Introduction

Breast cancer is the second most common type of cancer worldwide and the most common cancer in women (1). It principally affects post-menopausal women but when it is detected in younger patients, the prognosis is worse and a more aggressive behavior is observed. Indeed, higher grade, large tumors and lymph node involvement are more common in premenopausal patients (2). There have been numerous trials of breast cancer treatment in postmenopausal women, 6 articles talking about endocrine therapy were published in 2018 just from the American Society of Clinical Oncology ASCO (3), yet few trials have evaluated the long-term effects of preventive treatment in pre-menopausal women at risk of breast cancer.

The Gail model defines a high risk as having at least one breast biopsy with the presence of pre-cancerous lesions, with a 5-year predicted breast cancer risk >1.66% over the rest of the population, or a first-degree relative with breast cancer (4). The pre-cancerous lesions can be found by...
mammography, eco-sonogram or biopsy; and some of them are carcinoma in situ, atypical and hyperplastic lesions (5). Atypical hyperplasia (AH), confers an absolute risk that can generally be estimated generally as 1% per year, although a wider disease spread further increases this risk. However, preventive medications reduce breast cancer risk by 70% in AH (6). Other lesions like in situ ductal carcinoma, which now represents 20–25% of all breast cancers, confer a 2% annual risk to develop an invasive disease (7). The increased risk of developing carcinoma associated with these lesions was associated with the ipsi- and contralateral breasts (8).

On the other hand, the most frequent hereditary cause of breast cancer is hereditary breast and ovarian cancer syndrome (HBOC), which is caused by a germline mutation in either of the breast cancer genes (BRCA1 or BRCA2); which are considered to represent 20–25% of the total hereditary factors for breast cancer (9,10). Evidence indicates that specific mutations in other genes also confer increased breast cancer risk, including those in Ataxia-Telangiectasia mutated (ATM), Cadherine-1 (CDH1), Checkpoint kinase 2 (CHEK2), Nibrin gene (NBN), Neurofibromin-1 (NF1), Partner and localizer of BRCA2 (PALB2), Phosphatase and tensin homolog (PTEN), Serine/threonine kinase-11 (STK11), and Tumor protein-53 (TP53) also confer increased breast cancer risk (11).

Another important factor associated with the risk of developing or breast cancer in pre- and post-menopausal women is breast density (12). Controlling breast density can aid risk management, both in a population screening context and in terms of the management and surveillance of women at increased risk of developing breast cancer. In particular, this parameter can help identify populations that might benefit from enhanced surveillance or primary prevention interventions (13).

It is estimated that 11% of the breast cancer patients are pre-menopausal and more than 50% of them express hormone receptors, making them candidates to benefit from endocrine interventions (14). Amongst the endocrine interventions for hormone sensitive breast cancer, three main families exist: aromatase inhibitors (AI), selective estrogen receptor modulators (SERMs) and the recently developed family of selective estrogen receptor down-regulators (SERDs) (15). In terms of AIs, three of them can improve the efficacy of adjuvant endocrine treatment if used instead of, or sequentially, with tamoxifen, either non-steroidal (anastrozole and letrozole) or steroidal (exemestane) AIs. However, the use of AIs is associated with significant adverse events, such as arthralgia, bone pain and osteoporosis (16). The FATA-GIM3 study investigated the schedule and type of AIs to be used as adjuvant treatment for hormone receptor-positive early breast cancer. Accordingly, it was shown that 5-year treatment with AIs was not superior to a 2-year treatment with tamoxifen followed by a 3-year treatment with AIs (17).

