

# From the EDITOR

SPECIAL RETROSPECTIVE



**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*.

## Random Menopause-Related Thoughts: A Look Back Over 20 Years

I have been writing editorials for *Menopause Management* for half of my 40 years in menopause-related medicine. Don't ask me where the time has gone! But during that period I have authored over 100 editorials for this publication, and I thought it might be interesting—at least for me, and hopefully, for you—to look back on some of the comments, observations and conclusions I've reached. Some make me quite pleased, but some...well, hindsight is 20/20. Anyway, judge for yourself, as we consider the road traveled.

The *Menopause Management* editorials excerpted here are identified by date and title. Obviously, not all editorials have been chosen for these short excerpts, which were selected specifically to give readers an idea of their themes. In this way, a little of the history of the times is highlighted, changing trends identified, and challenges to dogma, veracity and honesty repeated.

Selecting which editorials to abstract was difficult. Space did not allow more, so personal bias was used to choose those with the most staying power (eg, November/December 1992, January 1993), and those that would best remind us of something interesting (eg, Summer 1989, November/December 1995) or important (eg, November 1990, July/August 2002). Please read and feel free to use your own bias to challenge or to recommend an idea for the future.

### Fall 1988

#### *Menopause Management:* *The Changes...and the Challenge*

*There are many reasons why we should know how to manage the menopause, but three reasons tell us why we should learn about them now...*

*First, the aging baby-boom generation, now entering its 40s, will enter the climacteric in just the next decade...*

Second, because the current life expectancy for women is 78 years, many more numbers of women will live well beyond the menopause...

A third and very important reason is that many of us are dropping the “Ob” from Ob/Gyn, probably because of today’s litigious climate...

Why then another publication? Although the medical literature reports on scientific findings relating to the human climacteric, not enough practical advice for direct clinical care is available. We are providing this forum to meet that need.

### Summer 1989

#### **The North American Menopause Society: Why Another Society?**

The News and Notices of our winter issue announced a conference on Multi-disciplinary Perspectives on Menopause, which is to take place in New York on September 21–23. This will also be the inaugural meeting of The North American Menopause Society. You may ask: why then, another society?...

...menopause management—as a discipline—cannot be limited to the practice of any single specialty. Rather, it comprises the expertise of a multitude of medical and basic sciences: cardiology, endocrinology, family medicine, geriatrics, gynecology, orthopedic surgery, psychiatry, psychology, anthropology, nutrition, sexology, and social sciences—to name a few. The purpose of The North American Menopause Society, therefore, is to provide a common meeting ground for those medical and paramedical specialties that are touched by some aspect of menopause.

### November 1990

#### **Our Responsibilities in HRT and Beyond**

...Clearly, the responsibility of the physician in caring for the menopausal woman reaches beyond the realm of hormonal therapy. We must counsel our patients about lifestyle changes, and we must screen them for risk factors of diseases that occur for non-hormonal reasons around the time of the climacteric. One of the most important lifestyle changes we can advocate is for them to stop smoking.

### November/December 1992

#### **The Challenges Ahead**

Only a new focus on preventive health care will prevent a total collapse of our healthcare system.

The menopause is an ideal time for women to reenter the healthcare system, to be evaluated, and to participate in appropriate preventive programs. Unfortunately, with the majority of third-party payors, the emphasis is not on preventive medicine. We urgently need policy makers to recognize the scope of symptom formation and disease often associated with the climacteric, and the impact the aging female populations will have on the healthcare industry in the next several decades...

We must make it an urgent priority to identify the population at risk, introduce cost-effective preventive treatment modalities, educate the population about preventive vs. crisis treatment, and maintain compliance. The goals are to enhance the quality of life while increasing its duration.

### January 1993

#### **Menopause Research—The Dilemma**

Addressing an NIH meeting in 1989 on the subject of menopause, I made the following comment: “We face a peculiar paradox. We currently have much of the necessary knowledge and tools required to prevent major morbidity and mortality, to enhance not only the quality but also the quantity of life after menopause, but only a small fraction of the eligible population currently receives proper care. We face a major healthcare crisis in the future and are always calling for more and more research, but we do not even utilize our current knowledge properly.”...

The dilemma is clear. We will always need additional research, but we fall short when it comes to applying our current knowledge. Our challenge is to address both issues with equal vigor.

### February 1993

#### **Menopause: What it Is—And What it is Not**

There is a lack of consensus regarding the important terminology that defines stages and events in a woman’s life...

While it is essential to define carefully what menopause is, it also is necessary to consider what menopause is not. Menopause is not the end of meaningful life. It is not a dramatic event leading to sudden behavior alteration, nor is it a disease.

The climacteric is not an endocrinopathy per se; clearly, however, it holds the potential for endocrinopathy...

One of the challenges facing us is to determine more clearly the specific effects related to the menopause and to differentiate them from those that are age-related or influenced by psychosocial-cultural factors, and in this day, by economic status as well. This task is not easy, but certainly can be accomplished.

#### April 1993

##### **Appropriate Postmenopausal Health Care: A Dilemma**

The physician who is concerned about providing appropriate care to postmenopausal women faces a curious dilemma. One objective of this clinician must be to provide primary preventive care with the goals of preventing illness, prolonging life, and enhancing the quality of life. While attempting to achieve this, the physician may be criticized for "medicalizing menopause."

I believe that this dilemma is due, in part, to the extreme positions that certain healthcare providers have taken. There are the "estrogen evangelists" who recommend estrogen replacement therapy (ERT) for every woman, while students of the "estrogen never" school find every possible reason not to prescribe ERT.

