From Our Readers …

The Permanente Journal,

I'm disappointed that an officially sponsored case vignette is so at odds with the values of Permanente medicine (Blue Sky Care Delivery 2015, Part 1. *The Permanente Journal* 2003 Fall; 7(4):47-50). First of all, the medical care is questionable. The computer recommends a home strep test and, when it's positive, offers antibiotics vs a watch-and-wait option. The most important consequence of strep throat, rheumatic fever, isn't mentioned. Second, the care isn't cost-effective. Why do a test, unless the result will influence treatment? Incidentally, I hope having to buy a computer doesn't become a financial barrier to care.

Finally, Dad is presented as a whining oaf. If Mom were presented as a "typical woman driver," you'd get letters about sexism. Well, this is sexist too, and cultural sensitivity shouldn't exclude men. I know this wasn't meant to be taken too seriously, and I'll try to keep an open mind about the Blue Sky—but not so open my brain falls out!

Scott McKenzie, MD
Internal Medicine
Panorama City

—Reply

The focus for our clinicians and other visionaries at the Phase 1 meeting was the manner and the modality of the care provided to Tommy and his parents and not the actual "clinical guideline" per se. That being said, if you read on to the second bullet on the same page, you will see that Tommy's "pediatrician's 'Web site' and the Pediatric Department's protocols guided the care provided to Tommy." We would all assume that KP protocols in 2015 will be guided by the same care, cost-effectiveness principles and attention that our KP clinicians provide today with the added dimension of providing as much information to patients to assure their engagement in the decision-making process. In the interest of time and message brevity, our visionaries only included elements relevant to the broader Care Delivery Vision, with the assumption that the reader/audience would understand its illustrative nature. Thanks for your interest in the Blue Sky Vision.

Terhilda Garrido, Senior Director
Clinical Systems Planning and Consulting
terhilda.garrido@kp.org

The Permanente Journal,

I recently came across an article by Eric Blau, MD (In the Shadow of Obesity. *The Permanente Journal* 2000 Summer; 4(3):47-55) while doing a Google search on Pararescue. The note by JP (400 lbs) broke my heart, especially as I am completing training in the VA as a psychiatrist and understand the heart and soul of JPs, having been blessed with their friendship. Please express to him that his brothers are available to support him through www.pjassn.org. Also, I understand that there might be some consideration of divided loyalties, but many VAs have a particular interest in traumatized soldiers—I know my VA would take him in with open arms. If you can find JP, you can give him my e-mail if it would be any help. He's already earned any services we can provide for him.

Regina Bahten, DO
University of Nevada, Reno
VA Sierra Nevada Health Care System

Greetings,

I enjoyed reading about the National Weight Control Registry, *(The Permanente Journal* 2003 Summer; 7(3):34-7) but I noticed an error. When you spoke of keeping off 30 pounds for one year, it was referred to as 6.6 kg. Thirty pounds equates to 13.6 kg, not 6.6 kg.

Regards,
Gale Carey, PhD
University of New Hampshire, Durham, NH

—Reply

We are pleased that you enjoyed reading this article and

Let us hear from you.

We encourage you to write, either to respond to an article published in the *Journal* or to address a clinical issue of importance to you. You may submit letters by mail, fax, or e-mail.

Send your comments to:
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Dr Jacobson,

I appreciated your attempt to interpret the Women's Helath Initiative (WHI) for some of the non-gynecologists who don't have time to keep up on all the current bantering about the WHI results (A Perspective on the Women's Health Initiative Findings. *The Permanente Journal* 2003 Fall;7(4):62-4). However, unfortunately, I think you fell into the trap that so many have—including the WHI investigators. And that is extrapolation. Your comment of "Asymptomatic perimenopausal women balancing the potential benefit and risk of hormone therapy (HT) might weigh "a 41% increased risk of stroke after one year of using E+P" or "1.29 times more likely to have a stroke" differently than "a 97.1% chance (risk) of not having a stroke after ten years of using E+P," etc. Please be reminded that the WHI specifically excluded peri- and symptomatic menopausal women from their study. I'm not sure you can confidently extrapolate the data from elderly 60+-year-old women on a 0.625 mg dose of CEE to a 50-year-old woman. The Nurses' Study[1] showed that stroke risk is dose-dependent: 1.3 RR with the 0.625 mg dose and 0.7 RR with the 0.3 mg dose. So for the WHI to only give the 0.625 mg dose and to get the same RR as the Nurses' Study RR confirms at least that part of the study in older women. But most of my patients who wish to stay on HT have decreased their dose by the time they're 55, specifically to decrease the risk of stroke.

I think we have to be very careful how much we extrapolate from the WHI. As Marcia Stephanic said at our regional teleconference: "This was not a menopause study, but a study of prevention in the elderly." So let's not apply it to the example you gave.

Katherine Brubaker, MD, Gynecolody
Milpitas Medical Offices, TPMG

Reference

1. Lokkegaard E, Jovanovic Z, Heitmann Bl, et al. Increased risk of stroke in hypertensive women using hormone therapy: analysis based on the Danish Nurse Study. Arch Neurol 2003 Oct;60(10):1379-84.

—Reply
Dr Brubaker,

The trap of extrapolation is what prompted the commentary, and the tools provided are intended as a springboard to facilitate careful discussion of the WHI findings with our patients in order to individualize their care.

The WHI, as I noted, was "designed to study major causes of death, disability, and frailty in postmenopausal women." Its goal was to use "prevention and intervention strategies and risk factor identification to reduce incidence of CHD, breast and colorectal cancer, and osteoporotic fracture in women." It is not a study of menopause or the elderly. I did not suggest that its design or intention was to study symptomatic perimenopausal women. Most practitioners are quite comfortable counseling their asymptomatic 63-year-old postmenopausal patients about WHI and HT. However, the reality is that it is the symptomatic perimenopausal woman that practitioners will have the most difficult discussions with regarding HT and WHI—and the situation described perfectly exemplifies the dilemma posed by the typical patient encounter that health care practitioners are facing on a daily basis.

Health care providers caring for these symptomatic perimenopausal women must decide how they are going to address the risks and benefits of HT with them in light of WHI. Even if a provider chooses to dismiss the findings as not applicable, patient awareness of WHI will often dictate that their questions and concerns be acknowledged and addressed. As I noted, individual "practitioners must clearly understand this WHI study in detail if they are to apply its results to individual perimenopausal patients."

There have been many powerful critical reviews of WHI. Creasman, Hoel, and DiSaia's recent commentary in the American Journal of Obstetrics and Gynecology (2003 Sep;189(3):621-6) is particularly scathing. They suggest that data of this type be "disregarded in managing patients," and conclude that "this, as well as other like publications, should be taken with a grain of salt."

However, despite such criticisms, virtually every major medical organization that is strongly associated with women's health care has essentially extrapolated the WHI findings and adopted positions similar to that stated in KP's Clinical Guidelines, namely that "the sole indication for HT is for the treatment of menopausal symptoms. When HT is elected for symptom relief, prescribe the lowest effective dose for the shortest possible time." These guidelines do not specify that this is only applicable to asymptomatic postmenopausal women with a mean age of 63, mean BP 128/76, mean BMI 28.5, etc. Our patients are keenly aware of positions taken by respected health care organizations, whether it's our own organization or the American College of Obstetrics and Gynecology or the FDA. As individual practitioners our practice is not dictated by any of these guidelines, but we should be cognizant of them and have an understanding of their foundation, even if one believes they were all trapped into their positions.

The quality of studies and data I would like to help me counsel my symptomatic perimenopausal patients just does not exist. While flawed, I still find WHI the best quality data available to extrapolate from. We have to start from somewhere, and for me its Table 1 summarizing WHI—from there it is easy for me to individualize.

Your attempts to compare WHI and the Nurse's study to better understand and explain WHI findings exemplify the unique approaches practitioners take to educate their patients, though I find the comparison akin to comparing apples and oranges because of the fundamentally different goals, study designs, and methodology of the two studies. And while personally I am unlikely to have a lengthy discussion with a 55 year old focusing on decreasing her dose of premarin from 0.625 mg to 0.3 mg so that she can reduce her risk of stoke—if that works for you and your patient population, that is great. Regardless of our different approaches, it is encouraging to see that your practice clearly reflects my concluding advice that "health care practitioners will need not only to critically assess the clinical significance, scope, and magnitude of study findings, but also develop tools that will enable our patients to do the same."

Thank you for your interest and comments.

Gavin Jacobson, MD
South San Francisco, CA