Regarding SERDs, fulvestrant is currently only SERD that has been approved for use in humans, a 7α-alkylsulphinyl analogue of 17β estradiol. Fulvestrant is a competitive inhibitor of estradiol binding to the ER, with a binding affinity of 89% (18). Fulvestrant is an oral SERD with a unique method of action. It is a highly specific inhibitor of ERs in the mammary gland, downregulating ERs through inhibition and degradation (19). In preclinical studies AZD9496 also proved to be a potent antagonist that degrades ERs. Recently, a phase I clinical trial of AZD9496 reported it was well tolerated and with an acceptable safety profile (20). GDC-0810, a novel non-steroid SERD, alters the conformation of ERα relative to that induced by currently approved therapeutic agents, suggesting a unique mechanism of action. GDC-0810 has robust in vitro and in vivo activity against a variety of human breast cancer cell lines and patient derived xenografts, including a tamoxifen-resistant model that harbors mutated ERα. Notably, GDC-0810 is currently being evaluated in Phase II clinical studies in women with ER-positive breast cancer (21). SERMs which exert estrogenic and antiestrogen actions, are the most frequently used for breast cancer (22). SERMs regulate transcripational events in target tissues by acting as agonists and mimicking the effects of estrogen in some tissues. In other tissues, they may act as antagonists by binding to specific ligand binding domains of ERs and inhibiting their biological activity (23). The therapy with SERMs were associated with lower risk of primary invasive ER positive breast cancer (24). Although not all hormone receptor positive breast cancers benefit from treatment with SERMs, they are considered as a classic endocrine therapy for early breast cancers (25). SERMs have been seen to be capable of reducing mammary density and thus, to have breast cancer-preventing activity (26,27). A list of current applications of FDA-approved SERMs and clinical trials is presented in Table 1.

Several authors have reported the use of SERMs as preventive treatment for breast cancer. For instance, administration of tamoxifen (the first generation of SERMs) for 5 years in a primary prevention setting decreased the risk of invasive breast cancer by approximately 30–
Table 1 FDA approved SERMs and clinical trials

| SERM            | Indication                                                                 |
|-----------------|-----------------------------------------------------------------------------|
| **FDA approved SERMs** |                                                                              |
| Tamoxifen       | Reduction of breast cancer incidence in high-risk women (28,39). Treatment of metastatic breast cancer (30) |
| Raloxifene      | Prevention/treatment of osteoporosis (31). Breast cancer prevention in post-menopausal women (32)          |
| Toremifene      | Treatment of metastatic breast cancer in postmenopausal women (33)          |
| Clomiphene      | Treatment of ovulatory alterations (34)                                      |
| Anordrin        | Anti-fertility treatment (35)                                               |
| Bazedoxifene    | Prevention/treatment of osteoporosis (36)                                    |
| Broparestrol    | Dermatological use. Breast cancer treatment (37)                             |
| Cyclofenil      | Potential ER breast cancer treatment (38)                                   |
| Lasofoxifene    | Prevention/treatment of osteoporosis. Treatment of vaginal atrophy (39)     |
| Ormeloxifene    | Oral contraceptive. Dysfunctional uterine bleeding treatment (40)           |
| Ospemifene      | Dyspareunia treatment (41)                                                  |
| **Clinical trials** |                                                                              |
| Acolbifene      | Phase III clinical trials for breast cancer treatment (42)                 |
| Endoxifene      | Hormone sensitive breast cancer treatment (43)                              |
| Afimoxifene     | Treatment of hyperplasia. Phase II clinical trial for breast cancer prevention (44) |
| (4-hydroxytamoxifen) |                                                                                        |
| Elacestrant     | Menopausal symptoms. Hormone sensitive breast cancer treatment (45)         |
| Enclomiphene    | Treatment of male hypogonadism (46)                                         |

