Expert: Don't Write Off Low-Dose HT for Bone

BY COLIN NELSON
Contributing Writer

DEDHAM, MASS. — Has the backlash against hormone therapy gone too far? Should doctors take yet another look at the evidence and find selective uses for HT that maximize its benefits and minimize its risks?

The answer to both questions is yes, according to Isaac Schiff, M.D., professor of gynecology at Harvard Medical School and chief of the ob.gyn. service at Massachusetts General Hospital. At a symposium on bone health sponsored by Boston University School of Medicine, Dr. Schiff recommended discussing HT with select patients as a double-duty medication for bone health and menopausal symptoms.

"Just as the pendulum went too far in the early 1990s—when all the retrospective studies suggested estrogens prevented heart disease, osteoporosis, Alzheimer's disease—after the Women's Health Initiative [WHI] the pendulum swung way too far to the other side, suggesting that estrogens are too risky," Dr. Schiff said.

News reports about the WHI trial tended to focus on the risks of HT and to overlook the benefits. Estrogen therapy is "certainly one of the most potent agents we have available" for preventing hip, vertebral, and wrist fractures, he said. "The problem when dealing with estrogen, of course, is all the other risks that have been identified."

When the National Institutes of Health announced the landmark findings of the WHI trial, HT prescriptions declined precipitously. "Overall health risks [of HT] exceeded benefits," investigators concluded after they stopped the trial early (JAMA 2002; 288:321-33).

According to the WHI findings, therapy with estrogen plus progestin was associated with a major increase in the relative risk of several serious health problems. For example, it was tied to a 29% increased risk of coronary heart disease (CHD), a 41% increased risk of stroke, a twofold increased risk of pulmonary embolism (PE), and a 26% increased risk of breast cancer.

Many observers found the absolute risks less alarming, however. According to the WHI data, if 10,000 women took estrogen plus progestin for 1 year, there would be an excess risk of seven more CHD events, eight more strokes, eight more PEs, and eight more invasive breast cancers. There would be no extra deaths. Among women with no uterus taking estrogen only, there would be 12 more strokes (JAMA 2004;291:1701-12).

HT would also confer some benefits among those 10,000 women. There would be six fewer colorectal cancers and five fewer hip fractures.

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Among women with no uterus taking estrogen, there would be six fewer hip fractures. The WHI did not state whether HT would relieve menopausal symptoms.

Dr. Schiff termed the findings on fracture prevention "quite impressive." Citing the reductions in relative risk, he noted that women taking progestin plus estrogen had a 29% reduction in lower forearm fractures and a 33% reduction in hip fractures.

In the estrogen-only arm of the study, there was a 39% decrease in hip fractures and a 38% decrease in vertebral fractures.

Studies of other drugs designed to prevent and treat osteoporosis have had difficulty showing a reduction in hip fractures. The effect of medium-dose HT on fractures "is equivalent to bisphosphonates," he said.

Hidden amid the WHI data is information on the impact of low-dose estrogens that might help clinicians balance benefits and risks of HT therapy, Dr. Schiff suggested.

At low doses, estrogens increased bone mineral density by 2.4% and 3.9% at the femoral neck and spine, respectively.

Dr. Schiff did not provide evidence from WHI to show that low-dose estrogens were associated with fewer fractures, however.

As the NIH noted in a 2000 consensus statement on osteoporosis, improvements in bone density do not always translate to a decrease in fractures. "The risks for osteoporosis, as reflected by low bone density, and the risks for fracture overlap, but are not identical" (NIH Consens. Statement 2000;17[1]:1-36).

Still, Dr. Schiff said that there is enough evidence to support prescribing low-dose estrogen for the prevention of devastating hip fractures.

Citing data on low-dose OCs in relatively young, healthy women, Dr. Schiff said that, in theory, lower doses of estrogen should yield fewer health risks in the middle-aged and elderly. And "even very-low-dose estrogen is quite effective at maintaining bone density."

That said, patients must be thoroughly informed about their individual risk profile regarding HT so they can weigh their risks and benefits and make informed decisions.

"A woman of age 50 is not worried about a hip fracture at age 80. She is worried about the potential for breast cancer at age 55," Dr. Schiff said.

And the data on estrogens and breast cancer are mixed. Some studies show an increased risk, some do not. "I tell my patients I personally have major concerns about the long-term risk" of breast cancer associated with estrogen therapy, he said.

