WHICH POSTMENOPAUSAL WOMEN SHOULD BE TREATED AND FOR WHAT IN THIS POST WHI ERA?

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Prior to the recent randomized clinical trials (RCTs), most of our practice was dictated from data from observational cohorts. These data were highly consistent and suggested many benefits of using hormonal therapy (HT) after menopause. In order to prove the benefits of HT, primarily for the prevention of coronary disease, several RCTs were designed. Most of these were secondary prevention trials, in older women with prevalent coronary disease. The largest of these, the trials of the Womens Health Initiative (WHI), included many older women, and because HT was initiated many years after menopause, it should not be considered as a primary prevention trial, as it was intended. These women were largely asymptomatic unlike the women observed in the cohorts providing the evidence for coronary benefit.

In reaction to the negative results of the RCTs in preventing coronary disease, and the possibility of more coronary events in the first year (early harm), the assumption has been made that HT has no prevention benefit. In that there was a modest increase in breast cancer in prior users after 5 years of use, even the protective effects against hip and other fractures in the trials were overshadowed by these findings. Although there were other findings in WHI, the above were the major factors influencing the assessment by some, that HT should not be used for postmenopausal women.

This assessment has been enforced by media coverage and WHI investigators who have extrapolated the results to the totality of HT, in all women, and for all types of HT. Thus many primary care physicians have determined that HT should not be used, even in symptomatic women. Although the RCT has been considered to be the gold standard in clinical research, there are several shortcomings which will be reviewed. The principal one for the purpose of this review is that the women studied in WHI were not the typical candidates for HT, that is, symptomatic women at the onset of menopause. Further only one particular type and dose of HT was studied. In depth analyses of the data from WHI show great consistency with the results of the older observational studies, and do suggest a possible benefit in younger peri- and early postmenopausal women. Other recent data have also reinforced these assessments.

Most recently, in response to the view held by many primary care physicians, that no postmenopausal women should be treated with HT, a conference was held which was comprised of various representatives from primary care societies from the US and Canada. This conference was sponsored by the American Society of Reproductive Medicine. The deliberations of this group have now been published. In brief, the statements suggest that healthy symptomatic women at the onset on menopause should be offered HT. In addition it is suggested that different doses and formulations ay be appropriate. Accordingly although all therapy should be individualized, consideration may be given to extending therapy beyond the often recommended time period of 2-5 years. Further, it may also be appropriate for some younger women to receive therapy primarily for the purpose of bone health and maintenance. These statements are similar to the deliberations of recent consensus meetings of other organizations such as the International Menopause Society and the North American Menopause Society, which will be reviewed.

Selected references:

