EDITORIAL

HRT today

The Woman's Health Initiative of July 2002 concluded that the overall health risks of long-term use of combined oestrogen and progesterone replacement therapy exceeded the benefits. This was a study performed on women in their middle sixties who were obese by World Health Organization standards, were unfit and had significant medical problems. The cohort of women under age 55 represented less than 10% of the women in the study. Based on this study of overweight, unfit women conclusions have been made that have created chaos in doctors' offices and women's minds across the world. The alternative health practitioners have grabbed the opportunity and played to the fears and concerns of both medical and lay people with menopausally related problems. There is hardly any evidence to support the alternative medical industry. In Australia approximately four times the amount of money spent on conventional hormonal therapy is spent on alternative therapy. These sales are created by skillful marketing with minimal scientific data to back up many of the statements in these marketing programmes.

Our problem as clinicians is how to get appropriate information across to a confused population of women and a vulnerable group of medical practitioners practising in an environment where litigation is becoming an increasing problem. If one looks at the Nurses Health Study and the studies in women in the younger age group, the findings of the WHI do not ring true. The clinician practising in the menopausal health arena today needs to be fully aware of the results of these studies in the appropriate age groups in which they were done.

Most menopause societies across the world have taken a conservative approach to the menopause, stating that women should take the lowest dose of hormones for the shortest possible time. But how low is low and how short is short? Many have taken the WHI study and said that 5 years is long term. However, if one looks at the longer-term studies in younger women, these data are not supported.

What is the evidence for alternative therapy? Krebs *et al*.[1] did a review of phyto-oestrogens for the treatment of menopausal symptoms and showed that they do not consistently improve hot flushes and other menopausal symptoms or quality of life. While evidence does suggest that phyto-oestrogens may have a minimal effect on vaginal health and bone mass density, no fracture data are available. These plant oestrogens are well tolerated. Preliminary evidence suggests that

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long-term use of isoflavones may be associated with an increased risk of endometrial hyperplasia, so they may not be as safe as many alternative practitioners would have us believe.

Another factor is that dietary supplements are not subject to the safety and efficacy testing applied to pharmaceutical products, and that they are not registered with the Medicines Control Council. The contents of these supplements may therefore be variable.

The swing to plant alternatives resulted from extremely poor media reporting of the WHI study and doctors' lack of knowledge on the exact interpretation of the statistical data presented. As John Studd has said (IMS 2005):[2] 'The WHI was the wrong study, in the wrong women, using the wrong doses at the wrong time.'

As clinicians we need to be fully aware of how these papers present their data. We need to interpret them for our patients. We need to balance our patients' needs against the benefits and the risk of any medical therapy. The lower doses of hormone replacement therapy may well offer an opportunity for the management of symptoms while minimising the risk in long-term therapy.

So what is the clinician to do when a patient presents in the early menopause with symptoms impacting on her

quality of life? There is no question that conventional hormone therapy will alleviate most of the symptoms. There is no question that there will be a decrease in fracture risk. There is no question that there will be an improvement in quality of life. But in studies done on equine oestrogen and medroxyprogesterone the long-term data indicate that this combination will increase the risk of breast carcinoma. However, this risk is extremely small: 8 extra cases in 10 000 women over 5 years. This needs to be balanced against the benefit to the patient's quality of life.

What is the clinician to do with a patient who has had a breast carcinoma and who has incapacitating symptoms without any alleviation with plant alternatives or SSRIs? Studies such as that by Batur,[3] who reviewed menopausal hormone therapy in breast cancer survivors, did not find an increase in cancer recurrence, cancer-related mortality or total mortality. Their conclusion was that 'despite conflicting opinions on this issue, it is important for primary care physicians to feel comfortable medically managing the increasing number of breast cancer survivors. In the sub-set of women with severe menopausal symptoms, hormone therapy options should be reviewed if non-hormonal methods are ineffective. Future trials should focus on a better way to identify breast cancer survivors who may safely benefit from hormone therapy vs. those who have a substantial risk of re-occurrence with hormone therapy use.'

So the clinician is beset with problems of media manipulation, of biases by medical journalists who are poorly trained or poorly equipped to understand the data presented to them in scientific papers. The clinician needs to be knowledgeable about these studies, needs to be informed about evolving therapeutic management, and together with the patient needs to make a balanced decision taking into account her fears and concerns and the benefits of appropriate management of the menopause.

As our population ages, more women will live decades into the menopause and more women will continue to have problems, and appropriate hormonal therapy will benefit these women with regard to their quality of life and long-term health benefits.

Is there a role for androgen therapy in these patients? The work of Davis and Dennerstein[4-6] indicates that a rapidly evolving subset of women will definitely benefit from androgen replacement at the same time as appropriate hormonal therapy. This area has lacked research in the past, but more is being published and more benefit of associated androgen therapy has been documented. The North American Menopause Society published a position statement in September 2005 on the role of testosterone therapy in postmenopausal women.[7] The problem is how to deliver it safely to our patients, and there is a paucity of choices in South Africa.

The field of management and care of menopausal women is an opportunity for the clinician to practise as a primary care physician to benefit women's health in the long term. Vastly more women will die of cardiovascular disease than breast cancer. The emphasis on breast cancer in the menopausal age group is inappropriate when one takes into account the high incidence of mortality related to cardiovascular disease.

It is incumbent upon clinicians to regularly and comprehensively review their patients' genital health and menopausal symptoms while having a holistic approach to women in this age group. This includes investigations of hormonal status, lipid profiles, exercise programmes, bone density and mammography, tailoring each to the individual. It is an amazing opportunity to benefit women who have treatment withheld for too long, mostly through ignorance or through clinicians not applying their minds to benefits available to this vulnerable group of women, who can significantly improve their quality of life.

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