40% (47). In a randomized phase III trial with a long-term follow-up, and in comparison to a systemically untreated control group, adjuvant treatment with tamoxifen for 2 years, resulted in a long-term reduction of breast cancer-related mortality in pre-menopausal patients with ER-positive breast cancer (48). Also, the results of the STAR study revealed raloxifene (a second-generation SERM) produced a substantial decrease in breast cancer risk in post-menopausal patients, although its performance was inferior to tamoxifen (49). Nevertheless, as a preventive strategy, raloxifene has a better safety profile (lower risk of endometrial cancer, less thromboembolic effects and fewer cataracts and cataract surgeries) (50). In a phase II trial, tamoxifen was compared to raloxifene and a placebo in pre-menopausal women with ER-positive breast cancer (51). It was concluded that tumor cell proliferation in pre-menopausal breast cancer patients was not reduced by a low weekly dose of tamoxifen or a standard dose of raloxifene. However, extensive modulation of Ki-67 was observed in the tamoxifen arm of patients with high CYP2D6 expression. Likewise, discontinuation of tamoxifen-based therapy was associated with changes in mammary density, with a mean increase of 1.8% (52). Acolbifene, and its pro-drug EM-800 (a fourth generation SERM), have been associated with growth inhibition of tumor xenografts. The lack of estrogen agonist activity of EM-800 in the uterus and its proven activity in tamoxifen-resistant metastatic diseases, make EM-800 an attractive agent for the treatment and prevention of ER-positive breast cancer (53). Regarding the use of SERMs as preventive agents in breast cancer, a review published in 2009 compared the effectiveness and the efficacy of medications to reduce the risk of primary breast cancer in women at risk. The review concluded that the efficacy of tamoxifen citrate (RR 0.70; 95% CI, 0.59 to 0.82; 4 trials) and raloxifene (RR 0.44; 95% CI, 0.27 to 0.71; 2 trials) reduced the risk of invasive breast cancer in women compared to a placebo by 0.7% to 1.0% per year (54,55).

Adverse effects caused by SERMs limit their general preventive use and there are several records of such events, including venous thromboembolic events, life-
threatening pulmonary embolism and an increase of endometrial cancer (56). To date, the impact of SERMs in breast cancer prevention in pre-menopausal women at high risk of developing hormone sensitive breast cancer has yet to be thoroughly reviewed. Considering the multiple benefits associated with preventative therapy and the early management of hormone sensitive breast cancer, a systematic review of the current literature has been carried out to evaluate the preventive benefits of different SERMs in this scenario.

**Aim**

The aim of this review was to analyze the most recent and complete studies that evaluate the effectiveness and safety of SERMs in pre-menopausal women at high risk of developing hormone-sensitive breast cancer.

We present the following article in accordance with the PRISMA reporting checklist (available at http://dx.doi.org/10.21037/tcr-19-1956).

**Methods**

This study was designed according to the guidelines of the 2009 Preferred Reporting Items for Systematic Reviews and Meta-Analysis statement (57).

**Eligibility criteria**

Original articles from 2008 to 2018 that reported randomized controlled trials that involve an intervention group in which SERMs were administered to pre-menopausal women at high risk of developing hormone sensitive breast cancer were included in this study. Articles not fulfilling all these criteria were excluded.

**Data collection**

Eligible studies were reviewed and the following data were extracted: (I) first author’s name; (II) year of publication; (III) study site; (IV) study design; (V) inclusion criteria and underlying disease; (VI) number of participants; (VII) age, menarche status, parity; (VIII) baseline, follow-up, change in Ki67 values and development of breast lesions.

**Risk of bias**

A systematic assessment of the bias in the studies included was performed by applying the Cochrane criteria (59). The items used to assess each study were: adequacy of sequence generation, allocation concealment, blinding,
drop-outs addressed (incomplete outcome data), selective outcome reporting, and other potential sources of bias. An evaluation of low, high or unclear risk of bias was assigned to each study, according to the recommendations of the Cochrane handbook. By labeling an item as “unclear”, it was attributed an unclear or unknown risk of bias. The risk of bias assessment was performed independently by two reviewers.

