OBG MANAGEMENT

The legacy of WHI? Confusion and apprehension, possibly

A survey finds widespread fog over the Women's Health Initiative. The forecast isn't for clearing skies.

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Patients, physicians, the media—in other words, just about everybody—are confused about the findings of the Women's Health Initiative (WHI),[1] according to a recent survey.

Why? And is this state of confusion permanent? Most of all, how are your colleagues dealing with that lack of clarity in their practice?

Questions put to your peers

In early September, the Hormone Foundation, public education affiliate of the Endocrine Society, released the results of a national survey of doctors involved in menopause care.[2] The survey was designed to gauge the effects of the WHI on clinical practice and was conducted on behalf of the Hormone Foundation with financial support from Novogyne Pharmaceuticals. Among the findings:

- Only 15% of the physicians believe their patients' perceptions of the risks of hormone replacement are accurate
- Only 18% of physicians—this includes ObGyns—report that they themselves have "no confusion at all" about the findings of the WHI
- 83% of physicians believe their patients are as confused now as when the WHI findings were released in 2002—or more so
- 81% of physicians believe the media are as, or more, confused as when the findings were released.[2]

So what is the state of menopause care today, 5 years after the WHI made its splash?

"There's a lot of noise," says Nanette Santoro, MD, director of reproductive endocrinology at Albert Einstein College of Medicine, Bronx, New York, and a member of the Hormone Foundation's Women's Health Task Force. "And there have been a lot of arguments back and forth."

What can a physician do to achieve a little clarity?

Staying up-to-date on the clinical practice guidelines is the best way to combat confusion, Dr. Santoro says. A good starting point, she notes, is the Hormone Foundation Web site (Hormone.org), which links to the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine (ASRM), and the North American Menopause Society (NAMS), all of which publish reliable guidelines.

"I think that's probably the best way of keeping abreast of what's happening now if [physicians] are not really deeply into menopause care," she says. "But getting filtered information, or getting information from pundits or from the media is, I think, more hazardous because the quality of that information can be variable. And the days of getting your information from pharmaceutical represen-

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Misinformation, frustration over WHI findings run high among the public, survey reveals

During the spring of this year, 404 physicians responded to a survey about menopause management in the 5 years since the first Women's Health Initiative (WHI) findings were published.[1] The physicians represented the following primary care specialties: endocrinology, obstetrics and gynecology, internal medicine, and family and general practice. To qualify for the survey, each clinician had to devote at least 70% of his or her working day to clinical practice and see at least two women each month with menopausal symptoms.

The survey was conducted by Richard Day Research of Evanston, Illinois, for the Hormone Foundation. To review the full survey, visit **www.hormone.org/pdf/meno_survey_qa.pdf.**

Here are highlights:

Primary medical specialty	
Family or general practice	29%
Internal medicine	27
Obstetrics and gynecology	40
Endocrinology	4
Percentage of patients with menopausal symptoms currently taking HT	37%*
Percentage reluctant to start HT	42%*
Percentage that specifically asks to be put on HT	19%*
Percentage that specifically asks not to be put on HT	29%*
For moderate or severe menopausal symptoms, do you think of HT as a:	
first-line treatment?	74%
second-line treatment (or third, fourth, etc)?	26%
Which of the following are very important to you when deciding whether to prescribe HT for your patients?	
Severity of symptoms	81%
Patient's personal medical history	77
Risks of HT	61
Range and specific types of symptoms	50
Patient request	44
Age of patient	33
Prevention of osteoporosis	24
Which risks concern you about prescribing estrogen–progestin therapy for menopausal symptoms?	
Blood clots	88%
Breast cancer	87
Coronary heart disease	74
Stroke	73
Dementia	14

tatives are long gone in this area because, again, it is not sufficiently reliable."

"Afraid of hormones"

In the years since early WHI findings were published, Anita L. Nelson, MD, has not noticed confusion so much as fear among her patients. Dr. Nelson is professor of obstetrics and gynecology at the David Geffen School of Medicine at UCLA in Los Angeles.

"I think the things that are concerning to patients by and large are breast cancer and, in women who have done more reading on it, some of them are concerned about dementia," Dr. Nelson says. "But by and large, other than those focused issues, it is hormones that patients are afraid of, and they sort of wave their hands in this global aura of 'badness' that they're afraid of."

