iv. Lower doses of oral estrogens may be safer in terms of VTE risk than higher doses
v. Not recommended for primary or secondary prevention of stroke
vi. Not recommended for women with elevated baseline of stroke
Source: March 2007 position statement of The North American Menopause Society

B NAMS Guidelines related to Depression, Dementia, Cognitive Decline
i. Evidence currently does not support use of ET/EPT for depression treatment (although NAMS recognizes studies showing benefits of ET for depression during peri-menopause)
ii. Initiating EPT after age 65 for primary prevention of dementia or cognitive decline may increase risk of dementia during ensuing 5 years
iii. Evidence insufficient to support or refute efficacy or harm of ET/EPT for primary prevention of dementia when initiated during the menopause transition or early postmenopause
iv. ET does not appear to convey a direct benefit or harm for treatment of dementia due to Alzheimer’s disease

C NAMS Guidelines related to Osteoporosis
i. There is strong evidence of the efficacy of ET/EPT in reducing the risk of postmenopausal osteoporotic fracture
ii. ET/EPT can be considered an option for women requiring drug therapy for osteoporosis risk reduction

D NAMS Guidelines related to Breast Cancer Risk of HT
i. Estrogen alone for < 5 years has little impact on breast cancer risk.
ii. ET for > 15 years may increase risk of breast cancer (based on limited observational data)
iii. Minimal data reports any change in breast cancer mortality with HT
iv. EPT may, to a lesser extent, ET, increase breast cell proliferation, breast pain, and mammographic density
v. EPT may impede the diagnostic interpretation of mammograms

E NAMS Guidelines related to Progestrone
i. Only for endometrial protection from unopposed ET in women with intact uterus
ii. Postmenopausal women without uterus should not be prescribed progestogen with systemic estrogen
iii. Progestogen generally not indicated with low-dose, locally administered estrogen for vaginal atrophy
iv. No evidence to recommend off-label use of long-cycle progestogen, vaginal administration of progestosterone, the levonorgestrel-releasing IUD (Mirena), or low-dose estrogen without progestogen as alternative to standard HT regimens

F ACOG Recommendation related to HT
i. Counsel women that although WHI findings indicate estrogen/progestogen is associated with increased risk of breast cancer, the absolute risk for any individual woman remains low
ii. Women taking estrogen only need to consider other risk factors, including heart disease, VTE, and stroke
iii. Breast cancer survivors should consider alternatives to HT for treating menopausal symptoms

G USPSTF Recommendations
i. Recommends:
   1. Clinicians should use a shared decision-making approach to preventing chronic diseases in perimenopausal and postmenopausal women
   2. The USPSTF did not consider the use of hormone therapy for managing menopausal symptoms
   3. Women and their clinicians should discuss the balance of risks and benefits before deciding to initiate or continue hormone therapy for menopausal symptoms
   ii. Recommends against:
      1. The use of ET for the prevention of chronic conditions in postmenopausal women
      2. Routine use of unopposed estrogen for prevention of chronic conditions in postmenopausal women who have had a hysterectomy

10. Promotion of bio-identical hormones by celebrities and news reports surrounding HT has made discussing symptom management with my peri-menopausal and menopausal patients easier. It is important to help your patients understand that these compounds have exactly the same chemical and molecular structure as hormones produced in the body, and that little evidence supports the perception of greater safety with bio-identical hormones. There is also no evidence that the results of the WHI were related to the molecular structure of the synthesized hormones or that customized or different hormone doses would have changed the outcomes. Finally, they should understand that many formulations of these hormones are not subject to FDA oversight and may be inconsistent in purity and dosage.
Clinical Information Related to Menopause Self Assessment

1. My comfort level related to prescribing hormone therapy (HT) to my peri-menopausal patients is high.

   Although genital symptoms are recognized and managed by highly reputable private and public organizations, concerns over the Women’s Health Initiative (WHI) and HT persist, especially in primary care where physicians are almost half as likely to support the use of HT as are gynecologists. Gynecologists, in turn, are only half as likely to support HT than they were pre-WHI.


2. Most of my peri-menopausal patients are prescribed hormone therapy.

   Data show many physicians inconsistently follow menopause symptom management and HT recommendations of reputable organizations, perpetuated by the complexity of the material and rapidly changing information. In general, primary care physicians are prescribing inappropriate therapies, providing inadequate complete advice or simply failing to address all of their female patients’ questions and concerns about menopause and treatment options for associated symptoms.


3. My comfort level related to prescribing alternative non-HT treatment for menopausal symptoms is high.

   In recent years, the WHI has undergone a paradigm shift since the WHI report in 2002, pointing to a significantly increased risk of major coronary heart disease in women assigned to HT compared to women assigned to placebo. These results have been supported by many retrospective, others prospective. More recent studies, however, have highlighted the early stage of postmenopausal, or in women using hormone therapy compared to pre-menopausal women.

