

Sweating profusely and turning beet red at the drop of a hat were clear signs that Pam Harrison, a medical writer in Toronto, had entered menopause. With a busy schedule covering scientific sessions in locations from Spain to Hawaii, Pam, then 49, couldn't afford to be embarrassed while interviewing movers and shakers in the medical community. After talking to her family doctor, she decided to take hormone replacement therapy (which is now more commonly called hormone therapy or HT).

That was a dozen years ago and Pam hasn't looked back. "It works brilliantly," she says of the estrogen and progestin (the synthetic version of progesterone) pills she continues to take on a daily basis. She's convinced it's the only thing that keeps her symptoms at bay – and her sanity intact.

Pam is something of an anomaly. Many other women abandoned HT almost a decade ago in the wake of a large study linking this therapy with heart disease and cancer. But after years of additional research, a new consensus is now taking hold: Hormone therapy

is a relatively safe and effective treatment for newly menopausal women who experience unwanted symptoms. More and more such women are rejoining Pam in the ranks of hormone users. And more doctors are prescribing HT because of its other benefits, such as a proven ability to protect bone health.

The estrogen revolution

Estrogen therapy was approved in the early 1940s for managing debilitating hot flashes, sleep disturbances and other menopausal symptoms. After a few blips (for example, it was linked to endometrial cancer in the mid-1970s before it was combined with progestin), HT was generally well accepted as harmless and probably beneficial.

A host of observational studies had backed this up, suggesting that HT helped prevent heart disease, and that symptoms of estrogen deprivation, including the hallmark hot flashes and vaginal dryness, could be controlled well by popping a daily estrogen tablet, along with progestin to protect the uterus. (In an >

HRT: round two

It's been 10 years since a major study scared women away from using hormone replacement therapy (HRT) to manage menopausal symptoms. But new research and treatment methods are bringing HRT back into play.

By Pauline Anderson

ILLUSTRATION: GRACIA LAM



observational study, researchers track subjects over time, measuring outcomes of interest without trying to affect the outcomes. In contrast, in a randomized controlled trial, which is the gold standard, researchers randomly give a treatment to some people but not others, then compare the outcomes.)

Not surprisingly, women looking for relief from hot flashes flocked to their doctors. One U.S. study found that in the early 1970s, 45 per cent of menopausal women interviewed had used hormone therapy for at least one month, and between 1987 and 1992, that proportion increased by 32 per cent. One major pharmaceutical company's HT products generated more than \$2 billion in sales in 2001 alone.

Then the bubble burst. A randomized study by the Women's Health Initiative (WHI) in the U.S. shocked the medical and lay communities alike in 2002, when it found that women taking hormones were at increased risks of heart disease and breast cancer. For the study, each of 16,608 postmenopausal women who hadn't had hysterectomies took either estrogen and progestin or a dummy placebo pill. The study was stopped early, after about five years, when it uncovered a 29 per cent increase in heart attack risk and a 26 per cent increase in breast cancer risk among the women taking replacement hormones.

And in 2003, observational research from the Million Women Study found even higher breast cancer risks among hormone users. Investigators for that study, which included 1,084,110 women in the United Kingdom, aged 50 to 64 years, reported that women taking hormones had a 66 per cent higher chance of getting breast cancer than those not taking hormones. As well, the risk of breast cancer increased the longer a woman used HT.

Fearing they were doomed to develop breast cancer or die of a heart attack, many women abruptly stopped taking hormones, and doctors stopped prescribing them. The Canadian Institute of Health Information found that the use of HT by older women in five provinces had fallen from 14 per cent before the WHI study to five per cent just five years later. Canadian hormone prescriptions dropped from 11.6 million per year at the time of the study to five million five years later.

A small risk

But now the pendulum appears to be swinging back in favour of HT. One reason, according to Dr. Michel Fortier, past president of the Society of Obstetricians and Gynaecologists of Canada (SOGC), and a professor of obstetrics and gynecology at Laval University in Quebec City, is that experts are trying to correct the misleading way the media and the public initially interpreted the findings of the WHI study. For one thing, that 26 per cent increased risk for breast cancer left some people wondering if this meant that 26 out of every 100 HT users would succumb to the disease.

It doesn't. The 26 per cent refers to the increased relative risk between women who are on hormone therapy and those who aren't. A better way to understand the stats is to look at absolute risks, says Dr. Fortier. Here are the numbers: In the WHI study, 164 of 8,506 patients on HT (1.9 per cent) developed breast cancer, as did 122 of 8,102 women who took the placebo (1.5 per cent).

The increased relative risk is the ratio of those two numbers. It's calculated by dividing the difference between them, 0.4 per cent (1.9 per cent minus 1.5 per cent), by the percentage of women who developed breast cancer while on the placebo. That works out to 0.4 per cent divided by 1.5 per cent, or about 26 per cent higher risk for the women who were taking hormones.

