Guidelines and recommendations on hormone therapy in the menopause

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As in other fields of medicine, it would have been easier for the primary practitioner to reach therapeutic decisions on the basis of simple, clear guidelines on postmenopausal hormone therapy (HRT). Unfortunately, this was not possible in the past 6 years, since the results of the Women's Health Initiative (WHI) study that was published in July 2002 were interpreted in various ways, leading to disruption of the previous consensus that stated "all menopausal women should consider HRT." Following the release of the WHI data, many societies and health organizations claimed that HRT is dangerous, and others recommended the use of hormones only when vasomotor symptoms are severe and cannot be controlled by alternative therapies. The phrase "the smallest dose for the shortest duration" became very popular, bringing this issue ad absurdum, namely prescribing HRT for a few weeks only, and then stopping it because of potential risks. The International Menopause Society (IMS) was among the few organizations that stood firm against these conceptual changes in practical guidelines, calling for a more scientific and rationale approach to the analysis and implementation of the WHI data. Luckily, the situation changed again in mid-2007, when WHI investigators admitted that age is a major factor in the benefit-risk balance for hormone users. While cardiovascular events, thromboembolism, and breast cancer are the main serious adverse reactions of HRT, it seems now that only breast cancer remains a major concern, although still debated. Because of the very low basal incidence of cardiovascular events and thromboembolism prior to age 60, the added risks related to HRT in young, healthy postmenopausal women are insignificant or minute. Several high-ranking ObGyn and menopause societies recently updated their recommendations in regard with HRT, re-confirming, and re-legitimizing the use of HRT in symptomatic women while re-assuring the medical community and the public about the safety of treatment in the early menopause.

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THE AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS[1]

The following are citations from those 2008 statements: "... it seems clear from statistical analysis of previous large studies that young women in early menopause not only having no excess cardiovascular risk, but that benefit may be shown in the future ... given the powerful effects of estrogen therapy in relieving menopausal symptoms, we believe that physicians may safely counsel women to use estrogen therapy for the relief of menopausal symptoms."

THE NORTH AMERICAN MENOPAUSE SOCIETY (NAMS)[2]

"Recent data support the initiation of HT around the time of menopause to treat menopause-related symptoms; to treat or reduce the risk of certain disorders, such as osteoporosis or fractures in select postmenopausal women; or both. The benefit–risk ratio for menopausal HT is favorable close to menopause but decreases with aging and with time since menopause in previously untreated women."

THE EUROPEAN MENOPAUSE AND ANDROPAUSE SOCIETY (EMAS)[3]

"The main indication for HRT use in postmenopausal women remains the relief of menopausal symptoms.... Treatment significantly decreases bone loss and risk of osteoporotic fractures.... In 50- to 59-year-old women a window of opportunity for a benefit in cardiovascular disease displays a high plausibility."

THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY (ACOG)[4]

"Recent analysis suggest that HT may not increase

CHD risk for select populations of women who have experienced menopause recently.... Some women may require extended therapy because of persistent symptoms."

THE AMERICAN SOCIETY OF REPRODUCTIVE MEDICINE (ASRM)[5]

"Hormone therapy is the most effective treatment for moderate-to-severe vasomotor symptoms.... HRT is not indicated for the primary or secondary prevention of coronary artery disease events. At the same time, perimenopausal women treated with hormones have no increased risk for CHD."

THE INTERNATIONAL MENOPAUSE SOCIETY (IMS)[6]

"Achieving good quality of life is a prime target in menopause medicine, which is as important as prevention and treatment of diseases.... There is no argument that HRT is the first choice, and the best modality to improve quality of life and sexuality in symptomatic postmenopausal women.... The target population for initiation of HRT is usually women up to age 55.... HRT initiated at the early postmenopausal period in healthy women is safe.... Like all medicines, HRT needs to be used appropriately, but it is essential that women in early menopause who are suffering menopausal symptoms should have the option of using HRT." In a more recent publication, based on a workshop held in Pisa in February 2009, the IMS updated its recommendations in regard with HRT and CVD[7]: "HRT in women aged 50–59 years does not increase the risk of CHD in healthy women.... In the WHI study, estrogen-alone therapy in the age group 50–59 years was associated with significantly less coronary calcification.... Early harm (more coronary events during the first 2 years of HRT) was not observed in the early postmenopausal period.... The number of CHD events decreased with duration of HRT in both WHI clinical arms.... It is unclear at present whether there is an increase in ischemic stroke with standard HRT in healthy women aged 50–59, nevertheless, even if statistically increased, the low prevalence of this occurrence in this age group makes the attributable risk extremely small.... The risk of venous thrombosis is approximately two-fold higher with standard doses of oral HRT, but is a rare event in that the background prevalence is low in a healthy woman under 60 years of age.... The risk is possibly less with transdermal therapy."

The prescribing physician has always to weigh potential benefits and risks of treatment. Although a decision-tree for initiation of HRT would be of great help, it appears that there should be no concern associated with its use for at least 5 years in healthy postmenopausal women younger than 60. Continuation of therapy beyond age 60 or for a longer term depends on the assessment of the individual benefit–risk balance. A nice presentation of a decision-making model by Martin and Manson is very useful and helpful in this respect.[8]

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