69 - Breast Cancer and HRT
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Welcome to the BioBalance Healthcast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And today we're going to talk about issues with breast cancer and hormone replacement therapy. Things like aromatase inhibitor, we're going to come to understand that terminology. It's a really important conversation because there are a couple of issues that come up in women who have had breast cancer and been treated for it and then begin to go through menopause. And there's a balancing question about the negative impact of the menopausal symptoms and there's an ongoing question about long term treatment strategies to reduce or prevent the recurrence of breast cancer. And all of that is extrapolated throughout the conversation about hormone replacement therapies.

KM: And it's a recent article on breastcancer.org which is a website that sends information to doctors and to people who have had breast cancer or are worried about it. They came out with a study that showed that testosterone pellets, which we've been using for patients with breast cancer for many years to decrease all of their symptoms in menopause and to prevent recurrence, they have done a study with testosterone pellets and found them to be not risky and to be exceptionally efficient at treating the symptoms that we can't treat with estrogen in most breast cancers. So if you have an estrogen sensitive breast cancer we don't give you estrogen after that so we have to think of something else. So when menopause hits we give testosterone instead. Now they had an additional caveat and they did their study with testosterone pellets and arimidex and arimidex is an aromataste inhibitor, and what that means is that it stops the aromatization. That means testosterone becoming estrogen, that's aromatization.

BN: The process of testosterone converting itself to estrogen.

KM: And it does in everyone but not very much generally, but as we get older, it gets worse. So we have to consider that in a breast cancer patient. Because we don't want more estrogen.

BN: Because estrogen stimulates breast tissue.

KM: Yes, and usually estrone is the bad guy. Estrone is the old lady estrogen as I like to call it. We don't have much of it before we go through menopause or before our testosterone drops, but we have a lot of it as we get older. Men even have it. So estrone is what we're trying to prevent. Testosterone becomes estrone and then estrodial we stop that process in breast cancer patients, because we really don't want any estrogen going to them.

BN: Which is part of the difference between relying on a logical extrapolation and relying on science. Because the logical extrapolation, if you understand about the hormone replacement, if testosterone is administered it coverts itself to estrogen. And in menopausal women who have breast cancer histories there's a risk factor for increasing stimulation in the breast tissue which them becomes a concern about the reoccurrence of breast cancer. So logic would say "oh my gosh, don't do that" but science says there is a way to do it if you do take into consideration these factors.

KM: If someone makes a blanket statement that testosterone is dangerous for breast cancer patients, you already know that there's a problem. Because that blanket statement means that every type of testosterone's dangerous, every way you give it. And even people who use trouble shooting like what we're talking about with the arimidex make it dangerous. It's not dangerous if you do it right. It's like if you drink too much water in a day, you could kill yourself. But water is necessary for you, so it's how you do it. And so that's what I'm looking at. I'm looking at how do we get patients to feel better? Get rid of all their symptoms, their depression, their fatigue, their hot flashes, their dry vaginas, their miserable sex lives, after losing their estrogen and being unable to replace it because of breast cancer. We want women who have had breast cancer to be whole again. And one of my pushes in legislation was to have breast cancer reconstruction made mandatory for insurance companies to cover in the state of Missouri. That went into law in 2000. And that's still law. I want woman who have had this to feel like they're well again. And to live their lives if they want construction then to be able to have it paid for. So in this way I want people to have their lives back with their hormones but this is a hormone that is not going to cause problems. Especially because pellets are the safest because they make the least estrogen. So I wouldn't say just any testosterone, gels tend to make a lot of estrogen, and anything that goes through the skin makes a lot of estrogen out of testosterone, so do vaginal tablets make a lot of estrogen. You have to be careful how you take your testosterone. And pellets are the safest, but then adding this drug called arimidex makes it extremely safe because it prevents any estrogen from being converted from the testosterone and you have somebody who was testosteronized not estrogenized and so their risk of recurrence is extremely low.

BN: So the net-net if you had arimidex to the testosterone pellet as a delivery system.

KM: It makes it safer.

