Letter to the Editor

Moving Into the 21st Century

In his editorial ("Women's Health Initiative, Round 2—Is This the Opportunity to Clear the Air on Postmenopausal Hormone Use?" July/August 2004, page 8), Dr. Utian made a number of thought-provoking points concerning the current state of affairs vis-a-vis hormone therapy. He clarified, again, what the WHI means and what it does not, and reviewed the important information it has to offer, as well as its significant limitations. The eyebrow-raising results of the estrogen-only arm of the WHI are referenced. He deplores, and rightly so, the fact that those results have been largely ignored by medical pundits and the media. And finally, Dr. Utian points out that, "Significant damage has resulted from the way the WHI results were originally reported," and, sadly, "Many medical professionals have lost respect for the WHI writing groups for a perceived bias in the manner in which the data have been written and reported."

I entirely agree with Dr. Utian. However, I believe that we in medicine are having the wrong conversation. We are discussing a type of hormone and a method of administering it that was novel and "modern" 50 or more years ago! As a clinician, I need answers to some unsettling questions.

- If one can provide estradiol (the primary ovarian estrogen) to patients, what benefit is there to providing something else?
- We know that oral estrogen stimulates hepatic production of clotting factors, thus increasing the risk of venous thromboembolism, myocardial infarction, and stroke; increases sex hormone-binding globulin, thus decreasing bioavailable estrogen and testosterone; increases the production of C-reactive protein; and increases the risk of gall bladder disease. And we know that transdermal estradiol does none of these things. The question becomes, why do we continue to prescribe oral synthetic estrogens? And why are we spending so much time and energy studying, analyzing and arguing about oral conjugated equine estrogens?
- A similar line of questioning could and should be made regarding medroxyprogesterone acetate (MPA), which reverses many of the positive metabolic and cardiovascular benefits of estrogen, and markedly increases the mitotic activity in breast tissue.
- Given the fact that natural micronized progesterone and other progestins are available, which do not carry the same negative baggage as MPA, why in the world do we continue to use it, analyze it, and argue about it?

We will never "get it right" regarding hormone therapy/estrogen therapy until we bring it into the 21st Century. Ovarian failure (AKA menopause) must be recognized as the endocrinopathy that it is. The condition must be diagnosed, treated, and monitored using the same state of the art technology that the endocrinologists employ for their diabetic and hypothyroid patients. "One size fits all" methodology should be relegated to the medical archives along with the practice of administering ancient hormones orally.

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Dr. Utian's reply:

I am always pleased when my editorials stimulate comment and opinion. Dr. Michael Born, from the Mayo Clinic Jacksonville, presents some thought-provoking questions that do call for discussion and answers. I can only hope that his challenge for more directed research is met. Readers are invited to respond with additional comments, and the entire topic could be considered for a debate at a future NAMS annual meeting.

Correction

In the July/August issue of *Menopause Management* we inadvertently spelled one of the participant's names incorrectly in our Clinicians' Forum feature. The correct spelling of the participant's name is Laszlo Sogor, MD, PhD. *Menopause Management* apologizes for the error.