However, since the human papillomavirus (HPV) has been implicated as the main causative agent in cervical cancer, OC use most likely acts as a co-factor in the development of this disease

GTD - GTNs

- Women with GTD should be advised to use barrier methods of contraception until hCG levels revert to normal.
- Once hCG level have normalised, the combined oral contraceptive pill may be used. There is no evidence as to whether single-agent progestogens have any effect on GTN.
- If oral contraception has been started before the diagnosis of GTD was made, the woman can be advised to remain on oral contraception but she should be advised that there is a potential but low increased risk of developing GTN. Intrauterine contraceptive devices should not be used until hCG levels are normal to reduce the risk of uterine perforation

GTD/GTN

- Oral contraceptives do not increase the incidence of postmolar gestational trophoblastic disease or alter the pattern of regression of hCG values

Combined oral contracetive pills

Non contraceptive benefits	
Cycle regulation	↓↓ endometrial ca 50% ↓↓
↓↓ menstrual flow ➡ ↓↓ anemia	↓↓ risk of fibroids
↑↑ bone mineral density	Possibly ↓ ovarian cysts
↓↓ dysmenorrhea	Possibly ↓ benign breast disease
↓↓ peri-menopausal symptoms	Possibly ↓ colorectal ca
↓↓ acne	↓↓ incidence of salpingitis
↓↓ hirsutism	↓↓ incidence or severity of premenstrual syndrome
↓↓ ovarian ca 50% ↓↓ after 5 Y of use	

Myth and Misconception & Facts

- Combined Ocs cause cancer
- Combined OC reduces the risk of ovarian and endometrial cancer
- The combined OC may also have a protective effect against colorectal cancer.
- There appears to be either no increase or a very slight increase in the risk of breast cancer in current combined OC users

- COCs must be stopped in all women over 35 years old
- Healthy non-smoking women can continue to use COC until menopause

- Both cancer and estrogen --> VTE independent risk factors - thromboembolism is one of the leading causes of death in cancer patients
- Progestin-only contraceptives increase the risk of VTE much less than estrogen-containing products

matur Suwun .....