

From the EDITOR



Dr. Wulf H. Utian, consultant in women's health and reproductive endocrinology, has served as Editor-in-Chief of *Menopause Management* since its inception in 1988. The Arthur H. Bill Professor Emeritus of Reproductive Biology and Obstetrics and Gynecology, Case Western Reserve University School of Medicine, he is also Consultant, Obstetrics, Gynecology and Women's Health Institute at the Cleveland Clinic, and Executive Director of The North American Menopause Society (NAMS). He is Chairman of the Advisory Board of Rapid Medical Research, Cleveland. He received his medical degree from the University of Witwatersrand, Johannesburg, South Africa, and his PhD from the University of Cape Town, South Africa, and is a Fellow of the Royal and American Colleges of Obstetricians and Gynecologists, as well as the International College of Surgeons. In 2007 he earned the DSc(Med) degree from the University of Cape Town, its highest degree and only awarded 11 times in over 100 years.

A pioneer in Women's Health issues and menopause research, in 1967 he established the Groote Schuur Menopause Research Clinic in Cape Town, the world's first such clinic. He was one of the three original founders of the International Menopause Society in 1976, of which he is Honorary Past President, and founded the North American Menopause Society in 1989.

He is the recipient of numerous national and international awards and research grants, and is still an active investigator with multiple grants. Dr. Utian has written over 200 papers related to the reproductive system in women and has authored five books on menopause and its effects on women. He is editor of *Menopause: The Journal of The North American Menopause Society*.

Working with What You Have, Not What You Wish For

Cape to Cairo

Recently I had the opportunity to investigate menopause management at the polar ends of Africa—Egypt in the North and South Africa at the bottom tip. My overwhelming conclusion is how wasteful we are of healthcare dollars in the US, and how blessed we are to have all that we have at our disposal. Also striking is that we really do exist in a global environment—with medical news traveling over the Internet like wildfire—and that ill-considered statements made to the North American media can have consequences way beyond that envisaged by those with loose tongues. However, this editorial is about observations in Africa, not North America, although I will comment on lessons we can learn from others less fortunate than ourselves.

South Africa

South Africa is a rainbow nation. Overendowed with natural beauty, wildlife diversity, a wealth of commodities, minerals, metals and gemstones, the country is both developed world and developing world in one, with both staring each other in the face.

On the one hand, there is unbounded optimism, explosive commercial and industrial growth (the new national bird being the 'building crane') and a reinvigorating infrastructure as the population looks forward with great excitement to hosting the 2010 World Soccer Cup. Tax revenues have never been higher and the country has a surplus with a positive balance of payments.

On the other hand, there is excruciating poverty, illegal immigration from the rest of Africa that has almost doubled the population and brought AIDS and TB in its wake, and rampant unemployment, estimated at up to 80% in some areas. More than 1,000 people die every day from AIDS-related complications, and estimates of the HIV-infection rate

vary from 15% to 20% of the total population. Despite government blindness to the problem, led by a President in denial, a significant percentage of healthcare dollars is being diverted to treat the problem, and less becomes available for everything else. There are power disruptions as power generation falls behind the rate of development. Crime is rampant and inexplicably violent.

Against this backdrop, menopause is a non-event for the bulk of the population. Health care to the upper and middle classes is, through private medicine, on a par with that in much of the rest of the world, except perhaps at the top-end of tertiary care. Health care for the poor is at the bare minimum. Even at the tertiary academic institution level there are financial limitations—one working osteodensitometer for one entire major academic hospital, no operative laparoscopy equipment at another.

Menopause is managed at North American levels for the privileged; management is essentially non-existent for the disadvantaged. Results from studies like the WHI had a major impact in South Africa on the upper end of care, with the international pharmaceutical industry sometimes inexplicably extrapolating American perceptions to the developing world.

The remarkable thing about all of this is that health providers at all levels work exceptionally hard and achieve outcomes beyond the level of technology or drugs to which we in the US have become so “addicted.”

Egypt

Although I had less opportunity and time to explore Egypt, I learned a lot. The country also exhibits marked socioeconomic extremes, and a diverse population quite different from that of South Africa. Enjoying the warm hospitality of my Egyptian hosts at the Egypt Menopause Society in Alexandria, I was quite stunned to hear of the negative impact that the July 2002 termination of the EPT arm of the WHI has had on menopause management in Egypt.

Health reimbursement agencies, largely governmental, stopped listing all estrogen and

progestogen products as available pharmacotherapy. One combined estradiol-norprogestogen product and tibolone were left as the only options available. With a market not seen as worth pursuing, the international pharmaceutical companies withdrew their products, so drugs are not even available for the privately insured or self-payers. Women with vasomotor symptoms have literally no alternative than to sweat it out or try the herbal products for their largely placebo effects. I believe I was more prescient than I anticipated when I castigated the NIH investigators at that time for the “inhumane” way they presented their exaggerated conclusions in 2002.

Against this backdrop Egyptian physicians and other health providers do the best they can to educate and treat the population with their limited resources.

Lessons Learned

Obviously, women world-wide experience menopause. But the menopause experience differs markedly—globally, culturally and socioeconomically. The global-information era results in rapid dissemination of study findings. A bulk of the interpretation, position statements, guidelines and response from the medical-industrial complex emanates from Europe and North America. Unfortunately, what may appear to be obvious, self-evident or a sensible response in Europe or North America can turn out to be inappropriate for Africa, or even to have negative consequences.

We in North America are generally fortunate to have multiple options at our disposal. But we ought to learn from the African experience that our wasteful use of technology without clear indications, or over-prescription of unnecessary drugs, will simply drive up healthcare costs without concomitant benefit to the health of the over-treated population.

A fine balance must be the objective of all, wherever we practice our skills.

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