

Clinicians' Forum

In this issue we introduce a new feature called Clinicians' Forum. From time to time, the editors of Menopause Management field interesting clinical questions and dilemmas. In this forum our Editorial Advisory Board members, experts in a range of fields related to midlife women's health, tell readers how they handle these situations.

Question: "How do you manage patients who have gone off HT and have decided to resume it?"

Answers

From the skeletal perspective I assess their risk factors for osteoporosis and perform a bone mineral density (BMD) test. If they have significant risk factors and a T-score of -1.5 or lower, (and there are no other secondary causes for low bone mass, such as hyperthyroidism) I advise them on three potential strategies:

1. A lower-dose HT. I would apply my own interpretation on the Women's Health Initiative (WHI) in the context of this particular patient.
2. Raloxifene
3. Bisphosphonates

If the patient or I choose not to use HT, raloxifene becomes a consideration if the spine BMD is low but the hip BMD is normal. If she has a low hip BMD, I lean more in the direction of bisphosphonates (because of the later data regarding non-vertebral risk reduction). I do explain to the patient that her absolute 5- to 10-year fracture risk is low (but not zero, vis a vis the NORA data) and that I have no evidence of the ability of any of these agents to reduce 5- to 10-year fracture risk in

women 50-59 years of age. However, since BMD will most likely decline, and, as a believer in the concepts of reducing life-time fracture risk, I usually nudge the patients with risk factors and a T-score approaching -2.0 to begin treatment in addition to adequate calcium and vitamin D. I do point out as well, especially for younger postmenopausal women who begin bisphosphonates, that I will probably prescribe bisphosphonates for 5-7 years and consider a "honeymoon" period, monitoring BMD and biomarkers of bone resorption to decide when or if to reinstate treatment.

— Paul Miller, MD

I will answer this from the standpoint of symptom management (e.g., the patient has decided to resume HT based on vasomotor symptoms/hot flushes).

I review three issues with the patient:

1. The findings of the WHI. Specifically, in addition to the overall findings, I review absolute risks, and I review the patient population studied and the extent to which my patient is similar to that population.
2. Available alternatives to HT and the strength of the data. This includes no therapy, use of oral contraceptives, progestin-only therapy, venlafaxine, Neurontin, and available data on CAM, including relaxation response.
3. If the patient wishes to re-initiate HT following the discussion of the first two issues above, I start with low-dose HT. I emphasize that there are currently no available data proving that one HT regimen/type of hormone, etc., is superior to another.



Bruce Kessel, MD

— Bruce Kessel, MD

If they resume HT because of signifi-

cant vasomotor symptoms that occur off therapy, I manage the situation like we have always managed those of women on HT—regular breast exams and mammography, evaluation of unexplained bleeding, etc. They will have been informed of the risks as well as the symptomatic benefits.



Michael R. McClung, MD

I attempt to use the lowest dose of HT that adequately controls their symptoms. Bone density testing is performed according to current guidelines (including the NAMS position). Very rarely is there justification for adding a second drug to prevent bone loss in women who are receiving "full-dose" estrogen. For women whose symptoms are controlled on lower doses, BMD testing is appropriate if they would be candidates for testing off of HT. Combining low-dose HT and another bone loss prevention drug may be justified if evidence of bone loss is noted and if biochemical indices of bone turnover are high. Perhaps HT should be discontinued (similar to the raloxifene recommendations) if patients are to be immobilized for several days or more, such as after abdominal surgery. Statins are used if the patient meets the criteria for intervention, regardless of whether the patient is on HT.

— Michael R. McClung, MD

There are three scenarios in which a woman might want to resume hormone therapy after stopping it.

Case 1: A woman who is having symptoms of vaginal dryness.

I would advise the woman to use vaginal estrogen. There are many different formulations and, in my opinion, they do a better job of maintaining vaginal physiology than do oral estro-

gens. Oral estrogen is not an appropriate choice for vaginal symptoms.

Case 2: A woman who is having hot flashes.

If the only reason for wanting to resume hormone therapy is hot flashes, I advise first trying remedies other than estrogen. These include:

- Soy protein isolate (20 or 30 grams per day)
- Tincture of black cohosh (6 to 10 drops twice a day)
- A low-dose SSRI or SSNRI (these have great promise, and are especially appropriate if there is an element of depression, such as that associated with early morning waking).

If those non-hormonal remedies don't work or are unacceptable, I recommend restarting with unopposed low-dose estrogen

(0.3 conjugated estrogens or its equivalent). I advise that full effects may not be seen for 8-12 weeks. If that is adequate to relieve symptoms, I recommend adding long-cycle progestin (2 weeks of progestin every 3-6 months). In my experience the vast majority of women 55 years and older get adequate hot flash relief with this regimen. If the low-dose estrogen relieves symptoms I also would consider going even lower, to an ultra low-dose estrogen (1/4 usual doses).

