

Yale CANCER CENTER *answers*

WNPR Connecticut Public Radio



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Sexuality, Intimacy, and Menopause

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Yale Cancer Center Answers

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Welcome to Yale Cancer Center Answers with your hosts doctors Francine Foss, Anees Chagpar and Steven Gore. Dr. Foss is a Professor of Medicine in the Section of Medical Oncology at Yale Cancer Center, Dr. Chagpar is Associate Professor of Surgical Oncology and Director of the Breast Center at Smilow Cancer Hospital and Dr. Gore is Director of Hematological Malignancies at Smilow. Yale Cancer Center Answers features weekly conversations about the research, diagnosis and treatment of cancer and if you would like to join the conversation, you can submit questions and comments to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC. This week you will hear a conversation about sexuality, intimacy and menopause with Dr. Elena Ratner. Dr. Ratner is Assistant Professor of Obstetrics Gynecology and Reproductive Sciences at Yale School of Medicine. Here is Dr. Francine Foss.

Foss Elena can you start by just giving us a little bit of background about yourself and telling us how you ended up specializing in gynecologic oncology?

Ratner My path to gynecologic oncology was kind of a natural one. I come from a long family of doctors, my mom, my dad and my grandmother and even my great grandmother were physicians, but not just doctors, also strong independent women. I studied women studies at college and I always knew those two passions, taking care of women and medicine, would at some point combine and they have beautifully and naturally in this subspecialty, which I think is the best subspecialty.

Gore Do you actually treat the cancer in patients?

Ratner I do, so the beauty of this subspecialty is that I am able to take care of my patients from the very first day when she gets diagnosed with the cancer through her surgery, through her chemotherapy and through her treatment and then through her wonderful life afterwards. I am also able to treat her children, her daughters and her granddaughters, so it truly allows me a very comprehensive, very personal relationship with my patients.

Foss Can you talk a little bit about what the different types of gynecologic cancers are and how patients actually get referred to your practice?

Ratner In gynecologic oncology we take care of women with ovarian cancer, uterine cancer, cervical cancer, cancer of the vagina or the vulva, but we also take care of a lot of women who do not have cancer, women who have precancerous conditions, again of the cervix or the uterus. Also, one of my passions is early detection and prevention of cancer, because I feel that in 2014 a lot of conversation should be about cancer prevention rather than treatment. I have a big population of women who have either BRCA mutations or for some other reason they are at high risk for developing ovarian cancer or uterine cancer.

Gore What is BRCA, I do not what that is?

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- Ratner Thank you, that is a great point. BRCA is a mutation, it is called BRCA mutation and among other mutations it increases the chance that women would develop different cancers including ovarian cancer or breast cancer. A lot now-a-days is being done about cancer prevention and a huge part of it is genetics, because what we are trying to do is we are trying to identify those women who we think would be at higher risk for developing those cancers.
- Gore So should I be having my wife and daughters screened for that gene? That is really scary.
- Ratner It is a complicated question. You are also talking to somebody who is biased, because this is very much my research and my passion, not everybody of course needs to be tested for those genes, but women who either have a family history of these cancers or for some other different risk factors would be considered at high risk. They definitely need to be evaluated and seen by a geneticist to determine whether they need to be tested.
- Gore If your grandmother had breast cancer, or an aunt or great aunt, is that sufficient? When should somebody be worried?
- Ratner Nobody should be worried but I think people should take it seriously and I think this is all part of this new thinking. The new thinking is that cancers should be prevented. We work so hard in trying to find cancers early and of course that is a huge part of it and I think that we need to continue working on that, but a bigger part needs to be we should try to prevent them.
- Foss Along those lines, there is a lot of scare now about HPV because we have this HPV vaccine that we are giving to our younger people. Can you talk a little bit about that as potential preventive malignancy and do you think that all of our teenagers should be getting that vaccine?
- Ratner Absolutely, the HPV vaccine is a great example that is a successful example of something that can begin to try to prevent HPV virus.
- Gore That is a papillomavirus?
- Ratner That is the human papillomavirus and we know the different strands of that virus could predispose women to developing cervical precancerous conditions and cervical cancers, so yes, right now the recommendation, and my personal opinion, is that all girls, from age 9 to 26, hopefully before their first sexual experience, should be vaccinated with the vaccine.
- Gore HPV is that the same as warts, is that genital warts?
- Ratner The genital wart is also HPV, but it is a different one. The warts actually are not truly precancerous and they actually do not progress to cervical cancer. They are caused by something called low risk HPV virus versus high risk HPV virus that is truly precancerous and can cause cervical cancer.