However, the point is that the absolute numbers are still relatively small. Out of thousands of women, only a few got sick, and for most of those women, their cancer may have been caused by other factors. The absolute increase in breast cancers probably attributable to HT worked out to be only eight more cases per year out of every 10,000 women taking the therapy.

So yes, HT carries an increased risk of breast cancer, but it's small. Even a woman with a family history of the disease – with a mother or sister who has been diagnosed, for example – could still be a candidate for hormone therapy, says Dr. Fortier. However, he draws the line at women who have had breast cancer themselves; they probably should not take additional hormones.

Can HRT protect the heart?

As for heart disease, many people felt that the WHI results were initially misinterpreted here too. For one thing, the mean age of the study participants was 63; two-thirds were over age 60 and 20 per cent were over 70 at the time of enrollment. "That's way too old for menopausal women to be starting to take hormone therapy," says Pam, who has written extensively on this topic for doctors. Dr. Fortier echoes this sentiment. Heart disease risk generally increases with age as damage to the heart accumulates over time, and HT cannot reverse that damage.

Sure enough, while the WHI study found the absolute risk for heart disease due to HT was six more cases per year out of 10,000 women,

new analysis showed that much of this increase was in the older age group – those who had started taking hormones well after menopause. In fact, women under 60 who took estrogen in the WHI study had 10 fewer deaths per 10,000 women per year. Other research in 2007 found there was less coronary artery buildup among younger women when they began HT before age 60.

Another study discovered that women who'd had their ovaries removed (an operation with effects that mimic those of menopause because of the loss of estrogen) and used HT lowered their risks of developing calcified plaque in their coronary arteries. This finding suggested that estrogen deficiency is related to an increase of plaque in the arteries. >

Yes, I have menopausal symptoms. But how bad is bad?

How you're affected by menopause is very individual, say doctors, but the cascading effects on the rest of your life are a good guide for when you might consider hormone therapy.

What you expect: As with other stressful events in life, there are strong personal and psychological grounds upon which each woman evaluates her own menopause experience. Lifestyle and social expectations are more important than genes. If you come from a family where it's fine to discuss your aches and pains in public, then you'll probably perceive your menopause symptoms as more severe.

What's normal: Most women experience about two years of the major symptoms, such as erratic periods, hot flashes, night sweats, moodiness,

poor sleep and fatigue. These symptoms usually decrease in frequency and gradually fade away within a couple of years after your last period.

Difficulty sleeping is probably the most common complaint for people over 40. But menopausal night sweats (hot flashes that wake you up) cause added sleep deprivation, making you tired at work and cranky toward family. Your sleep will improve as the hot flashes fade – usually within two years after your last period. But by that time you may also start having new age-related sleep problems that aren't caused by menopause.

While 75 per cent of women have hot flashes, less than a quarter of them find them serious enough to seek treatment.

What's worrisome: If you spend months waking up four times a night and stumbling through work the next day, then, "it's important to get some relief so you can function," says Dr. Barbara Sherwin, a professor of psychology and obstetrics and gynecology at McGill University in Montreal. Hormone therapy is still the most effective way to reduce hot flashes, which allows more sleep, less fatigue and a sunnier disposition. – *Mary Malone*



Premature menopause

Some women go into menopause prematurely – in their early forties or even younger. For these women, many experts agree that hormone therapy is a wise treatment option, at least until they reach the natural age of menopause (around 50 years). After that, if they have serious menopausal symptoms, they should talk to their doctors about continuing HT.

But despite emerging evidence of HT's positive cardiac effects, as shown on all of these women, experts agree that patients should not take HT just to cut their heart disease risks. It looks promising, but the jury is still out on prevention.

New, safer therapies

Lower doses could strike the perfect balance between efficacy and possible harm. The estrogen used in the WHI study was taken in a daily dose of 0.625 mg. But a lower dose (0.3 mg) may do the trick in terms of controlling hot flashes – and research suggests it may be safer, says Dr. Ruth McPherson, a professor of cardiology and biochemistry at the University of Ottawa. "Many women can do well on smaller doses. By modulating the dose of estrogen needed to prevent symptoms, we can probably come up with regimens that are safer for the breast, as well as safer for the heart."

At her doctor's urging, Pam recently reduced her HT dose to 0.3 mg daily. After a few rocky weeks, Pam says she feels fine now.

Premarin, which is conjugated equine (horse) estrogen, was selected for the WHI study because it was the HT used by most menopausal women in North America at the time, says Dr. Fortier. It is still widely available today. There has been some suggestion that synthetic hormones, such as Estrace (estradiol), are safer than Premarin because they

more closely match your own body's estrogen. But while these new synthetic hormones are gaining popularity, there is no scientific data to support their superiority to Premarin, says Dr. Fortier.

