who had used ERT for 10 years or more and quit fewer than 15 years before the study began were at double the risk of those who had never used ERT. Those who used ERT for 10 years or more but had quit more than 15 years before the study began were at 1.3 times the risk of those who had never used it. Overall, when all women who had ever used ERT were considered together, regardless of the length of use or when they had quit, average risk of dying from ovarian cancer was 1.23 times that of those women who had never used it.

No Data on Combination HRT

The ACS epidemiologists noted that their findings may or may not apply to combined hormone replacement therapy (HRT), explaining that there is no clear consensus among previously published studies as to whether the addition of progesterone to estrogen protects against ovarian cancer, raises the risk, or has no effect at all.

Data relevant to that issue were recently presented at the 2001 annual meeting of the American Association for Cancer Research by James Lacey, MPH, PhD, and colleagues from the National Cancer Institute. They reported on follow-up of 40,762 women who enrolled in the Breast Cancer Detection Demonstration Project between 1979 and 1981. In this cohort, use of ERT alone doubled a woman’s risk of developing ovarian cancer whereas use of estrogen plus progesterone was associated with a 30% increase that was not statistically significant.

Heart Disease More Common than Cancer

“There is continuing debate about the overall impact of ERT on life expectancy,” said Michael Thun, MD, Vice President of epidemiology and surveillance research at the ACS and a co-author of the JAMA article. “This is largely because the reduction in heart attacks seen in many epidemiological studies has not yet been replicated in clinical trials. But death from heart disease is still more common than death from breast and ovarian cancers combined,” he says. “If ERT does in fact lower cardiovascular disease risk, this benefit could outweigh the increased cancer risk.”

Data from the NCI study reported by Lacey et al. are reassuring in that they suggest that estrogen taken in combination with progesterone may not increase the risk of ovarian cancer. Such combination regimens have become the standard for hormone replacement in women with intact uteri.

Thun stressed that the balance of risks and benefits with hormone replacement therapy is different for each woman, and depends on variables such as age, body mass, whether and when she has had children or has had a hysterectomy, whether she has a personal or family history of cancer, as well as other factors.
of prevalence rates, from about 20% to 88%. To help further clarify this issue, Timothy Siegel, MD, and colleagues from the Center for Prostate Disease Research, Rockville, MD, compared erectile function in patients receiving radical prostatectomy, external beam radiation, or watchful waiting.

Siegel et al. used data on more than 800 prostate cancer patients that had been collected prospectively as part of the Department of Defense Center for Prostate Disease research program. Prior to treatment, 69% of the men reported normal erectile function. At an average of 53 months after treatment, 10% of men who had undergone radical prostatectomy and 15% of those treated with external beam radiation had intact erectile function.

In contrast, 38% of the men who chose watchful waiting had adequate erections after six months. Overall, more than 80% of the men who were treated by prostatectomy or external beam radiotherapy developed ED during the study, regardless of age.

ED Should Be Expected with Active Treatment

“Patients who elect non-nerve sparing radical prostatectomy or external beam radiation therapy should expect a high incidence (greater than 85%) of erectile dysfunction after therapy,” the authors wrote. “In our experience, erectile dysfunction did not develop based on the type of therapy received, but only whether a patient received active therapy for prostate cancer.”

In an accompanying editorial, Ian Thompson, Jr., MD, University of Texas Health Sciences Center at San Antonio, commented that, “These sobering results disagree with the common perception that erectile dysfunction is nonexistent with surveillance, and is infrequent after radiation and slightly greater with surgery.”

In a second editorial, Irwin Goldstein, MD, Boston University School of Medicine, focused on the importance of outcomes studies in urological oncology that use well-validated survey instruments for assessing sexual function, and of collecting and analyzing data on physiological and psychological variables relevant to sexual function.

SMOKERS AT HIGHER RISK OF COMPLICATIONS FROM BREAST RECONSTRUCTION SURGERY

Women who quit smoking for at least three weeks prior to breast reconstruction surgery after a mastectomy may significantly reduce their risk of complications, according to a report in Plastic and Reconstructive Surgery (2001;107:342-349). In many cases, the risk can be reduced to that of nonsmokers, according to the study.

The study is based on records of more than 700 women who had undergone breast reconstruction surgery with either an implant or a TRAM (transverse rectus abdominis musculocutaneous) flap.

Of the participants, 155 were current smokers at the time of the procedure, 76 were ex-smokers, and 517 were nonsmokers. Women who had quit as recently as three weeks prior to undergoing either type of surgical procedure were classified as ex-smokers.

The fact that the former smokers’ overall complication risk was similar to that of nonsmokers surprised investigators, said Randall Yetman, MD, co-author and plastic surgeon at the Cleveland Clinic. Almost 40% of the smokers experienced complications, such as

“I routinely tell my breast cancer patients that smoking might increase their risk of complications and that most of these complications detract from the appearance and feel of the reconstructed breast.”