One reason is the WHI. "Obviously that contributed to it," she says. But a bigger cause of fear among her patients, a large percentage of whom are referred, is the fact that "their physicians have been taking them off of therapy. They're not offering it," she says, "or they are putting up a sort of barrier by saying, 'You have to go see Dr. Nelson before you can start taking those medications.'"

The problem doesn't end there, she adds. "The sad thing is that they are by and large not offering them alternative medications while they're waiting for the transition—or if they are, sometimes they are actually giving them hazardous

What do you see as valuable about estrogen–progestin therapy for menopausal symptoms?	
Relieves hot flashes	100%
Relieves vaginal dryness and painful intercourse	92
Improves sleep problems	88
Prevents bone loss	84
Reduces depression and mood changes	68
Reduces risk of colorectal Ca	37
Prevents cardiovascular disease	16

Which risks concern you about prescribing estrogen-only therapy for menopausal symptoms?	
Blood clots	86%
Breast cancer	71
Stroke	68
Coronary heart disease	51
Dementia	8
Uterine cancer	4

What do you see as valuable about estrogen-only therapy for menopausal symptoms?	
Relieves hot flashes	99%
Relieves vaginal dryness and painful intercourse	94
Improves sleep problems	84
Prevents bone loss	81
Reduces depression and mood changes	71
Reduces risk of colorectal Ca	35
Prevents cardiovascular disease	19

In your view, are the risks of HT understated, overstated, or accurately perceived by the following groups? *Means, based on the following: 1 = understated 2 = accurately perceived 3 = overstated*	
Media	2.9 (Mean)
Patients	2.7
Family or general practitioners	2.4
Internists	2.4
ObGyns	2.0
Endocrinologists	2.1

As of today, how much confusion do you feel there is about the WHI findings? *Means, based on the following: 1 = not confused at all 2 = not very much confusion 3 = some confusion 4 = great deal of confusion*	
For you personally	2.3 (Mean)
Media	3.7
Patients	3.7
Family or general practitioners	3.1
Internists	3.0
ObGyns	2.5
Endocrinologists	2.5

*Mean

drugs. One of my favorite things is when patients who have high blood pressure are denied estrogen but are given Bellergal [ergotamine, belladonna alkaloids, and phenobarbital], which has a vasoconstrictive medication in it."

"We do want folks to review the data," she says, noting that ObGyns are "true believers" and unlikely to quit prescribing hormone therapy (HT). It is the internists and the family medicine physicians "who still have significant misgivings about the safety of these therapies in recently menopausal women."

Joanna Shulman, MD, agrees. She is associate professor and director of the medical student clerkship in obstetrics and gynecology at Mount Sinai School of Medicine in New York City.

"The internists I work with or that my patients see tend to be terrified of hormone therapy. So I think they tend to discourage their patients."

Mea culpa, anyone?

Confusion over the WHI is an issue for another prominent ObGyn—Wulf H. Utian, MD, PhD, editor-in-chief of *Menopause Management* and executive director of NAMS. In an editorial in the September/October issue of *Menopause Management*, Dr. Utian faults the National Heart, Lung and Blood Institute of the National Institutes of Health (NIH) for starting a "firestorm in women's health" by publicizing the abrupt termination of the estrogen–progestin arm of the WHI study.[4]

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Utian notes that he pointed out his dismay over the WHI way back in 2002, when he wrote, again in *Menopause Management*: "The manner in which the study was terminated was poorly planned, abrupt, and inhumane. Predictably, the media response was enormous, ranging from thoughtful to sensational. Panic was caused, numerous women discontinued therapy, and women and their health providers alike have been thrown into a state of confusion, distrust, and quandary of what to do next."[4]

Bruce Wineman, DO, concurs. Although he retired from practice as a reproductive endocrinologist at the Marshfield Clinic in Marshfield, Wisconsin, shortly before the WHI findings were first published, he maintains his license and stays active in the ASRM. "The worst part of the WHI is that they got so much press with it," he says, "and that the group of women that they chose was exactly the group of women that was going to have the maximum amount of negative effect."