   Sources:
   b. Reid RL. Hormone therapy: the Women’s Health Initiative has caused confusion and concern. Fertility and Sterility. vol. 66, no. 3, September 2001.

4. I consistently initiate discussions about menopause and HT with my peri-menopausal patients during routine exams.

   Complicating matters for primary care physicians and patients, women feel reluctant to discuss HT and menopause with their healthcare providers. In one study, one noted study that almost half of women [in the study] left the physician’s office with unanswered questions about HT and menopause, with almost two-thirds of the third that HT was not even discussed in their appointment. Similar clinical challenges are experienced by younger physicians, who generally feel their knowledge of HT is insufficient and are unprepared to counsel women about HT. This statement is supported by Hess, et al., who found that “fewer than half of [primary care physicians] are knowledgeable...about the rapidly changing field of HT and menopause management and that fewer than one third of residents feel adequately prepared to counsel women about it.” Hess also points out that experiential learning, either through clinical instruction, increases knowledge and comfort with HT and menopause issues.

   Sources:
   a. Cifuentes E, Clinton BA, Davis J, McDonnell K. Women’s knowledge about hormone, hormone replacement therapy (HRT), and interactions with medical providers: a pre-WHI exploratory study. J Women’s Health Gent Based Med. 1999;8(9):1007-15.

5. I try to accommodate a patient’s request for specific therapy related to menopausal symptoms even if I am not familiar with that treatment.

   The goal is for you and your patients to arrive at shared decision-making, where you are provided with available options for treatment and the risks and benefits of each option. Studies find that only a fraction of patient/physician conversation discussions on alternative medical treatments, and/or the uncertainties associated with them. Both of these issues are particularly important in menopause, since many women today choose to use complementary and alternative therapies, often with very little information about their potential risks and benefits.

   Sources:

6. I am comfortable assessing the psycho-social factors of menopause.

   The incidence of depression during the menopausal transition remains variable, likely due to variability within studies. Some populations come from menopause clinics, which may be more likely to attract patients with severe symptoms; others are community-based. The studies also vary in their definition of “menopause” and menopausal transition, basing definitions on a variety of factors including age, hormonal status, symptomatology, or menstrual cycle irregularities. Some studies are retrospective, others prospective. However, point to a significantly increased risk of major depression in perimenopausal women.

   One of the largest such studies is the Study of Women’s Health Across the Nation (SWAN), which found that the menopausal transition to be associated with an increased risk of depression. In SWAN, women in the early or late stages of perimenopause had the highest risk of depression; this risk was also higher in the early stage of postmenopausal, or in women using hormone therapy compared to pre-menopausal women.

   Source:

7. I am comfortable assessing the somatic symptoms of menopause.

   Treatment of vasomotor and other somatic symptoms has undergone a paradigm shift since the WHI report in 2002, which has dramatically decreased the use of hormone therapy. However, during the days, weeks and months following the Women’s Health Initiative Study, an flurry of media reports created confusion and concern among women using HT and physicians who prescribe HT. The overall message from media sources was that HT did more harm than good and the risks of increased breast cancer rates and cardiovascular concerns outweighed the benefits to women experiencing the menopausal and vasomotor symptoms. As a result of these safety concerns, the use of HT since WHI has dramatically decreased. As many as two-thirds of women stopped HT, becoming highly symptomatic. These concerns persist, especially in primary care where physicians are almost half as likely to support the use of HT as are gynecologists. Gynecologists, in turn, are only half as likely to support HT than they were pre-WHI, although guidelines have been established and recognized by highly reputable private and public organizations. Inappropriate therapies are prescribed or physicians simply fail to address the issue with patients, resulting in women whose symptoms go untreated.

   Sources:
   b. Reid RL. Hormone therapy: the Women’s Health Initiative has caused confusion and concern. Fertility and Sterility. vol. 66, no. 3, September 2001.

I am familiar with most recent data related to HT in pre- and post-menopausal patients.

A recent article from the New England Journal of Medicine and subsequent media reports will no doubt further impair communication between primary care physicians and their patients. These reports, along with misleading, et al., highlighted a 60% lower risk of severe coronary artery calcium (a major risk factor for heart attacks) in women who regularly use estrogens, [17]. News reports following the article pointed out significant flaws with the WHI, along with misleading and incorrect conclusions made in the final report. [18]

Sources:

My daily schedule allows me to stay current on new studies and findings related to HT.

A.NAMS Guidelines: ET and EPT recommended for:
   a. Moderate-to-severe vasomotor symptoms
   b. Moderate-to-severe symptoms of vulvar and vaginal atrophy
   c. 1. Vaginal, not systemic HT if symptoms only indication
   iii. Not recommended as single or primary indication for coronary protection in women of any age

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