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- Gore So, any of our listeners who happen to have genital warts do not need to particularly be worried about that, but they should probably still be seeing their GYN, I guess?
- Ratner That is correct.
- Foss Can you talk about how frequent these GYN cancers are and is the incidence of these cancers going up or down now that you are talking about screening? Hopefully they will go down in the future, but what is happening right now?
- Ratner Right now, we are at this place where we are discovering a lot of new information, so it is a little bit to earlier at this point to really see the fruits of these discoveries, but I think looking forward 10 to 20 years from now, when my kids are going to be the age where they would be developing this cancer, I do truly feel that we are going to see a significantly decreased incidence of this cancers.
- Gore And I know that this probably is not your disease area, but I am sure many of your patients ask you about whether mammography is really helping or not helping in increased radiation risk and what is your take on that, about screening mammograms, since we are talking about prevention?
- Ratner Again, I am biased, you are talking to an oncologist whose job and whose passion is to prevent cancers. I think everything in life and everything in medicine has its risks and its benefits. I believe that mammograms unquestionably have much more benefits than they do risks and breast cancer is one of those cancers that actually can be detected early and that is why the outcomes can be very, very good, so I think not doing the mammograms would lose that advantage of being able to diagnose these cancers early.
- Foss Could you just reiterate for us the necessity for the Pap smears and how we are still talking about getting those every year and are there certain populations that need them more often or less often than that?
- Ratner The guidelines for Pap smears have changed significantly over the past five to seven years. When I talk to my patients about Pap smears, I talk about how these guidelines are really more for the well being of society and not necessarily individual patients. In my practice, I address every patient individually. There are some women who do not need it every year. There are a lot of women who can stay with the guidelines and get it every other year or even less frequently if HPV status is checked. But there are a lot of women that I do not follow the guidelines with and I do get it every year if I am worried that they would be at a high risk of developing malignancy or pre-malignancy.
- Foss Some of the cancers that you deal with, say endometrial cancer and ovarian cancer, can be difficult to detect. I wonder if you could talk to us about way of preventing those cancers?

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- Ratner That is exactly the problem. Endometrial cancer is a bit easier because with endometrial cancer you usually would have symptoms when the cancer is first discovered, usually you would have bleeding and any women who has any vaginal bleeding after her menopause needs to see a physician because that is never ever normal. Usually when these women have bleeding they present to their provider, they get a biopsy and usually endometrial cancers also get diagnosed early. Ovarian cancer, that is a challenging cancer, it is unfortunately the cancer for which there is no effective early detection. I have, as I mentioned, a whole program in which I deal only with this early detection, prevention of ovarian cancer partly by identifying women who are at high risk but partly just monitoring daughters and granddaughters, all of my patients who have developed ovarian cancer. There is a lot of literature about what can be done, like ultrasounds twice a year blood tests for tumor markers, however, none of them really have been found to be effective, definitely not as effective as Pap smears for cervical cancer or mammograms for breast cancer.
- Gore What do you recommend to these offspring of people who have had ovarian cancer or who have a positive history of this BRCA gene?
- Ratner That is where it gets very complicated and that is why it is so important to correctly identify the women who are at risk. Because if women do carry a genetic predisposition to developing ovarian cancer then we have specific guidelines for what needs to be done, it does not always need to be surgery or it does not have to be surgery at a later age, but those women are watched very very closely.
- Foss I hope we do not have a lot of nervous people in the audience after hearing this. Can you just tell us the frequency of these women who have that genetic predisposition, how common is that?
- Ratner I think the opposite. I think if anybody is nervous about it, this talk should actually do the opposite because I think what we are talking about today is all those things that we are doing to prevent cancers and all these new modalities and all these new programs that we are establishing so cancers do not develop, and ovarian cancer is very rare, 1.4% in the general population. The BRCA gene, even though now we think it's a little bit more frequent, is still very rare, so I think that this definitely should not make women nervous, but the contrary.
- Gore And you said that there are nonsurgical interventions that can be used for people who are deemed to be at high risk for ovarian cancer, is that just frequent exams or other medicines they can take?
- Ratner Again, every patient is seen individually, everything has its pluses and minuses. Birth control pills have been found to significantly decrease risk of ovarian cancer. So women who have used birth control pills for let's say five years during their life, have a decrease in ovarian cancer risk as high as 50%.