BN: The data actually shows that they don't have a recurrence of breast cancer. They don't run any risk or increased risk for that.

KM: They don't run any more increased risk. It doesn't prevent it all together because there are always other reasons to have recurrences.

BN: Exactly. And they don't have the difficult menopausal symptoms that cause them a serious decline in quality of life.

KM: Right, the real take home message is that if you use testosterone and arimidex then your risk of recurrence is lower than if you took nothing, than if you took tamoxifan. The combination decreases your risk below both of those. It's amazing because even arimidex competing in side by side studies far outstrips tamoxifan in effectiveness in terms of preventing recurrence. So when you put testosterone and arimidex together you not only have no symptoms or few symptoms and your life is much more comfortable but you can also be confident that you are not going to be at higher risk of recurrence.

BN: And this breastcancer.org study that's reported says that this was tested on women who were 5 years beyond treatment for breast cancer. So their survival rates of a 5 year window had already been passed. And then the study goes on to say that out of 43 breast cancer survivors 39 had been diagnosed with early stage breast cancer and 4 were diagnosed with advanced stage. Arimidex and testosterone planted under the skin every 90 days. Most of the women, 38, had completed treatment more than 5 years before the study had started. And the results of the study, women reported their menopausal symptoms had eased, their estrodial levels which were measured regularly during the study remained low, which is what you are saying the arimidex does. None of the women had any side effects of complications from the treatment at all. None of the women diagnosed with early stage breast cancer had any recurrence during the study for as long as they followed them. And the cancer didn't grow in 3 of the 4 woman who had advanced stage cancer.

KM: And that is phenomenal.

BN: That's absolutely phenomenal. So that data is out there and what it does is give hope to the women who are suffering and give information for doctors who work in this field to provide better care and better treatment.

KM: That's true. When arimidex first came out there were several different aromatase inhibitors phemara and arimidex. I choose arimidex to use with my patients because it's the only one that doesn't cause weight gain. And I'm very concerned about if you have two drugs and they both work and one causes weight gain I'm not going to use that one. I'm going to choose the one that doesn't because that's a big problem for women and we don't want to have that issue too that just makes them feel worse. So I started using arimidex with testosterone after reading all the new studies that said if you have someone that doesn't have breast cancer that arimidex decreases their risk of ever getting breast cancer. So it's a preventative measure as well. So in many cases where I test the blood and I see that the patient has low testosterone and high estrone and possibly high estrodial I use arimidex in those patients to prevent them from getting breast cancer and there's a huge body of people who worry about it, they have family histories. These are the studies that show it really does actually work to prevent. So when those came out and I started offering that to patients we saw a much lower risk, although you have to wait years and years, we've seen fewer and fewer people

who get breast cancer in our practice. Some people come to the practice with a small area that we can't even see on mammograms. So it's hard to tell in the first couple of years that kind of doesn't count after therapy if they get breast cancer because they probably already had it. It takes 11 years for breast cancer to go from one cell to something we can see.

BN: 11 years? So you don't know when they may have gotten it?

KM: 11 years. And so it's silent before we can see it. So often times the arimidex if it's early, I believe with what this shows, even if it's advanced, would stop it or slow it down.

BN: Well the survivability rates for all of these diseases are significantly impacted with early detection.

K: Right, that's really our only defense. Find it as early as possible and take care of it and then treat yourself so that you cannot get it back. But we also have prevention in the form of arimidex.

BN: So you treat yourself to not get it back but more than just breast cancer you treat yourself with the arimidex and testosterone so that you don't have the menopausal issues and side effects that you would have had whether you had breast cancer or not.

KM: That's right. And there's one other thing about testosterone that's really interesting and that's that testosterone improves the number and activity of t-cells. T-cells are what people with aids don't have any of, or have few of. But when we get older our t-cells start dropping slowly. And so as we age we tend not to be able to fight cancers as well. So t-cells are the cells that go and gobble up cances cells. So when we treat people with just pure testosterone we decrease their risk of all cancers because we're giving them a boost to their t-cell activity and the number of t-cells from the thymus and from the bone marrow. That is something that testosterone alone does very well. So when you put these two things together, decrease the estrogen and then increase the cells that fight cancer, that's why this outcome is so good.

