All cells respond to signals sent from other cells. One main way that cells use to communicate is hormones. Hormones can be either small proteins (e.g. insulin) or they can be derived from steroids (e.g. estrogen). The signaling cell produces the hormone that is then taken up into the target cell to cause a change in behavior. Hormones can cause a cell to produce new proteins or to stop making products that were already being produced. One possible outcome of hormone signals is the growth and reproduction of the target cells.

Cancer cells, while abnormal, may retain the ability to respond to hormonal signals. The idea behind the majority of hormone-based cancer treatments is to starve the cancer cells of the hormonal signals that would otherwise stimulate them to divide. The drugs used in these treatments work by blocking the activity of the hormone in the target cell. Some newer treatments under investigation are designed to prevent the production of the hormone, cutting off the signal at the start. Some forms of breast, ovarian and prostate cancer are subject to hormonal treatments.

The hormonal treatments described in this chapter are often combined with surgery and/or radiation and/or chemotherapy. In these situations, the hormonal treatments are referred to as an 'adjuvant' treatment.

The hormonal treatments described on the following pages all work by interfering with hormonal signals but they may attack different parts of the pathways involved. The types of hormonal antagonists (and specific drugs) discussed include:

- **Selective Estrogen Receptor Modulators (SERMs):** These agents work by interfering with the activity of the estrogen receptor. Drugs that work this way include tamoxifen (Nolvadex®), raloxifene (Evista®) and toremifene (Fareston®).
- **Aromatase Inhibitors:** These drugs work by blocking the production of estrogen by the enzyme that makes it from its precursor. Drugs that work this way include anastrozole (Arimidex®), exemestane (Aromasin®) and letrozole (Femara®).
- **Receptor Down-regulators:** This class of drugs works by lowering the levels of the receptor for estrogen. Fulvestrant (Faslodex®) is a drug in this category.
- **Selective Androgen Receptor Modulators (SARMs):** These agents work by interfering with the activity of the androgen receptor. Drugs that work this way include flutamide (Eulexin®) and bicalutamide (Casodex®).
- **Other Hormone Treatments:** These drugs work to affect the production or activity of hormones in a manner that is not covered in the above categories. The way by which these drugs work may not be entirely clear. An example of this type of drug is megastrol (Megace®).
- **Glossary of Hormonal Treatment:** An easy to use table of hormonal treatment drugs including trade name,
Selective Estrogen Receptor Modulators (SERMs)

Many individuals with breast cancer have tumors driven to grow by the naturally occurring hormone, estrogen. One of estrogen's normal activities is to cause the proliferation of cells in the breast and uterus; each month new cell linings must be created for the milk glands (breast) and the endometrium (uterus). In some breast cancer patients, this normal expression of estrogen contributes to the growth and division of the cancer cells. For these patients, treatment with selective estrogen receptor modulators (SERMs), also known as anti-estrogens, is appropriate.

The drugs work by causing changes in the shape of estrogen receptors (ER), preventing the action of the hormone. The drugs only affect a subset of the cells capable of responding to estrogen but the precise mechanism of this selectivity is not yet known. It is this selective action that has earned the drugs their name. The blockage of estrogen in the target cells causes changes in gene expression and alters the behavior of the cells, preventing cell division.

In 1992, tamoxifen became the first SERM to be used for the treatment of breast cancer. While it does decrease estrogenic effects in the breast, it unfortunately has a pro-estrogenic activity in the uterus, causing a rise in uterine cancer for tamoxifen-treated breast cancer patients.

Recently, next generation SERMs such as raloxifene have been investigated for their potential as breast cancer treatments. This drug appears to have anti-estrogenic effects in both breast and uterine tissues. Two six-month studies conducted in 1999 show that raloxifene does not stimulate endometrial growth. Studies of 969 postmenopausal women taking raloxifene showed that treatment with the drug did not lead to a significant increase in endometrial thickness as compared to women taking a placebo.

The results of the STAR trial showed that raloxifene was equal to tamoxifen for the prevention of invasive breast cancer in post-menopausal women and had somewhat improved side effects.

"On September 13, 2007, the U.S. Food and Drug Administration approved raloxifene hydrochloride tablets (EVISTA, Eli Lilly and Company) for reduction in the risk of invasive breast cancer in postmenopausal women with osteoporosis and in postmenopausal women at high risk for invasive breast cancer."