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Gore Wow.

Ratner So very high reduction, and for women who have these different mutations that would predispose them to ovarian cancer, there are very specific guidelines for when prophylactic, or we call it risk reducing surgery, would be recommended.

Foss What about with endometrial cancer and the same types of hormones, does it increase or decrease the risk?

Ratner It does not increase it.

Foss So that is good news for folks out there.

Ratner Absolutely.

Gore Is that true for hormone replacement therapy as well? I know that is a very controversial area, right?

Ratner It is very different. Hormone replacement therapy is when hormones are given to women after menopause, as you guys know a lot has changed over the past 10 years with the Women's Health Initiative Study, but the bottom line is that women who are using just estrogen for their symptoms, who have previously had a hysterectomy and do not need additional progesterone, they are not at increased risk of breast cancer or really any other cancer.

Gore We may want to go back to that after the break. We are going to take a short break for a medical minute. Please stay tuned to learn more about sexuality, intimacy, and menopause with Dr. Elena Ratner.

*Medical
Minute*

Smoking can be a very strong habit that involves the potent drug nicotine and there are many obstacles to face when quitting smoking. But smoking cessation is a very important lifestyle change especially for patients undergoing cancer treatment. Quitting smoking has been shown to positively impact response to treatment and it decrease the likelihood the patients will develop second malignancies. Smoking cessation programs are currently being offered at federally designated comprehensive cancer centers such as Yale Cancer Center and at Smilow Cancer Hospital at Yale-New Haven. The smoking cessation service at Smilow operates on the principles of the US Public Health Service Clinical Practice guidelines. All treatment components are evidence based and therefore all patients are treated with FDA approved first-line medications and smoking cessation counseling. This has been a medical minute brought you as a public

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Gore Welcome back to Yale Cancer Center Answers. This is Dr. Steven Gore and I am joined tonight by my co-host, Dr. Francine Foss and our guest Dr. Elena Ratner, and we are discussing female cancers or GYN cancers as well as sexuality, intimacy and menopause in the treatment of cancer. Dr. Ratner, before the break we were starting to talk about hormone replacement therapy for people who are postmenopausal and whether that increases their risk of cancer and maybe you can go into that a little more.

Ratner Absolutely, as I mentioned before, the Women's Health Initiative Study made a lot of revelations about hormone replacement and when the study was published a lot changed in the use of those hormones. Now-a-days, we really use hormone replacement therapy only for symptoms, not routinely like we used to and we also now use it really just for the time that you need to use it until the symptoms go away. But the Women's Health Initiative Study showed that a combination of estrogen and progesterone did have an increased risk of breast cancer. The study is disputed by many people, by many subsequent publications due to certain factors such as the age of the women was much higher, it was 63 as the average age, which is much higher than women when they are usually on these hormones and so forth, but a subsequent study from exactly the same population showed that if the women had a hysterectomy previously and did not need the progesterone to protect the uterus, their risk of breast cancer was not increased and that is why in my population, even of cancer survivors in many different circumstances, I am very comfortable using estrogen for women who are symptomatic.

Gore You mean just for hot flashes, is that the main symptom?