Dr. Schiff said that he prescribes estrogens for the minority of women with very severe hot flashes. For vaginal dryness topical estrogen therapy can help. Very-low-dose estrogen (e.g., an estrogen patch with 0.25-mg Premarin or 0.5-mg estradiol) will also help with urogenital symptoms. ■

Surveyed Rheums Diagnose, Treat Osteoporosis Aggressively

WASHINGTON — Endocrinologists and rheumatologists are the most aggressive specialists when it comes to the screening, diagnosis, and treatment of osteoporosis, Tiffany Karas, M.D., and her associates reported in a poster at the annual meeting of the American Association of Clinical Endocrinologists.

Of 122 physicians who responded to an electronic survey, there were 27 geriatricians, 25 endocrinologists, 23 obstetrician/gynecologists, 20 rheumatologists, 19 primary care physicians, and 8 orthopedic surgeons. In screening for osteoporosis, 94% of the entire group said they would order a dual-energy x-ray absorptiometry (DXA) scan for a patient with two or more risk factors, said Dr. Karas and her associates, of Loyola University Medical Center, Maywood, Ill.

The risk factors most likely to prompt DXA scanning were height loss (93%), chronic prednisone use (89%), and menopause (86.6%). Among the risk factors least likely to prompt DXA were low testosterone (60%) and vertebral deformities (74%) in an elderly male patient. In general, all physicians surveyed were much less likely to order DXA for men with indications than for women. "This is one area where continuing education about osteoporosis may improve patient care," the investigators noted.

Endocrinologists and rheumatologists were more likely to order DXA given any risk factor or patient scenario than were the other specialties, while orthopedic surgeons were the least likely. Rheumatologists were the most likely to initiate treatment in patients, followed by endocrinologists, geriatricians, primary care physicians, and ob.gyns.

Alendronate and risedronate were deemed the most efficacious treatments by more than 98% of all physicians, while calcium/vitamin D and calcitonin were thought to be the least efficacious. Overall, patients were more likely to be screened, diagnosed, and treated for osteoporosis by female physicians who had been in practice more than 6 years and who practice in urban, academic settings, Dr. Karas and her associates reported.

—Miriam E. Tucker

Bisphosphonate 'Adherence Gap' Calls for Positive Reinforcement

BY BRUCE JANCIN
Denver Bureau

VIENNA — Most physicians remain unaware of the factors that motivate women to stay on osteoporosis therapy, according to the results of a new survey released by the International Osteoporosis Foundation.

As a result of this physician/patient disconnect, 85% of surveyed physicians reported having patients who have discontinued bisphosphonate therapy without consulting them, and 71% still didn't know why their patients had stopped, according to the findings, which were presented at the annual European congress of rheumatology.

The goal of the survey was to shed new light on the poorly understood adherence gap in osteoporosis therapy. "Adherence gap" is a term used to describe the phenomenon whereby nearly 80% of women who take a once-daily bisphosphonate and more than half who take a once-weekly agent discontinue therapy within the first year.

The telephone survey, conducted earlier this year in five Western European countries, involved 500 primary care physicians and rheumatologists and 502 postmenopausal women with osteoporosis. Of the women surveyed, 38% were previously on a bisphosphonate but had discontinued it; the rest were currently on a bisphosphonate.

Overall, 64% of women cited a positive motivating factor—such as the desire to do something to help themselves, or a wish to stay independent—as their primary reason for staying on bisphosphonate therapy. But only 13% of physicians said they motivated patients by explaining the benefits of bisphosphonates. Instead, the majority of physicians indicated they emphasized the negative consequences of nonadherence. And 86% of physicians said they were unsure about how best to encourage patients to continue on therapy.

Women cited drug side effects and the inconvenience of bisphosphonate therapy, especially the need to remain upright after taking the oral medication and the necessity of fasting before and after taking the drug, as the main reasons for discontinuing treatment. But lack of understanding on the patient's part was the reason for nonadherence most often cited by physicians. And they had a valid point: Of the women surveyed, 27% said they thought their fracture risk was the same regardless of whether they took their medication. Another 17% didn't think their bisphosphonate had any benefit at all. Also, 51% of women couldn't recall being advised on how long to stay on their medication.

The congress was sponsored by the European League Against Rheumatism. The International Osteoporosis Foundation survey was funded by an unrestricted educational grant from GlaxoSmithKline and Roche. ■

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