Counseling menopausal women about hormonal therapy

By Gary S. Packin, DO

Many women have expectations of pursuing active lifestyles in their later years in which they maintain physical, mental and sexual functions at premenopausal levels or as close to them as possible.

Today, women who have just entered menopause can expect to live at least 30 more years after a significant decrease or cessation of ovarian function. Not surprisingly, this has prompted a search for medical therapies that would improve the quality of life for these women, as well as prevent or delay many of the disease processes that interfere with the enjoyment of increased lifespans.

While hormonal therapy (HT) has been an obvious path to consider for those women, it has not been a path without bumps along the way.

Looking to the past

Estrogen therapy has been available for more than 50 years. Originally it was called hormonal replacement therapy or HRT. Now, it is often referred to simply as hormone therapy or HT, because it is not truly a replacement therapy.

For a time, HT was viewed as the “Fountain of Youth.” Because of that view, some physicians prescribed HT for almost all menopausal women whether they were symptomatic or not. HT was promoted to prevent bone loss, heart disease, hypertension, Alzheimer’s disease, depression and other significant disease entities associated with aging. The 1990s even saw some healthcare professionals prescribing HT “by the buckets” to women even before they entered their menopausal years. This overzealousness arose from observational and retrospective studies that suggested HT was safe. Therefore, why not treat all but the few women with known contraindications? Thus, women were given pills, creams, gels, lotions, patches, vaginal preparations and every other available vehicle for hormone delivery.

The perception was that women who did not take estrogen in some form would be at risk. That began to change as caution flags were increasingly raised by the medical community—even by those who agreed that HT had potential benefits. Concern grew that hormonal treatments were being prescribed to patients without clear indications, which might harm some individuals. In addition, studies began to emerge about the safety of estrogen with regard to heart disease and breast cancer.

In July 2002, HT for menopausal women took an “about face” because of the highly publicized—now considered controversial—findings of the Women’s Health Initiative (WHI). See www.nhlbi.nih.gov/whi for history and updates.

WHI seemed to indicate that HT had little or no benefit and that it had statistically significant risk of contributing to many benefits when it comes to treating patients with menopausal symptoms. But at the same time, we must consider patients as individuals and counsel them accordingly.

One of the first important steps we must take is to let our personal biases and experiences give way to evidence-based medicine. The health and well-being of our patients should be our utmost concern, and we must remember that the withholding treatment can be harmful as administering it improperly. A patient who is experienc-
ing incapacitating vasomotor symptoms, for example, has few options to estrogen therapy. It is unlikely that any alternative treatment would be effective enough to return her to a productive and satisfying lifestyle.

In addition, counseling a woman about HT requires a thorough understanding of her medical condition, emotional status, social background, cultural background and education.

Women should be counseled in language and terms that they can understand. The risks and benefits of therapy must be explained in an unbiased fashion. At the same time, physicians must be aware that cultural bias may preclude or prevent some patients from considering treatment or at least make them resistant. Because of this, physicians should consider obtaining assistance from professionals who are familiar with other cultures. Fear and misunderstanding can be significant factors in treatment failure and discontinuation of treatment.

In expanding our medical understanding of HT, we must remember that as researchers report study data on risks and benefits of treatment, interpreting the findings is often confusing. Statistical analysis is sometimes done incorrectly or left purposely vague. DOs should read the “fine print,” particularly by looking closely at the “material and methods” section of each article to formulate an opinion as to the validity of the conclusions. Many of the conclusions of the WHI study, for example, were flawed, but they made newspaper headlines and dramatically changed physicians’ willingness to prescribe HT. One of the factors that led to a misunderstanding of the WHI findings was a lack of appreciation for the difference between relative risk and absolute risk, both of which are important aspects of patient counseling (see Page 17 for additional information). If an event occurs only on rare occasions, then even a large increase in this absolute risk is small when compared with the relative risk. For example, if the risk of a meteor hitting earth is increased by 100%, the absolute risk is still very small. When relative risk is presented to patients without benefit of this kind of clarification, they may become frightened and refuse therapy.

Osteopathic physicians should use common examples to explain risk, because patients want to know, “If I take this medication, what is my risk of having complications?” If you are not sure, tell them so. They value not just the opinions of their healthcare professionals but their honesty as well.

**Special considerations**

Although the WHI was flawed, we should not go back to an era of thinking that HT is without notable risks for some patients. Cardiovascular risks related to HT, for example, include cardiac and thromboembolic phenomena. These risks can be minimized by careful patient selection and screening. Patients with known cardiovascular disease, hypercholesterolemia and lipid abnormalities should be treated with caution. In addition, the benefits of treat-

---

The treatment of menopausal women with hormonal therapy has been highly controversial, with recommendations ranging from treating all menopausal women to treating none of them.
Cancer risks are more difficult to analyze and explain. Both medical history and family history are important cancer screening tools for physicians to use. Patients who have breast or uterine cancer should undergo appropriate consultations and evaluations. They should not, however, be excluded from treatment simply because of cancer risk—particularly if their symptoms are severe and alternative therapies cannot alleviate their symptoms.

Metabolic diseases, liver abnormalities and depressive disorders also raise concerns regarding HT. Patients who are being treated with antihypertensive and antiseizure medications should be made aware of the potential for adverse interactions. Patients with diabetes mellitus should be cautioned about potential fluctuations in their glucose levels as a result of using HT, and they should be instructed in how to deal with these fluctuations.

Bear in mind that there is some confusion about the use of treatments that promote themselves as “bio-identical.” It is beyond the scope of this article to review this topic comprehensively, but suffice to say that no evidence to date clearly demonstrates the safety of any hormonal compound over another.

In addition, remember that alternative treatments, including nonmedical treatments, should be discussed and offered. There may also be a middle ground for certain patients between hormone and nonmedical treatments. For example, patients who mainly experience vaginal and urinary symptoms as a result of menopause may benefit from using vaginal estrogen preparations. These seem to have minimal systemic absorption and thus seem to pose little risk when properly administered.

**Final notes**

Properly counseling women about HT requires adequate time and understanding of each patient’s medical condition and social situation. Remember that your objective is to convey the purpose and goals of treatment and to help patients understand the benefits and risks of treatment—and to do so at each patient’s level of comprehension.

In general, clear lines of communication are important, and this must be emphasized to the patient. Cultural and language barriers should be recognized and addressed. Support personnel can be extremely helpful in keeping lines of communication open and helping you navigate barriers. Ensure that each patient knows she has access to you, your staff and support personnel for follow-up questions, and give her written information (see the “Patient Particulars” section on Page 17).

HT that is administered under medical supervision with patients’ consent and understanding can be of great assistance during this transitional time. Administered for a limited period of time in an evidence-based manner, HT can minimize risks to patients while significantly improving their quality of life.

Gary S. Packin, DO, is director of reproductive endocrinology and infertility and a clinical associate professor at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, Department of Obstetrics and Gynecology. Dr Packin is board certified in obstetrics and gynecologic surgery and reproductive endocrinology by the American Osteopathic Board of Obstetrics and Gynecology and the Advisory Board of Osteopathic Specialists. He can be reached at packings@verizon.net.