Ratner There are a lot of symptoms with menopause, hot flashes is just the one that usually comes to mind, but there are many more and many are very complicated. So some of them are hot flashes, difficulty sleeping, mood changes, some of it is cognitive changes and that is actually one that I see very frequently where women after menopause complain of this brain fog. A lot of women here in the Yale community who are professors, they have a very hard time continuing with their teaching and their publications because they feel that their brain does not work as well as it did before menopause.

Gore I feel like I have brain fog, but I do not have that excuse.

Ratner And the other thing of course is sexual, a loss of desire and vaginal dryness are also very common symptoms.

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- Foss How long do the women need to actually take this replacement therapy, say that female professor, I might be one of those, by the way, but how many years do you actually need to continue on that and are those changes reversible with time?
- Ratner That is an excellent question and sadly I have no answer for you. It is very individual dependent. Some women are on it for a relatively short period of time and then we try to decrease the dose and they do well and they carry on without anything, and there are some that need it for a long time. I have somebody who is in her 90s and every time we try to decrease the hormones, she feels a difference and for her it is for major quality of life and we are continuing.
- Gore You talked about some of the sexuality issues that come with menopause both in terms of libido or desire as well as vaginal lubrication and stuff like that, are there any particular sexuality issues around cancer survivors or active cancer patients, obviously I guess if you have had GYN surgery you may have some psychological if not physical issues, maybe you can go into that some.
- Ratner Absolutely, the reason why my other passion became sexuality and intimacy is because it very much is not being addressed. At major institutions like Yale, we do such a great job with treating cancers, as in curing people, but what we as providers consider success, I find that patients do not necessarily see it the same way, and I have met many women through the years who have been cured by us, whose lives were prolonged by our treatment, who return and continue to feel different and continue to feel that the treatment and the cancer has left damage that is not being addressed and that is what brought me to this field of sexuality, intimacy and menopause where I spend a lot of my time trying to help women who are either being treated for cancer right now, or cancer survivors, to help their quality of life, part of which is unquestionably sexuality and menopause. This affects many women, the age of my women ranges from 15, I have some girls who were child cancer survivors who are now trying to start being sexually active and have issues and it ranges all the way to the 90s, where women continue to have vaginal dryness and it interferes with their sex lives and so it ranges all different ages. It affects women with all kinds of cancers. The majority of my women who have this issue had ovarian, uterine cancer, and a huge portion of these women are survivors of breast cancer.
- Foss Can you talk about the typical modalities such as hysterectomy and radiation therapy to the pelvis and how those specifically affect sexual functioning?
- Ratner The ones you mentioned of course are the biggest culprits. Women who had cervical cancer, who have had radical hysterectomies, who have had radiation to those areas, have significant vaginal dryness and loss of nerves and sensation. So that is a very specific group of women for whom we do a lot of very specific treatment, but then there are women who are on tamoxifen or Arimidex.
- Gore What are those drugs?

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Ratner Those are the drugs that are used in breast cancer for some women who either had breast cancer in the past or do not have breast cancer, and the drugs are being used to prevent or decrease the risk of these women developing cancers in the future, but a lot of these drugs cause vaginal dryness as well as hot flashes and menopausal symptoms.

Gore So the good news, you do not get cancer, the bad news is you are miserable and cannot have a sex life, is that right?

Ratner Exactly, you totally nailed it on the head, that is exactly what it is.

Gore Why would I want that?

Ratner In this day and age, we need to be able to address everything. We no longer see women and see them as this one specific problem that our specialty treats. I feel like women need to be seen as a complete human being who have their lives, who have their desires, they are mothers, they are wives, they get chemotherapy, they go home and they want to have a normal life and that is what we are here for.

Gore Is there hope for these people in terms of their sexuality? What kind of things can you do to help?

Ratner Absolutely, we dedicate a lot of our time now and effort to create, again, very individual, very specific plans and treatments for these women. Some of them can have hormones like we talked about before and that helps a great deal. Some of them cannot and for those women, we have now created this comprehensive program where we use acupuncture and reflexology and we have a special Zumba exercise class and we use a lot of herbal medications. A big component of this practice is also therapy. When I started this program together with Mary Jane Minkin, years ago, we found that the medical approach is only half of the battle, that a lot of this is psychologic.