**Data analysis**

We analyzed the results of eligible trials to obtain more precise estimates of the major health outcomes. Standard deviations (SDs) of the mean difference were calculated using the following equation:

$$SD = \sqrt{(SD_{pre})^2 + (SD_{post})^2 - [(2R)(SD_{pre})(SD_{post})]}$$  \[1\]

where $SD_{pre}$ and $SD_{post}$ are the standard deviations at the pre-treatment and post-treatment stages, respectively, and we assumed a correlation coefficient $R=0.5$. If the outcome measurements were reported as the median and interquartile range, mean and SD values were estimated using the method described by Hozo et al. (60). The risk ratios (rate ratio, hazard ratio, or relative risk) from each trial were estimated and used them as the effect measures (55,61).

**Results**

**Flow chart and characteristics of the studies included**

A flow chart of the selection process followed is shown in Figure 2. The articles whose titles and/or abstracts were irrelevant in the context of this review were discarded through the initial screening. Among the 15 full-text articles initially considered to be eligible, 8 studies were excluded for the following reasons: they included post-menopausal patients and/or different treatments, they were published before 2008, they were reviews, and/or they dealt with advanced breast cancer.

After the final assessment, only 7 studies met the study criteria and were included in the systematic review (51,53,62-66). Two studies involved the use of two treatments and as each treatment could be analyzed separately, these studies were divided to assess the treatment outcomes with different SERMs independently (51,63). A total of 1,139 participants were involved in the 7 studies examined, in which the number of participants ranged from 14 to 672. In accordance with the inclusion criteria, the studies were all published between 2008 and 2018, and they were conducted in the United States, Brazil, Canada and Italy. Other important characteristics of the studies included are summarized in Table 2.

The risk of bias (Table 3) was presented on 2 of the 7
studies, because there was no control arm, only reporting the analysis of the treatment group. Nevertheless, the other 5 studies did not present any risk because of they were randomized, double blind type of studies.

The Ki-67 antigen was analyzed before treatment and at the treatment’s end point in just 3 of the 7 studies, obtaining results that reached statistical significance (P<0.001) in only 2 studies. In the study by Lucato et al. (63), the Ki-67 antigen was not measured before treatment, yet the values obtained after treatment were not significantly different between the two groups. Likewise, the results presented

Figure 2 Flow chart of the study selection process.

Table 2 Demographic characteristics

| Author               | Year | Country | Design         | Duration   | Participants | Age, mean, SD | SERMs                  |
|----------------------|------|---------|----------------|------------|--------------|---------------|------------------------|
| Fabian (53)          | 2015 | USA     | Pilot study    | 6–8 months | 25           | 42.8 (5.2)    | Acolbifene 20 mg per day |
| Lima (62)            | 2012 | Brazil  | *              | 22 days    | 40           | 25.94 (1.41)  | Raloxifene 60 mg per day  |
| Lucato (Tam) (63)    | 2015 | Brazil  | *              | 22 days    | 16           | 22.31 (6.07)  | Tamoxifen 20 mg per day   |
| Lucato (Ral) (63)    | 2015 | Brazil  | *              | 22 days    | 14           | 25.29 (6.51)  | Raloxifene 60 mg per day   |
| Eng-Wong (64)        | 2008 | USA     | Phase II trial | 2 years    | 37           | 43 (6.3)      | Raloxifene 60 mg per day   |
| Bramwell (65)        | 2010 | Canada  | **             | 5 years    | 672          | 45 (6.7)      | Tam/placebo 20mg per day    |
| Serrano (Tam) (51)   | 2013 | Italy   | ***            | 6 weeks    | 50           | 44 (2.51)     | Tamoxifen 10 mg per week   |
| Serrano (Ral) (51)   | 2013 | Italy   | ***            | 6 weeks    | 50           | 46 (3.2)      | Raloxifene 60 mg per day   |
| Decensi (66)         | 2009 | Italy   | ****           | 2 years    | 235          | Undefined     | Tamoxifen 5 mg per day     |

*, randomized, double-blind study; **, randomized placebo controlled study; ***, three-arm randomized double-blind clinical trial; ****, randomized, double-blind, placebo-controlled trial with a 2×2 factorial design.