BN: So if you get this treatment early, if you have a family history but you have not identified that you have breast cancer, and you take this treatment you significantly increase the chances that you won't develop breast cancer.

KM: Or it will be delayed and delayed until you die of something else. I mean you know that you don't have to have that.

BN: It's like men and prostate cancer. If you live long enough eventually you'll die of prostate cancer.

KM: Right, but we try to delay it until you're 110 and then you have something else.

BN: Exactly. In this research there was some other news on menopause that I thought was interesting as well. I don't know if you wanted to talk about that or not. But there were some of the myths for treating or for home remedies to reduce menopausal symptoms. And one was flaxseed. My wife has gotten real high on flaxseed and we have a whole quart jar full of flaxseeds and she throws a whole handful in this and that and the other.

KM: That's good, that's a good way to take it. It's not the reason to take it.

BN: Is it? What the hell's it for? She just says eat it you'll like it.

KM: Flaxseed's an anti-oxidant and part of why we get cancers and we age is oxidation of our cells. Not oxygenation but oxidation.

BN: So is that like fighting the free radicals?

KM: Yes.

BN: She should have told me that.

KM: She should have told you that. Flaxseed is also good for dry eyes.

BN: You just put them on.

KM: Okay. Taking it orally helps dry eyes and you can take it as a pill that has the oil in it, or you can use actual flaxseed. Most people who are very dedicated to health and take the time put it in their food or in their shake.

BN: But this research says flaxseed doesn't help with hot flashes.

KM: No it doesn't help with hot flashes. And that's what they were saying, it doesn't help with hot flashes and it doesn't.

BN: So it's not a panacea take flaxseed and your life will be wonderful.

KM: Well not for that reason. But there's a good reason to take it.

BN: I'm not arguing that.

KM: The same with fish oil. People take fish oil so they won't have hot flashes but really that doesn't do much because it's helping other things. It's decreasing the inflammation in your body, and it's decreasing your triglycerides. So it's really helping a lot of things but it's not helping menopausal symptoms.

BN: Okay. Were there other things on there you wanted to talk about? Weight loss helps hot flashes.

KM: Weight loss makes hot flashes worse.

BN: Oh this says weight loss may help hot flashes.

KM: Well if you're really obese you make a ton of estrogen. Not the good kind, the bad kind. So if you're really obese you don't have hot flashes because it's feeding back to your brain and shutting down the hot flashes. Hot flashes happen because your pituitary gland is making FSH and LH. And it used to stimulate our ovaries to make estrogen. Estrogen would then feed back to our brains and shut down FSH. When you don't have ovaries that are working any more, they don't respond. And therefore the lower the estrogen, the more the hot flashes happen. So skinny little people generally have the worst hot flashes. And then really obese people don't have any. I always hear people at the beauty shop and they're like "oh I'm so lucky! I don't have hot flashes and I never have." And they feel superior to everyone. But they weigh 300 pounds. So I know why they don't have hot flashes. But somewhere in the middle.

BN: They probably don't sleep on tempurpedic mattresses either.

KM: No those make you really hot. Yea, that's true. But the people in the middle, there's a huge range of normal sized people. Some people who are exactly the same body type, one person will have horrible hot flashes, and one won't.

BN: And the differential is caused by the feedback loop for the estrogen?

KM: Estrogen and your pituitary gland working together and when you stop having estrogen then your FSH keeps going. The reason that testosterone works is because testosterone fools the pituitary gland. It goes to the pituitary and says oh we have testosterone, it hits the same receptor sites as estrogen and it shuts off the hot flashes, so that's why testosterone works for this.

BN: So today's conversation is about different medical treatments that impact both the existence of menopausal systems and talking pretty significantly about breast cancer and the new research that's out there about breast cancer and hormone replacement therapy. If you're interested in checking this out yourself you can go to the website www.breastcancer.org or you can contact us directly.

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