How to Approach Treatment for Menopause

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In Canada, the median age of menopause is 51.[1] With the aging demographic there is a large cohort of women who will reach this decade and by 2026, 22% of the Canadian population will be over the age of 50.[2] While we often think of hot flashes and intractable vasomotor symptoms as the hallmarks of menopause, it should be noted that other symptoms starting in late peri-menopause and continuing onwards include depression, changes in cognition, aches and pains, sleeps disturbances, urogenital symptoms, sexual dysfunction and dry mouth.[3-5]

Meet Mary

Mary, 54, presents with intractable hot flashes and night sweats. She is a G3P3 non–smoker without any significant co-morbidities. She has tried many over the counter products, but none of them have helped her. She now has significant sleep interruption and feels that this is impacting on her ability to perform during the day.

Her mother has a history of osteoporosis. She would like some help, but she is under the impression that hormone treatment will give her heart disease and breast cancer.

In 2002 and then in 2004, the two arms of the Women's Health Initiative were stopped prematurely. The first reports on the Estrogen Progestin arm (EPT) stated that hormone therapy HT increased heart attack and stroke and subsequent reports emphasized the increased risk for breast cancer.[6]

Reports in the media quoted relative risks rather than absolute risks. There was a 29% increase in the risk of coronary heart disease, a 41% increase in the risk of stroke and a 25% increase in the risk of breast cancer. The Estrogen arm (ET) reported in 2004 also cited results as a relative risk with a 39% increased risk in stroke.[7]

How Do I interpret Relative Risk?

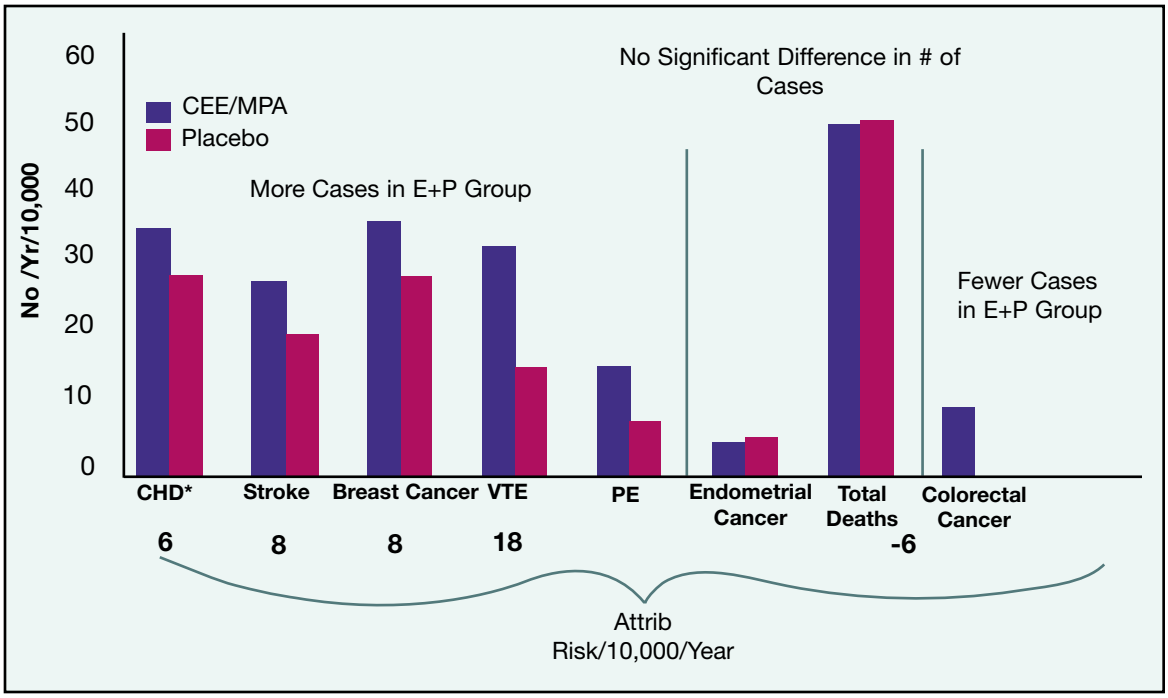
A relative risk (RR) is the ratio of risk between users and non users. Therefore a RR for breast cancer 1.24 means a 24% increase risk above baseline but remains meaningless unless you know the baseline risk.

Absolute risk means the baseline risk multiplied by the relative risk. In this case 30/10,000 is the baseline risk and the absolute risk in the EPT arm for breast cancer was 28/10,000 users.

The attributable risk in this case is eight cancers per 10,000 women per year, after five years of exposure. Figure 1 presents the data in absolute risks and benefits.

It is also important to know that the average age of the population was 63.6 years. We recognize that data from an older menopausal population likely does not apply to younger newly menopausal women. In the EPT arm, only 33.4% of the participants were younger than 60 years of age and more than 20% were greater than 70 years of age.[6] What then became important, was to look at the data in that group that primary care are prescribing to.

Figure 1: WHI E+P: Results Absolute Risks & Benefits



Women's Health Initiative Steering Committee. JAMA 2004;291:1701-12.

Secondary Analysis

One of the first secondary analyses to be reported looked at postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause.[8] What was found was that when women with a history of cardiovascular disease were excluded, the hazard ratio for coronary heart disease (CHD) by decade after menopause was a low of 0.78 for less than 10 years. The study concluded that for women less than 60 years of age who use HT for the first time in the menopausal transition for less than five years, they do not have increased risks for heart attack and stroke. The same can be said for breast cancer in this group. Dr. Jacques Rossouw, lead author of WHI studies was quoted by Time magazine, as saying: "If women start hormone therapy within the first 10 years after onset of menopause to treat hot flashes and night sweat and remain on the hormones for no more than four to five years, they can take the fear of heart disease out of the question."[9]

Similarly in 2006, an editorial by Dr. Collins put breast cancer into perspective by reminding physicians that when menopausal women present with distressing vasomotor symptoms, they can be reassured that short term (less than 5 years) use of combined EPT or estrogen (E) alone will have little appreciable effect on their personal breast cancer risk.[10] Longer use of combined EPT undeniably increases their breast cancer risk to a greater extent than exposure to E alone. He did point out that the level of risk remains similar to risks that many women accept through their lifestyles such as obesity, lack of regular exercise and daily ingestion of alcohol.

How would you counsel this patient? It is important to understand the data as it pertains to Mary at 54 and be able to offer hormone therapy as an option.

Take Home Messages

- Most complimentary alternative medications for vasomotor symptoms are little more than placebo[11]
- There is no increase in CAD in newly menopausal women starting HT
- The absolute risk of breast cancer with short term exposure of menopausal hormone therapy (MHT) compares favorably to risk related common lifestyle choices such as alcohol use, obesity and lack of exercise.

Women with risk factors for stroke should have those factors addressed

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