Table 3 Risk of bias

| Author               | Risk of bias |
|----------------------|--------------|
| Fabian et al. (53)   | High         |
| Lima et al. (62)     | Low          |
| Lucato et al. (63)   | Low          |
| Eng-Wong et al. (64) | High         |
| Bramwell et al. (65) | Low          |
| Serrano et al. (51)  | Low          |
| Decensi et al. (66)  | Low          |
in the study by Serrano et al. were also not significant (P=0.78), whereas the studies by Eng-Wong et al., Decensi et al. and Bramwell et al. (64-66) did not evaluate the Ki-67 antigen. In 3 of the selected studies, the breast density was evaluated in mammograms and no major differences in the relative mammmogram density were observed following raloxifene therapy (64) when assessed by two different radiologists 1 (P=0.93, P=0.86) and 2 years (P=0.58, P=0.05) after the onset of treatment. However, MRI was also used to measure the breast volume in this study and important differences were evident after the 1st (P=0.0017) and 2nd year (P=0.0004) of treatment. In a study of acolbifene (53), no significant changes in the mammary density were observed after 9 months of treatment (P=0.067). However, a 20% reduction of the mammary density was detected after a 2-year treatment (P=0.003) when the effects of tamoxifen were evaluated (66: see Table 4).

Only 3 of the 7 studies reported the frequency of adverse events indicated by the patients. These events were mainly gynecological, such as hot flushes, irregular menses and amenorrhea, or neurological, such as headache, mood alterations and dizziness (Table 5).

**Discussion**

To the best of our knowledge, this systematic review is the first to compile the evidence obtained from diverse studies that evaluate the use of SERMs in pre-menopausal patients with high breast cancer risk, including early breast cancer or in situ lesions.

According to the National Comprehensive Cancer Network (NCCN) guidelines, there are 3 important agents that can reduce the risk of developing breast cancer. For pre-menopausal women at a high risk of developing breast cancer the gold standard therapy is tamoxifen, a daily dose of 20 mg for 5 years reducing risk by 49% to 86% (67). Data regarding the risk reduction associated with the use of raloxifene at a daily dose of 60 mg is limited to post-menopausal women and it is considered to be inappropriate for pre-menopausal women unless as a part of a clinical trial (68). The final agents indicated are AIs and specifically, exemestane and anastrozole, the use of both limited to post-menopausal women except when part of a clinical trial for pre-menopausal women. Indeed, to date the FDA has not approved the use of these drugs to reduce the risk of breast cancer (69,70).

It is important to highlight that several studies have analyzed different combinations of drugs with hormonal therapy to treat hormone sensitive breast cancer. For example, the HOBOE-2 phase III trial that included 1,065 patients, analyzed the role of AIs and zoledronic acid as an adjuvant treatment of pre-menopausal endocrine-responsive breast cancer. The conclusion of this study was that in pre-menopausal early breast cancer patients, the combination of zoledronic acid and triptorelin is more effective than that of tamoxifen and triptorelin in terms of disease-free survival (DFS) (71). In another study (72), 694 patients were analyzed and the overall survival among post-menopausal patients with hormone receptor-positive metastatic breast cancer who had been randomly assigned to receive the AI anastrozole along with the SERD, fulvestrant, as a first-line therapy was compared to that of patients who received anastrozole alone. The authors concluded that the combination of fulvestrant and anastrozole was associated with enhanced long-term survival compared to anastrozole alone, despite the substantial crossover to fulvestrant after progression during therapy with anastrozole alone (72).

