

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 in Women's Health to the Cleveland Clinic Foundation, 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.

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*.

The North American Menopause Society's March 2007 Hormone Therapy Position Statement: Background, Process and Clinical Implementation

One summer's day in July 2002 a volcano erupted in Washington, DC. This was the press conference announcing the termination of the estrogen/progestogen arm of the Women's Health Initiative (WHI), and the ashes have continued to fall. Being Washington, DC, the impact was as much political and economic as it was medical. Much like the prevailing physician and consumer opposing viewpoints on postmenopausal hormone therapies (HTs) before that event, there was an almost religious or cult-like response to the announced data. They were either instantly and implicitly believed, or instinctively and vehemently opposed. This unfortunate split-opinion occurred despite the fact that neither group, and probably even the investigators and Writing Group for the WHI itself, really fully comprehended the reported preliminary data or their meaning. The WHI believers were invariably thrilled with the results—perhaps feeling vindicated for their previous rejection of so-called “HRT.” The deniers were shell-shocked. The rest of the population—both health providers and health consumers—were just thoroughly alarmed and confused.

It was against this background that an advisory panel of experts incorporating all camps was brought together by The North American Menopause Society (NAMS) to develop a Position Statement on postmenopausal estrogen and progestogen use.¹ The first NAMS Position Statement, developed in the short

space of 3 months, clearly reflected the confusion that was prevalent at that time, and made a definitive effort to define acceptable criteria for clinical practice. Given the absence of comprehensive data, and the variance of clinical opinion, a unique approach was instituted to report both “areas of consensus” and “areas of non-consensus” amongst the panelists and NAMS Board.

Since that time, considerably more data from both the WHI and other sources have continued to flow and, with the luxury of time and added understanding, the NAMS estrogen and estrogen-progestogen Position Statements have evolved through several revisions.^{2,3} The current issue of NAMS’s peer-reviewed scientific journal *Menopause* contains the 2007 Position Statement in full.⁴ Key points from that statement are published in this issue of *Menopause Management*.

I have previously reviewed the background of development and clinical application of guidelines, consensus opinions and position statements, emphasizing that “it is literally impossible to undertake and complete evidence-based clinical research in any area of medical science that incorporates all populations, sub-populations, conflicting and confounding factors, co-morbidities and risk factors, and combinations and permutations of medications. In short, therefore, the guideline-development concept would be flawed were it to rely entirely on the base of evidence existing at any one point in time. The process has to allow for clinical and scientific judgment to be taken into account by both the developer and those who ultimately put the recommendations into clinical practice.”^{5,6}

The need for this balance—between prevailing evidence, clinical experience and common sense—is well exemplified by the latest media flurry, surfacing just as this new NAMS Statement was being finalized. In a December 2006 oral presentation on data taken from the National Cancer Institute’s Surveillance Epidemiology and End Results (SEER) database,⁷ breast cancer incidence was reported to have declined overall by 7% between 2002 and 2003, with the steepest decline (12%)

occurring in women between the ages of 50 and 69, diagnosed with estrogen-receptor-positive breast cancer. From this, the researchers concluded that as many as 14,000 fewer women were diagnosed with breast cancer in 2003 than in 2002. The authors emphasized that epidemiology can never prove causation. This did not prevent major media comment ascribing the reduced incidence to the almost 50% decline in

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HT usage after the July 2002 WHI EPT-arm termination. While almost certainly a contributing factor, there are additional possible explanations, and it will be interesting to observe the trend over subsequent years, as well as that for other conditions like stroke, which were also impacted by HT.

The important point about an announcement like the above is that a well-considered position statement must allow this to be a consideration in the inevitable discussions that will continue to occur between prescriber and consumer. This latest version of the NAMS HT Position Statement has indeed succeeded in taking all of the above considerations into account in a clear position on the current suggestions for appropriate use of estrogens and progestogens in the care of postmenopausal women. The recommendations are lucid, direct and practical, and cover most clinical situations. You are strongly advised to read the introductory section, explaining level of risk, and to carefully consider it as you review the statements put forward. The suggestions for future research and key references are not published here, but are in the complete document in *Menopause* (2007;14:168-182).

This document has also been released internationally, and will follow the tradition of

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Disclosure:

For the Advisory Panel, Dr. Archer reports Agile, Berlex, Johnson & Johnson, Novo Nordisk, Organon, Ortho McNeil, Pfizer, Solvay TAP, Wyeth (consultant), Barr/Duramed, Berlex, Organon, Solvay, Warner Chilcott, Wyeth (research support), Novo Nordisk, Organon, Wyeth (speaker); Dr. Bachmann reports Berlex, Duramed, Johnson & Johnson, Pfizer, Roche, Wyeth (research support), Johnson & Johnson, Wyeth (speaker); Dr. Gallagher reports Organon, Pfizer, Wyeth (consultant, research support); Dr. Grodstein reports no significant financial relationships; Dr. Heiman reports Bayer, Pfizer (research support), Eli Lilly (expert panel); Dr. Henderson reports Council on Hormone Education, Wyeth (consultant); Dr. Hodis reports no significant financial relationships; Dr. Karas reports Wyeth (consultant); Dr. Lobo reports no significant financial relationships; Dr. Manson reports no significant financial relationships; Dr. Reid reports Paladin Labs Canada, Wyeth Canada (advisory board), Berlex Canada, Wyeth Canada (speaker); Dr. Schmidt reports Novogen, Watson (research support); Dr. Stuenkel reports no significant financial relationships; Dr. Utian reports Barr/Duramed, Berlex, Depomed, Endoceutics, GlaxoSmithKline, Johnson & Johnson, Merck, Novartis, Organon, Pfizer, Roche/GlaxoSmithKline (advisory board, consultant), Amylin, Barr, Berlex, Bristol Myers Squibb, Duramed, Eli Lilly, Forest, Galen, GlaxoSmithKline, Johnson & Johnson, Neurocrine, Novartis, Novo Nordisk, Organon, Pfizer, Pharmacia, Procter & Gamble, Roche, Sepracor, Solvay, 3M, Wyeth, Yamanouchi (research support).

For the disclosures of the NAMS Board of Trustees who are not serving on the Advisory Panel, see full document.¹

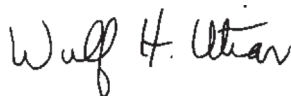
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From the Editor

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being translated into multiple languages. Once again, NAMS confirms its mission as representing the definitive source for scientific, balanced and trustworthy menopause-related information, with the objective of enhancing the quality of life for women through and beyond menopause.



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