CPC Corner

health systems

Doctor, Should I Take Hormones?

By Laura Kale, MD

Introduction

Perimenopausal and menopausal women today face a dilemma when deciding whether to begin or continue a regimen of hormone therapy (HT). Before the estrogen-only arm of the Women's Health Initiative was stopped,[1] most women were urged to take hormone therapy. This practice ended when the study showed an increased risk of breast cancer and when this and other studies[2] showed no protection against heart disease.

The basic clinical response to the question, "Doctor, should I take hormones?" is outlined by two aspects of clinician-patient communication: 1) the clinician should elicit pertinent history from the patient to provide a foundation for the most appropriate response to the question; and 2) the clinician should present to the patient relevant facts with which the patient can make an informed decision.

Eliciting Pertinent Medical History to Determine HT Suitability and Risk

To evaluate the suitability of HT for the patient, the clinician may begin obtaining the pertinent medical history by stating simply, "I would like to ask you a few questions to see if you are an appropriate candidate for hormone therapy." The patient may then be asked if she is having menopausal symptoms such as hot flashes, night sweats, insomnia, irritability, or vaginal dryness. If the patient answers in the affirmative for any or all of these symptoms, the clinician should clarify the extent to which the patient feels disabled by the symptom or symptoms. The clinician may ask whether the symptoms are interfering with the patient's ability to function in daily life, in relationships with family or friends, or with the patient's ability to function at work.

The clinician should then ask a series of questions that establish presence of any risk factors associated with HT. This questioning should determine whether the patient has a history of blood clots, heart disease, stroke, breast cancer, osteoporosis, or gallbladder disease; whether and how much the patient currently participates in exercise activities; whether the patient's diet includes at least 1500 mg of calcium daily; and whether the patient smokes. The patient's past experience with HT can be determined by such questions as the following:

- "Have you ever taken hormone therapy?"
- "How did you feel when you were taking hormone therapy?"
- "Did you have any complications or side effects that limited your use of the hormones?"

The clinician should also present the concept of potential risks and should discuss each risk specifically.

Assisting the Patient in Making an Informed Decision

To help the patient decide whether to begin HT, the clinician should provide an overview of the situation. This may be done by telling the patient, "When making this decision whether to use hormones, we have to weigh the potential risks and the benefits. In most women, estrogen very effectively reduces many symptoms of menopause. We should evaluate your own risk factors before beginning this therapy." The patient should also be told that HT may be the best choice if the patient has multiple debilitating symptoms but that alternatives to HT are available if the patient has only a single, isolated symptom. For example, vaginal estrogen or moisturizers may be used to treat isolated vaginal dryness, and antidepressants such as fluoxetine may be used for relief of hot flashes or mood disturbance.

The clinician should also present the concept of potential risks and should discuss each risk specifically. For example, the clinician might say, "Let's talk about the potential risks of HT. For years, we strongly encouraged use of hormones for all menopausal women to protect them against heart disease and osteoporosis. However, we have now learned that there are some potential risks in taking hormone therapy."

Risk of heart disease can be introduced by explaining that early studies[3-6] showed a favorable effect of HT on lipid profile, leading to the flawed assumption that patients receiving HT would have a lower risk of heart disease. Some women actually have an increased risk of heart attack during the first two years of estrogen use,[7] and these women may have underlying heart disease that is difficult to assess: Many affected women do not exhibit classic symptoms of heart disease.

A discussion of osteoporosis risk can begin by saying,

Laura Kale, MD, is an Ob/Gyn with The Southeast Permanente Medical Group in Atlanta, Georgia. Email: laura.kale@kp.org.

"Estrogen does help prevent osteoporosis. All women should have an intake of 1500 mg of calcium daily, either through diet or supplements. To increase bone density, weight-bearing exercise is important and should be done at least two or three times a week. If you are not doing these two things, it is important to begin now. Do not smoke; and limit your alcohol intake to fewer than seven drinks per week. If you have or are at high risk of developing osteoporosis and you have menopausal symptoms, you might choose to treat both with hormones. If you are not symptomatic, there are other potentially safer medications to use instead of HT, such as Fosamax or Evista. We can assess your risk for osteoporosis to help you make that decision."

A discussion about breast cancer risk can begin by saying,

"The relation between hormone therapy and breast cancer is controversial.[8-12] Of the 50 or so good studies, half show a cumulative, long-term increase in the risk among women taking only estrogen. This risk is increased one tenth of 1% for each year of use,[1] so it takes ten years of use for the risk to increase by 1%. If we assume that the average woman has a 1/8 (12.5%) risk in her lifetime, it would take ten years for the risk to increase to 13.5%. For women who take estrogen and progesterone, the risk may not even be this high. We're hoping that further studies will shed more light on this area."

Other risks, too, may be discussed by saying, for example,

"While taking hormones, you have a very slightly increased risk of stroke,[1,6] blood clots developing in the legs or lungs,[1,6] and gallbladder disease.[13,14] The risk is small but may be greater for women who have a history of these conditions or have a family history of these conditions."

To close the discussion, the clinician may summarize the situation by offering statements such as the following:

- "As you can see, there is no simple answer to your question of whether to take hormone therapy. This is not one of those medical conditions when I can tell you the right thing to do."
- "Only you can assess the severity of your symptoms, and only you know what risks you may be willing to take to relieve those symptoms."
- "If you choose to take hormone therapy, we'll start with the lowest dose possible so that we reduce the risks as much as possible. We can further assess your risk for those diseases I mentioned, and that may help you to make your decision."

By communicating with patients in this informative, interactive way, the clinician can tailor treatment so that the patient achieves maximum relief—emotionally as well as physically—from the discomfort of menopausal symptoms. ❖

The relation between hormone therapy and breast cancer is controversial.[8-12]

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