Case 3: A woman who is concerned about osteoporosis.

The first issue to consider is whether she really has something to worry about. Most women are unnecessarily alarmed about osteopenia. I counsel each woman about her absolute 5-year fracture risk. For most women in their 50s, this risk is quite low. Therefore, they can afford to put off treatment for several years. If the risk of fracture is very high, I treat with a



Bruce Ettinger, MD

bisphosphonate; otherwise I would prescribe low- or ultra low-dose estrogen. Promising data are emerging, showing that ultra low-dose estrogen may be a good choice in this situation. It's low enough that it will protect against bone loss without stimulating the lining of the uterus; thus, progestin might not be needed at all!

— Bruce Ettinger, MD

In those patients who have gone off HT and have decided to resume, the presumption is that they are having sufficiently significant disruptive transitional symptoms (hot flashes, sleep disturbances, vaginal dryness). If they have a clearly visible endometrial echo that is thin and distinct (< 4-5 mm) with an intact hypoechoic zone surrounding it, in keeping with the concept of lowest effective dose for the shortest period of time possible, I often tell them to begin an oral estrogen (like conjugated equine estrogens 0.3mg or 17-beta Estradiol 0.5mg) every other day in an unopposed fashion. If the symptoms are not totally relieved after several weeks, I tell them to go to this dose every day. Recognizing that this is an extremely low dose of estrogen, if their symptoms are still not relieved I let them double this dose. Initially, the dose is doubled every other day for 2-3 weeks, after which it can be doubled every day, if necessary.

After 3 months of this unopposed estrogen I have them do a 12-day withdrawal with 200 mg of oral micronized progesterone before bed. I instruct them that this will most likely result in a withdrawal bleed. I then have them come in and repeat a transvaginal ultrasound. If they maintain a thin, distinct linear endometrial echo, we try a progesterone withdrawal at 4 months (again with ultrasound confirmation of maintenance of a thin echo). If this works, we will go to 5 months and then again at 6 months. In such patients in whom an endometrial echo is easily visible I can

thus reduce the total progesterone exposure to two, 12-day courses per year. If the endometrial echo is not as thin as expected, either monthly sequential progesterone or some form of continuous combined HT would be more appropriate.

The key to successful use of less than monthly progesterone in this instance is the use of transvaginal ultrasound in a patient with an easily visible endometrial echo to begin with. In those patients in whom an endometrial echo is not well visualized because of obesity, axial uterus, previous surgery, or multiple myomas, I would use a continuous combined preparation. I often tell patients to start initially every other day to see if this relieves their symptoms. If not, we will go to a dose every day.

— Steven R. Goldstein, M.D.



Steven R. Goldstein, MD

I usually go over their reasons for wanting to resume HT. Any reason is fine with me, as long as there is no absolute contraindication. I then recommend starting on a lower dose than they had previously used, and I will then go over different routes and different choices of progesterone and schedules.

I have recently started an interesting study. Before a woman starts ET or HT, we run a new screening test with the P-100 machine, which was recently approved by the FDA. The screening test gives an overview of increased or decreased arterial or venous clotting. If it shows increased clotting, we recommend that they not start therapy. If it is normal, we repeat it 8 weeks later to



Lila Nachtigall, MD

note any changes since starting therapy. We think this is helpful to the patient and the doctor. When we have enough data, we hope it will be helpful to all.

— *Lila Nachtigall, MD*

Patients referred to me all have sexual difficulties, so my advice to reinstate any HT would be limited to expected sexual benefit. I would leave HT for other needs to the referring physician.

If a woman has lost genital sexual responsiveness, or she has dyspareunia on the basis of atrophy, she is probably looking at long-term treatment. Therefore, I would suggest an estradiol vaginal ring (Estring) or estradiol vaginal tablets (Vagifem) rather than HT.

If, however, the problem is lack of well-being associated with poor sleep, emotional liability and other symptoms, and initiating systemic estrogen is discussed, I usually advise transdermal estrogen to minimize increased sex-hormone binding globulin with lowering of testosterone and estrogen. Oral progesterone, (Prometrium) also may be prescribed as necessary. The gel can be extremely gradually reduced to avoid a repeat of symptoms in a few years, if the advice regarding HT remains the same.

— *Rosemary Basson, MBBS, MRCP*

Do you have a clinical question or situation that you would like to pose to our panel of experts?

All queries should be submitted to the managing editor at: lmckeown@menopausegmt.com. To reach the managing editor by phone or fax, please call 732-282-0703 or fax to 509-463-0447. Please include your name, professional title and a phone number or e-mail address.

Suggested Reading for Informed Decision-Making

(continued from page 41)

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