The PALOMA 1 study analyzed the safety and efficacy of palbociclib (cyclin dependent kinase 4/6 inhibitor) in combination with letrozole as a first-line treatment in patients with advanced ER-positive, HER2-negative breast cancer. This phase II study concluded that the addition of palbociclib to letrozole significantly improved the progression-free survival (PFS) in women with advanced ER-positive and HER2-negative breast cancer (73). Subsequently, the phase III PALOMA 3 study was carried out to analyze the PFS of 521 patients, indicating that the median PFS was 9.5 months (95% CI) in the fulvestrant plus palbociclib group and 4.6 months in the fulvestrant plus placebo group (95% CI, P<0.0001). The conclusions were that palbociclib combined with fulvestrant resulted in a longer PFS than fulvestrant alone (74). All these studies are searching for the perfect combination of drugs that are likely to be effective against ER positive breast cancer and that could improve the overall survival of these patients.

Nevertheless, SERMs are still the most commonly used hormone therapy, with tamoxifen and raloxifene the most commonly tested SERMs in trials, with acolbifene studied in only one trial. The efficacy of tamoxifen in lowering breast cancer risk was confirmed in a long-term follow-up of the main chemoprevention trials (75,76). Moreover, numerous preclinical studies have investigated the anti-proliferative effects of tamoxifen (77,78). Alternatively, raloxifene has been shown to be effective in breast cancer prevention, the most important effect of which was to decrease breast volume evaluated by MRI (79). Notably, it also has an
### Table 4 Reducing risk factors

| Study                      | Ki-67 no treatment | Ki-67 post treatment | P       | SD of the mean difference | Mammographic density | Volume by MRI |
|----------------------------|--------------------|----------------------|---------|---------------------------|----------------------|---------------|
|                            |                    |                      |         |                           | Mean pretreatment    | Mean post-treatment | Pretreatment to 1\textsuperscript{st} year | Pretreatment to 2\textsuperscript{nd} year |
|                            |                    |                      |         |                           |                      |               |                |                                            |                                            |
| **Ki-67 expression**       |                    |                      |         |                           |                      |               |                |                                            |                                            |
| Acolbifene (Fabian et al.) (53) | 6.6±4.8            | 2.1±1.9              | <0.001  | 4.186                     |                      |               |                |                                            |                                            |
| Raloxifene (Lima et al.) (62) | 22.16±1.9          | 2.161±0.181          | <0.001  | 1.905                     |                      |               |                |                                            |                                            |
| Tamoxifen (Lucato et al.) (63) | Undefined         | 2.02±1.09            | 0.205   | Undefined                 |                      |               |                |                                            |                                            |
| Raloxifene (Lucato et al.) (63) | Undefined         | 3.13±3.23            | 0.205   | Undefined                 |                      |               |                |                                            |                                            |
| Raloxifene (Eng-Wong et al.) (64) | Undefined         | Undefined            |         | Undefined                 |                      |               |                |                                            |                                            |
| Tamoxifen (Bramwell et al.) (65) | Undefined         | Undefined            |         | Undefined                 |                      |               |                |                                            |                                            |
| Tamoxifen (Serrano et al.) (51) | 18±4.47            | 19.5±4.41            | 0.78    | 3.027                     |                      |               |                |                                            |                                            |
| Raloxifene (Serrano et al.) (51) | 21.5±4.18          | 21±2.16              | 0.78    | 3.027                     |                      |               |                |                                            |                                            |
| Tamoxifen (Decensi et al.) (66) | Undefined         | Undefined            |         | Undefined                 |                      |               |                |                                            |                                            |
| **Breast density by imaging** |                    |                      |         |                           |                      |               |                |                                            |                                            |
| Raloxifene (64)            | 39% [7–78]         | 1 year: 1% (−3 to +5) | P=0.86;  | −17%                      | −16% (−5 to 25)      |               |                |                                            |                                            |
|                            |                    | 2 years: 1% (−2 to +5) | P=0.05;  |                          |                      |               |                |                                            |                                            |
|                            |                    | 9 months: −11% (−5%±30%) | P=0.067 |                          |                      |               |                |                                            |                                            |
| Acolbifene (53)            | 35.8% (2.9–76.3)   | 12 months: −9.9% (−16.2 to −3.6) | P=0.003 | Undefinded |                      |               |                |                                            |                                            |
| Tamoxifen (Decensi) (66)   | 49.9% (45.4–54.4)  | 24 months: −16.2% (−22.6 to −9.8) | P=0.003 | Undefinded |                      |               |                |                                            |                                            |