Utian believes a mea culpa is in order. "There are reams of important and pertinent data coming out of all the substudies of the WHI," he writes. "For these to be accepted with confidence, it is well time for the NIH to bring all their WHI investigators together to develop a transparent and comprehensive summary of their results. It is also time for the WHI investigators to cease their stubborn defense and misrepresentation of their 2002 data, and to return to scientific integrity."[3]

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—Bruce Wineman, DO

Same view in the trenches

Mohamed Mitwally, MD, spends 90% of his day in clinical practice at the Reproductive Medicine and Fertility Center in Colorado Springs, Colorado. He estimates that roughly half of his perimenopausal and menopausal patients troubled by vasomotor and other symptoms are currently on HT. Since the WHI's initial findings were published, Dr. Mitwally has "absolutely" had to spend considerably more time educating his patients—"and educating physicians," he says. His patients are reluctant to take HT because of press attention to the WHI. And other physicians are reluctant to give HT because they understand that the WHI is a randomized trial "and so don't question it."

Dr. Mitwally blames two entities for this state of affairs. "The credit goes to the WHI," he says. "They did a wonderful job of screwing people up" with a "very poorly designed study." There is also "a lot of misinformation," thanks to the media. "They just want to get any bad news and magnify it."

In the wake of the WHI, Dr. Mitwally recalls, "it was like chaos" for 3 or 4 years—and there is still a lot of confusion.

Nevertheless, when a patient complains of moderate or severe vasomotor symptoms, Dr. Mitwally usually turns to HT as a first-line therapy. "It is excellent for these patients," he says, although he emphasizes that "every patient should be managed separately."

"I think the most important thing in the whole issue of HT is that physicians should leave these patients to subspecialists," he says, by which he means reproductive endocrinologists and ObGyns with expertise in menopause care.

Plethora of products

One of the more surprising impacts of the WHI is the array of estrogen products now available. Because the WHI was expected to confirm observational data that suggested that estrogen reduced the risk of cardiovascular disease, the number of products in development skyrocketed.

"I think something like 35 compounds got approved while the study was under way, so there is more stuff than ever," says Dr. Santoro. "But that actually was attractive to some people in the survey and has been found to be attractive to patients because it does give

more choices the way things are going, which is toward more of a customized approach to giving hormones."

Raksha Joshi, MD, chief medical officer and medical director of Monmouth Family Health Center in Long Branch, New Jersey, a federally funded qualified health migrant center (FQHC), says the broader array of estrogen products adds to the time she spends educating patients.

"We do tell them about the other forms of estrogen and their bioeffectiveness and what they would achieve for this particular woman," she says.

For patients who report moderate to severe menopausal symptoms, Dr. Joshi considers estrogen a first-line therapy, but recommends concurrent lifestyle changes.

"Of course, the WHI has not disappeared," she says, so concerns about risks remain. "But in the transition, when the symptoms are paramount, I would tailor the treatment to what the woman wants to get out of it. But I think it is important for the woman to understand that this is not a panacea and that it will not cure all her symptoms. Therefore, lifestyle changes and getting hormone replacement therapy should go concurrently."

As for alternative therapies, women are increasingly likely to ask for or about them.

"We talk about that," says Dr. Shulman. "If they're miserable and they don't think they're appropriate candidates for estrogen, we talk about other things. Or some people will come in and say, 'I don't want to take estrogen. Is there anything else?'"

In these cases, Dr. Shulman recommends a number of options. "Effexor has shown some benefit, apparently, in the literature," she says. "And I mention black cohosh, which is in a lot of popular over-the-counter type remedies and which, apparently, recently was shown to have possibly some benefit." Of course, "there's a tremendous placebo effect with all of these," she observes.

"And then I suggest things like getting plenty of exercise and eating sensibly, and I take my other patients' recommendations. One patient told me that she takes a cool shower every night before going to bed and finds it beneficial, so I don't know—it's one of those 'can't hurt, might help' things."

Estrogen got a "bad name"

When she looks back over the past 5 years, Dr. Shulman thinks the WHI's effects have been destructive in many ways.

"I think the most important thing is that [HT] got an undeservedly bad name when the Women's Health Initiative was published," she says. The WHI "really did a disservice for women who could benefit from [HT] enormously and weren't really at risk—not just for vasomotor symptoms but also emotional lability, depression, increased anxiety, things like that."

"I have many women for whom I did prescribe estrogen, and they're still on it and will probably never get off because they think that I saved their lives. So for women to be scared unfairly by the Women's Health Initiative and to have to suffer with vasomotor and emotional problems is really a disservice."

Dr. Wineman agrees, and points out that even some professional organizations are beginning to reconsider the initial WHI findings. "They're beginning to say, 'I really believe that there are certain women who would probably benefit a great deal more than we once thought, and perhaps we jumped to some wrong conclusions.'" ■

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—Joanna Shulman, MD

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