Gore So, psychotherapy you mean?

Ratner Correct. So with the help of our psychologist Dwain Fehon at Yale and his interns we are able to offer these women a very comprehensive approach where they are seen by a medical provider but also by a special sex therapist and it is not just for women, it is for couples, it is for husbands, because this is not an individual problem. This affects the whole family and the couple.

Gore And I was going to ask you, I can imagine that if my wife or partner had this cancer, especially genital cancer or some variety, I might be afraid to be sexually intimate with her. I would be afraid it might make things worse, I might hurt her, or I mean is there any disfiguration or anything like that I have to worry about, or she has to worry about?

Ratner Those are exactly the things that we hear from the husbands. A lot of these cancers get diagnosed

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during intercourse, and then women, in addition to having to go through surgery and chemotherapy and treating and all that, they also psychologically remember that this happened when they had sex and maybe she forgets but the husband remembers. So a lot of the couples counseling that we do actually has to do with that, trying to separate the diagnosis from intimacy and from sexuality and we are actually quite successful in doing that.

Gore And what about lesbian couples? I think we should not disregard them, are there issues there as well?

Ratner Absolutely, I think the most important thing that I would like to get across today is that this is an incredibly common issue, even in women who do not have cancer, forty million American women who do not have cancer have some sort of female sexual dysfunction. In the breast cancer population and gynecologic cancer population that number is almost 90% to 97%. This is incredibly common and I talk to all my patients about it. I just bring it up and I just tell them, you know, this is so common and if you are affected by it, you are not alone, and I think many times just hearing that allows the women to be able to be more open minded, to be able to get the treatment, and to just feel better that she is not alone and that treatments are available.

Foss Do you find that it is hard for people to break down those barriers, because it is not something that we are used to talking to doctors about?

Ratner Absolutely, and I think the doctors are probably as much to blame, if not more. I think we as providers do not talk about it enough and we are not as comfortable talking about it and I was not comfortable talking about it, but now I am great at talking about it. And I think part of it is just making it standard of care. Now it is totally part of my interview, together with everything else, I ask about smoking, I ask about everything else, and I ask about this because this is a normal part of life.

Gore We certainly have evolved in the last ten years as providers to assess pain scores on a regular basis, even if that is not their presenting symptom. Maybe we need to talk about sexuality scores or at least to bring this into our comfort zone in terms of routine discussion.

Ratner Exactly correct, and I do a lot of teaching now to residents and to other providers, on exactly what you just said, teaching them and making this come in place and making this comfortable and just routine, because it is.

Foss Elena, can you speak a little bit about drugs like Viagra and how they apply to women and female sexuality and whether you use those kinds of drugs in your practice?

Ratner When traditional remedies are not an option for women, for example with breast cancer when hormonal treatment can increase the risk of recurrence and we stay away from that, we then go

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into more alternative treatments. We use a lot of herbal medication and Viagra is actually something that we use. It is not FDA approved for women. We use it completely off indication, but I have a lot of women who swear by it.

Gore And I heard something about antidepressants being used for hot flashes. Is that still something that is used?

Ratner Absolutely, again, we use those in women especially with breast cancer for whom hormones cannot be used. After herbal medications, if those do not work enough, we use a lot of antidepressant medication and actually there are a lot of new ones that are coming on the market that should be even better.

Foss There is also some controversy about soy, and we have been talking back and forth about whether soy is good or not good, can you touch a little a bit on that data?

Ratner The scientist in me is not able to really give you an opinion because the studies have not been great. What do I tell my patients, I tell my patients not to go too crazy.

Dr. Elena Ratner is Assistant Professor of Obstetrics Gynecology and Reproductive Sciences at Yale School of Medicine. We invite you to share your questions and comments, and you can send them to canceranswers@yale.edu or you can leave a voice mail message at 888-234-4YCC and as an additional resource archived programs from 2006 through the present are available in both audio and written versions at yalecancercenter.org. I am Bruce Barber hoping you will join us again next Sunday evening at 6:00 for another edition of Yale Cancer Center Answers here on WNPR, Connecticut's Public Media Source for news and ideas.