Values given as the mean ± standard deviation.
Table 5 Adverse events

| Adverse events   | Acolbifene (Fabian et al.) (53) | Raloxifene (Eng-Wong et al.) (64) | Tamoxifen (Bramwell et al.) (65) |
|------------------|---------------------------------|-----------------------------------|---------------------------------|
| Hot flushes      | 16%                             | 57%                               | 82%                             |
| Irregular menses | 32%                             | 86%                               |                                  |
| Amenorrhea       | 67%                             |                                   | 67%                             |
| Dizziness        | 16%                             |                                   |                                  |
| Muscle cramps    | 25%                             |                                   |                                  |
| Diarrhea         | 16%                             |                                   |                                  |
| Myalgias         | 64%                             | 17%                               |                                  |
| Vaginal discharge| 11%                             | 27%                               |                                  |
| Headache         | 25%                             | 12%                               | 32%                             |
| Mood alterations |                                  |                                   |                                  |
| Breast pain      | 25%                             |                                   |                                  |

overall better toxicity profile but weaker activity against intraepithelial lesions (80). Based on the known properties of SERMs, research into these drugs has become more intense in recent years, diversifying the types of patient studied and expanding the horizons of the population that can benefit from their use. Indeed, it is known that they can reduce ERα expression to levels similar to those found in non-neoplastic breast tissue, and decreased the mortality due to breast cancer up to 25–30% (81).

In the studies selected here, modulation of the Ki-67 risk biomarker was often investigated as one of the main outcomes, not least because its reduction is associated with a superior recurrence-free survival and a prognostic factor to determine the patients’ status after chemotherapy in short and long-term follow-up (82). Two of the studies analyzed reported a significant change in the mean Ki-67 expression following treatment with acolbifene (53) and with raloxifene (62). Interestingly, while Ki-67 was not measured at the pre-treatment stage in the study carried out by Lucato et al. (63), its post-treatment expression was low and there were no significant differences between the raloxifene and tamoxifen therapies tested. In general, the results of the studies analyzed so far reveal that acolbifene, raloxifene and tamoxifen each produce an important anti-proliferative effect. Another important factor is the change in mammary density during treatment, which was evaluated in 3 of the studies selected. Interestingly, while 3 different treatments appeared to alter breast density, only tamoxifen produced a significant change in this parameter when the pre-treatment values were compared with those after 2 years of treatment (66), reducing breast density by 20%.

It is important to note that although the selected articles had the same goal, to assess the beneficial effect of SERMs in pre-menopausal women with a high risk of developing breast cancer, different variables were measured. Thus, while some evaluated Ki-67 expression, others analyzed the breast density and its characteristics before and after treatment. This variability in the parameters measured could affect our true understanding of the effectiveness of SERMs as preventative agents. The correct identification of pre-menopausal patients at high risk of breast cancer is also an important aspect of the disease history that could potentially have a meaningful influence on the incidence and mortality rates.

Despite the small body of studies interested in demonstrating beneficial effects of SERMs on the risk of ER positive breast cancer, it was possible to establish the importance of preventive treatment with SERMs in pre-menopausal women. This systematic review provides valuable information regarding the possibility of designing new prevention trials with SERMs, the results of which could help select an appropriate preventive treatment, with major benefits and minimal toxicity.

Conclusions

This systematic review found that adjuvant treatment
with SERMs reduces the risk of developing breast cancer, modulating Ki-67 expression and breast density in pre-menopausal women with a high risk of developing early breast cancer. The data obtained also highlighted the need for more systematic trials of the therapeutic use of SERMs in pre-menopausal women with a high risk of breast cancer. Such studies should assess all the critical variables and factors that might influence the risk of developing breast cancer.

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Footnote

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