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BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 34. No. 2

WOMEN'S HEALTH

New evidence will reignite controversy about breast cancer risk with hormonal contraceptives.

The lower estrogen doses and different progestins in newer hormonal contraceptives were generally thought to be safer than the older ones.

Now a study suggests that newer hormonal contraceptives also raise breast cancer risk by about 20%...similar to older options.

But tell women not to panic. Other evidence shows no risk.

And even with the new study, risk is very low. About 7,700 women need to use hormonal contraception for a year for one to be diagnosed with breast cancer. The risk remains very low even after 10 years of use... treating 5,300 women seems to lead to one more breast cancer diagnosis.

This analysis also suggests a possible breast cancer link with levonorgestrel IUDs (*Mirena*, etc)...but it's too soon to say if progestin or underlying risks are to blame. Explain the progestin-only pill, depot medroxyprogesterone, and implant aren't linked to breast cancer so far.

Continue to recommend, furnish, or prescribe a contraceptive based on patient preference, efficacy, safety, etc...and breast cancer risk.

No personal history of breast cancer. Feel comfortable recommending hormonal contraception. Point out benefits beyond preventing pregnancy... reducing ovarian and endometrial cancer risk, easing heavy periods, etc.

Reassure women with a family history of breast cancer or a BRCA gene mutation that most evidence suggests their breast cancer risk will not increase further with hormonal contraceptives.

But suggest NON-hormonal options instead as women age into their 50s...since breast cancer and clot risk increase with age.

Personal history of breast cancer. Avoid hormonal contraception.

Hear our team clarify the impact of the new evidence with *PL Voices*. Use our *How Safe Is My Birth Control?* handout to educate patients...and learn more in our CE, *Selecting & Prescribing Hormonal Contraception*.

(For more on this topic, see Clinical Resource #340203 at PharmacistsLetter.com.)

Primary Reference – Morch LS, Skovlund CW, Hannaford PC, et al. Contemporary hormonal contraception and the risk of breast cancer. N Engl J Med 2017;377:2228-39.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What is known about hormonal contraceptives and the risk of breast cancer?**

ANALYSIS OF NEW STUDY

2. **What type of study was this? How were the patients selected for inclusion?**

3. **How were the patient groups and outcomes defined?**

4. **What were the results of the prospective cohort study?**

See LEADER NOTES for answers to discussion questions.

5. What were the strengths and weaknesses of the prospective cohort study?

6. Were the results expressed in terms we care about and can use?

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

7. Do the results change your practice? How?

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

G.E. is a 32 year old who presents to your office for her gynecologic exam. Her last pap smear was three years ago and has never been abnormal. Her only medication is a combined oral contraceptive (drospirenone 3 mg/ethinyl estradiol 20 mcg, *Yaz*, etc).

In updating her history, you note that she married four months ago and is not interested in having children. Also, her maternal aunt was diagnosed with breast cancer last year, and is now cancer free after undergoing bilateral mastectomy.

Since she does not want to become pregnant for the long-term, she would like to discuss alternative forms of contraception with you and the side effects profiles of each type.

See LEADER NOTES for answers to discussion questions.

8. What are G.E.'s options for contraception and how do they compare?

G.E. is interested in a one of the IUD options and asks about their effects on cancer risk, particularly breast cancer, in light of her aunt's recent diagnosis.

9. How should you counsel G.E. regarding the risk of breast cancer with hormonal contraception?

G.E. is most comfortable with avoiding hormonal contraception. You schedule insertion of the copper IUD during your next procedure clinic.

10. What follow-up should be done after insertion of an IUD?

See LEADER NOTES for answers to discussion questions.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com
Commentary, Applying Study Results to Patient Care: Relative Risk, Absolute Risk, and Number Needed to Treat. Pharmacist's Letter/Prescriber's Letter. October 2017.
Commentary, Glossary of Study Design and Statistical Terms. Pharmacist's Letter/Prescriber's Letter. October 2017.
Chart, Postmenopausal Hormone Therapy. Pharmacist's Letter/Prescriber's Letter. August 2017.
PL Voices, Choosing Hormone Therapy for Menopausal Symptoms. Pharmacist's Letter/Prescriber's Letter. August 2017.
Chart, Comparison of Oral Contraceptives and Non-Oral Alternatives. Pharmacist's Letter/Prescriber's Letter. June 2017.
PL Voices, Management of Menstrual Migraine. Pharmacist's Letter/Prescriber's Letter. June 2017.
Commentary, Intrauterine Contraceptives: IUDs. Pharmacist's Letter/Prescriber's Letter. February 2017.
Chart, Contraception for Women With Chronic Medical Conditions. Pharmacist's Letter/Prescriber's Letter. August 2016.
Commentary, Hormonal Contraception in Older Women. Pharmacist's Letter/Prescriber's Letter. December 2015.
PL Voices, Choosing a Hormonal Contraceptive. Pharmacist's Letter/Prescriber's Letter. October 2015.
Chart, Choosing a Hormonal Contraceptive. Pharmacist's Letter/Prescriber's Letter. October 2015.

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