



INTERNATIONAL MENOPAUSE SOCIETY

THE SOCIETY FOR THE STUDY OF ALL ASPECTS OF THE CLIMACTERIC IN MEN AND WOMEN

Press Statement

ISSUED ON BEHALF OF THE INTERNATIONAL MENOPAUSE SOCIETY BY

Amos Pines, *President*, David Sturdee, *General Secretary* and

Martin Birkhäuser, *Treasurer*

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Hormone therapy and cardiovascular disease in the early postmenopause: the WHI data revisited

The publication of data from the Women's Health Initiative (WHI) study follows a certain pattern: first, we were given preliminary data^{1,2} which provided the basis for stopping the study before the end of its scheduled follow-up period; then we received separate and detailed manuscripts on cardiovascular endpoints in its two arms (combined conjugated equine estrogens (CEE) + medroxyprogesterone acetate in women with an intact uterus³ and CEE-only in hysterectomized women⁴); now, we are given a final manuscript⁵ which recycles the previous information, but with a focus on age groups and time since menopause, including analyses for the two arms combined.

The practical, clinical message that came out of the preliminary data was so loud and clear that it was immediately adopted by many health authorities like the US Preventive Services Task Force (USPSTF) and the European Agency for the Evaluation of Medicinal Products (EMA): the use of hormone therapy (HT) is dangerous at any age and therefore should be avoided, unless there is a substantial reduction in quality of life because of menopausal symptoms. Later on came the detailed articles on cardiovascular morbidity, which showed that the harm was actually confined only to older women, especially those recruited beyond the age of 70 years, and that there was even some cardiovascular benefit and reduced mortality in hormone users during the early postmenopause period. However, the apparent age-specific different risks, and the known fact that most women actually use HT only for a limited time in their late forties or early fifties, did not change the opinion of the health authorities in the US and Europe. Almost 5 years after the initial WHI publication comes the third and final chapter in the trilogy, saying that age matters in regard to the cardiovascular adverse effects of HT.

The International Menopause Society (IMS), in its Statement on HT in February 2004 (updated document released in February 2007), was the first organization to

Executive Director: Mrs Jean Wright
PO Box 687, Wray, Lancaster LA2 8WY, UK
Tel: +44 15242 21190 Fax: +44 15242 22596
e-mail: jwright.ims@btopenworld.com

emphasize the importance of age in determining the risk profile of HT. But the IMS brought it one step further by **taking a positive**, rather than a defensive attitude toward the use of hormones in the menopause. HT is indicated primarily for symptoms that are related to estrogen deficiency and menopause, and there is no reason to withhold this therapy from women who need it. The absolute numbers of women who could benefit or be harmed by HT for the age group 50–59 years in the WHI study, as compared to the placebo group, were in the range of 0–1 extra case per 1000 women per year of hormone use. This defines those events as ‘rare’, according to standard nomenclature.

Therefore, the IMS believes that healthy women in their early postmenopause period should not be concerned because of the ‘alleged risks’ of HT. The cardiovascular risks (coronary artery disease and stroke), attributed by WHI investigators to HT back in 2002, now seem irrelevant, at least for women who entered the study before the age of 60. The WHI data on breast cancer, which had initially a very alarming impact, were also re-analyzed recently. The WHI figures (from the controlled and observational studies) actually accord with previous data, reassuring women that there is no extra risk of breast cancer during the first 7 years’ use of standard doses of estrogen/progestin and for as much as 15 years of estrogen-alone therapy. The IMS also emphasizes the importance of dosage, route of administration and type of hormone as possible determinants of the risk–benefit balance.

In our view, the WHI study did, however, provide one service to menopause medicine after all. The debate and turmoil which ensued following the WHI studies showed that we cannot discuss ‘hormone therapy’ as one entity, that there is no ‘class effect’ for the adverse reactions of hormones, and that referring to ‘postmenopausal women’ as a unified and homogeneous population is wrong. The critical period for hormone use is during the menopause transition and the first years after the menopause. Indeed, hormone replacement therapy (HRT) is important in the early postmenopause to improve quality of life. Furthermore, there are enough data to support its use as part of an overall strategy in maintaining the health of postmenopausal women. On the other side of the equation, serious risks are negligible in the early postmenopause. The IMS recommends that decisions on the use of hormones, or on the continuation of HT, should be individualized, taken at the discretion of the well-informed woman and her health professional.

References

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