Inhibitors and Down Regulators

Additional hormonal treatments have been developed which can act as alternatives to treatment with SERMs (tamoxifen/raloxifene) or be utilized if SERMs are ineffective. Tamoxifen and raloxifene are both designed to interfere with the action of estrogen once it has entered a target cell. There are several other points of attack that may be taken to prevent signalling via estrogen. The most direct approach is to prevent the production of the estrogen by blocking the enzyme that is responsible for its formation, aromatase.

A second approach is to remove the target of the estrogen (the estrogen receptor). Both of these approaches to therapy have been developed for the treatment of breast cancer. Because these hormone treatments block estrogen production or function, they can have negative side effects on pregnancy. Therefore, they are used to treat postmenopausal women.

Aromatase Inhibitors

After menopause, women produce a consistent low level of estrogen that is derived from androgen precursors. These precursors are converted to estrogen through the actions of the enzyme aromatase. By blocking the action of this enzyme, aromatase inhibitors prevent the formation of estrogen. There are two types of aromatase inhibitors that have been approved as treatment for postmenopausal women with estrogen-receptor positive metastatic breast cancer: steroidal inhibitors such as exemestane (Aromasin®) and non-steroidal inhibitors that competitively bind to aromatase (anastrozole and letrozole).
Anastrozole  
Exemestane  
Letrozole

An advantage of these drugs is that they do not appear to have the side effect of increasing the risk of endometrial cancer.\textsuperscript{10}

Because they interfere with the activity of the sex hormone estrogen, aromatase inhibitors do have additional side effect of impacting sexual function and satisfaction.\textsuperscript{10}

**Estrogen Receptor Down-regulators**

By decreasing the concentration of estrogen receptors and their activity, the effects of estrogen can be negated.

**Fulvestrant**

**Selective Androgen Receptor Modulators (SARMs)**

Testosterone and dihydroxytestosterone (DHT) are two hormones (androgens) produced in the testes and adrenal glands. Among other activities, these hormones bind to specific receptors in the cells of the prostate. A normal function of this binding is to regulate the growth of the prostate cells, however, in cancer cells this regulation is compromised. The androgens bind to the receptors in cancer cells and contribute to their growth and division.

Anti-androgen molecules have been created, that can enter cells and prevent the binding of testosterone to the receptor proteins. This occurs via the preferential binding of the drug molecule to the androgen receptors. The binding of the drug prevents the androgens from binding and therefore reduces their pro-growth activities.\textsuperscript{11}

**Bicalutamide** (Casodex®)

**Flutamide** (Eulexin®)

**Nilutamide** (Nilandron®, Anandron®)

The drugs are frequently used in combination with surgery to cause the maximal reduction in androgen levels.\textsuperscript{12,13} [PubMed] Additional drugs are also being studied for their ability to reduce androgen levels in prostate cancer patients and to overcome the drug resistance seen in some patients.\textsuperscript{13,14}

**Additional Hormone Treatments**

Additional agents have been developed to interfere with the hormonal control of cell division. These agents may mimic naturally occurring hormones or may work through novel or unknown mechanisms. Examples of this type of drug include:

**Megestrol** (Megace): this drug interferes with the production and/or activity of estrogen.\textsuperscript{15}

**Know the Flow: Hormonal Treatments**

Know the Flow is an educational game for you to test your knowledge. To play:

- Drag the appropriate choices from the column on the right and place them in order in the boxes on the left. Note that you will only use five of the six choices to complete the game.
- When done, click on ‘Check’ to see how many you got correct.
- For incorrect answers, click on ‘Description’ to review information about the processes.
- To try again, choose ‘Reset’ and start over.

**Processes in order**

- 1
- 2
- 3
- 4
- 5
Processes

- Learn more
- Learn more
- Learn more
- Learn more
- Learn more
- Learn more
- Learn more
- Learn more
- Learn more
- Learn more

You did it!
The process is in the correct order!

Play again

4. [http://www.aafp.org/afp/990915ap/131.html]
5. Vogel VG; Costantino JP; et. al.; for the National Surgical Adjuvant Breast and Bowel Project (NSABP). Effects of Tamoxifen vs Raloxifene on the Risk of Developing Invasive Breast Cancer and Other Disease Outcomes: The NSABP Study of Tamoxifen and Raloxifene (STAR) P-2 Trial. JAMA. 2006;295:2727-2741. Published online June 5, 2006. [PUBMED]
6. Land SR; Wickerham DL; et.al. Patient-Reported Symptoms and Quality of Life During Treatment With Tamoxifen or Raloxifene for Breast Cancer Prevention: The NSABP Study of Tamoxifen and Raloxifene (STAR) P-2 Trial. JAMA. 2006;295:2742-2751. Published online June 5, 2006. [PUBMED]
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