But research does confirm that the widening selection of non-oral forms of HT – for example, patches, creams and gels – can effectively deliver estrogen in possibly safer lower doses. In contrast to oral estrogen that passes through the liver, which can have negative side-effects, the estrogen in patches and gels is absorbed through the skin.

Delivery through the skin also reduces risk for clotting. The WHI study found 18 more blood clots per year (and eight more strokes) among 10,000 women on oral HT compared to a similar group of women not taking hormones. But "it appears there's very little risk for women using an estrogen patch or estrogen gel," says Dr. McPherson. "That's considered a preferable mode of administration for many women, particularly those who have risk factors for clot formation, deep-vein thrombosis, pulmonary embolism or stroke."

Protecting your bones

Many experts recommend that women who are at serious risk of osteoporosis consider hormone therapy. "A woman who is at increased risk for osteoporosis, who has small breasts and probably low levels of circulating estrogen, likely has a very small risk of breast cancer, so she may well decide to take estrogen. And certainly, the benefit, in terms of bones and fracture risk, may well outweigh any small effect on breast cancer risk," concludes Dr. McPherson.

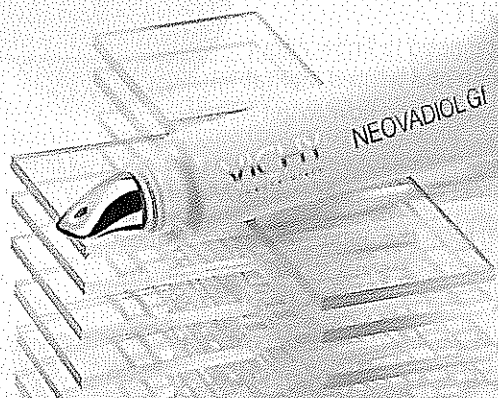
Dr. Jerilynn Prior is a professor of endocrinology and metabolism at the University of British Columbia in Vancouver and founder of the Centre for Menstrual Cycle and Ovulation Research. She says that if a woman is in early menopause, and she has more than a 20 per cent 10-year risk of fractures (doctors calculate these risks using information on things such as age, bone mineral density and prior fractures) and has uncontrolled hot flashes, she can consider >

VICHY

LABORATOIRES

DURING MENOPAUSE,
FOR THE MOST
AFFECTED ZONES.

NEOVADIOL Gf
EYES AND LIPS CONTOURS
DENSIFYING AND TIGHTENING CARE



INNOVATION

Cold applicator.
Immediate wrinkle-smoothing effect.



-33.7%
ON THE
APPEARANCE OF
THE UPPER LIP
WRINKLES*



-22.4%
ON THE
APPEARANCE OF
CROW'S-FEET
WRINKLES*

#1 BRAND IN CANADA*
EXCLUSIVELY IN PHARMACIES

*Test results on 40 women for 1 month.
* AC Nielsen, skincare, pharmacies, Canada sales in \$, 2010.

HEALTHY LIVING • Medical News

estrogen plus progesterone. Such a woman might also consider taking a bisphosphonate, an agent that prevents bone loss, before decreasing the hormone therapy, she says.

Preventing bone loss is not the only apparent health benefit of HT. The WHI study found a small decrease in the risk of colon cancer – six fewer cases per year per 10,000 women taking the therapy.

Short-term or long-term?

How long women should remain on hormone therapy is a matter of some debate. According to Dr. Fortier, there's no time limit. "You use it as long as you need it," re-evaluating that need each year, he says.

But other experts are more restrictive. "We can't recommend estrogen for more than perhaps 10 years," says Dr. McPherson. However, she adds, "I certainly don't feel strongly about a woman continuing on estrogen, particularly if she continues to be symptomatic and has no evidence of risks related to estrogen – she hasn't had a deep-vein thrombosis or a premalignant breast lesion."

The SOGC maintains that HT is a safe and effective option for up to five years. Dr. Prior, too, sets limits. If you take HT (she doesn't recommend it to women who don't have severe hot flashes), five years should be the maximum. She believes that staying on estrogen puts major demands on the body in terms of cell growth, inflammation and oxidative stress – "demands that are justified for having babies, but are not safe as we get older."

The debate will almost certainly intensify as, for more women, the postmenopause years last longer than the menstruating years. In some ways, both menopausal women and their doctors are treading new terrain, learning as they go.

Right now, it comes down to individual choices. Pam has weighed her own risks and benefits very closely. "Do I care about quality of life? Absolutely. Do I feel the risks of HT are worth the benefits? Yes. And as long as I don't read about a new reason why I should stop HT, I'm staying on it for as long as I want." *hm*