It would appear to me that members of the medical community have helped to create this dilemma. Too often, the medical and popular media—inappropriately—equate menopause with hormone replacement therapy (HRT)...

#### October 1993

##### **Menopause Education, Instant Experts, and the NAMS Gallup Poll**

A cause of singular concern to me in recent years has been the amount of misleading information provided on the subject of the menopause. In particular, I am troubled by the escalating volume of magazine articles and books written by "lay instant experts" who lack experience and background in basic science, health care, or well-documented research findings—and who, more often than not, express opinion rather than fact...

#### January 1994

##### **Examining the Effect of ERT on Breast Cancer**

Studies suggest that postmenopausal ERT has no negative effect on recurrence of disease or survival

in postmenopausal women who develop carcinoma of the breast. However, when a woman with pre-existing breast cancer requests ERT, management decisions must be made on an individual basis. It would appear that, other than previous breast cancer, there are no definitive breast conditions that contraindicate ERT. However, as in all instances where ERT or HRT is being prescribed, it is mandatory that the woman be well-counseled so that she can make an informed decision and her care can be individualized. In general, a conservative approach appears justified because definitive answers are unavailable at this time. Fortunately, studies are commencing that soon may provide solutions to this vexing dilemma...

#### July/August 1994

##### **Thyroid Function and Menopause**

...Hypothyroidism can cause lethargy, poor memory, cold intolerance, and weight gain. The non-specific nature of these symptoms can result in thyroid dysfunction being overlooked, the necessary treatment being delayed, or—equally unfortunate—the wrong treatment being prescribed. Therefore, it is prudent always to have a high index of suspicion for thyroid dysfunction when evaluating women for "climacteric syndrome."

#### November/December 1994

##### **Predicting Endometrial Pathology by Timing of Withdrawal Bleeding to Sequential HRT**

A disturbing aspect of modern medicine is the speed at which limited information is incorporated into current practice dogma. Case in point: using the day of bleeding onset in response to sequential estrogen/progestin therapy as a predictor of endometrial hyperplasia...

The lesson to be learned from this is that we should scrutinize all studies very carefully before allowing the results to affect the dogma of clinical practice.

#### May/June 1995

##### **Heart Disease in Women: Where Are We?**

Each year in the U.S., ten women die from heart disease for every death due to breast cancer. Yet the healthcare system has historically underestimated the severity of heart disease—and women have a greater fear of breast cancer...

### July/August 1995

#### **Has “Less than Monthly Progestin” Come of Age?**

...It would therefore seem that the time has arrived to offer patients on sequential HRT a reduction from 12 withdrawal bleeding episodes a year to only six, and possibly fewer by administering progestin at two- to three-month intervals. While current evidence would suggest this regimen to be appropriate and safe therapy, I would suggest we continue to monitor patients so that any increase in hyperplasia (and potentially uterine carcinoma) can be avoided. In the continuing challenge of minimizing risks and maximizing benefits for women on long-term HRT, longer withdrawal intervals for progestin may likely prove to be the best protocol.

### September/October 1995

#### **Postmenopausal HRT and Breast Cancer Revisited**

...I do believe we will have to address a point of real concern: the role of added progestin. Undoubtedly of value in obviating the estrogen-induced increase in uterine cancer, there is no protective effect—and possibly a compounding of risk—for breast cancer. Progestins blunt the beneficial effect of estrogens on lipids, and there is direct animal-based evidence that progestin/progesterone negates estrogen-induced increase in coronary blood flow. When evaluating risks versus benefits, I would speculate that, in the future, progestin may have a minimal therapeutic role, if any.

### November/December 1995

#### **NAMS: A Success Story of Remarkable Growth and Development**

As the Sixth Annual Meeting of The North American Menopause Society in San Francisco proceeded, I was overcome by an escalating sense of amazement and satisfaction. Those few members who were present at the New York inaugural meeting in 1989 will well remember a meeting in which probably the only consensus was lack of consensus. There appeared to be conflict between physicians and nonphysicians, men and women, young and old, basic scientists and clinical scientists. Indeed, for a while I questioned my

own mental stability in attempting to draw an interdisciplinary group into discussion of the menopause.

Yet, in six brief years, a new Society nurtured by a few loyal members, and a dedicated Board of Trustees, has grown into a large international organization...

### March/April 1996

#### **Incorporating New Options for Osteoporosis Management into Clinical Practice**

Options for clinical management of osteoporosis have increased as rapidly as the recognition of the problem by the general public. Currently, it is more often the exception than the rule for a perimenopausal woman not to raise the topic during a medical evaluation...

To provide optimal clinical management, the practitioner needs to constantly bear in mind the objective of this action; that is, the avoidance of fractures...

Achievement of this goal necessitates incorporating into standard practice effective screening mechanisms. These include a comprehensive history and physical and selective use of screening tests. Densitometry of the spine and hip is the current gold standard for risk assessment...

An understanding of the technology, physiology, and interpretation of these tests is a necessary requirement for proper clinical management...

### May/June 1996

#### **Testosterone Therapy after Menopause**

The word is out in the popular media—testosterone enhances sexuality, has a euphoric effect on mood, and healthcare providers are being uncooperative and are resistant to prescribing it for all women. Consequently, practitioners are receiving more and more requests for androgen prescriptions. But, how strong [are] the data, and what are the concerns?...

There [are] literally no data available for risk or benefit of long-term postmenopausal testosterone therapy. Does it increase or decrease the risk of coronary heart disease, or have no effect? We simply don't know. Given the adverse effects of progestins, it would be surprising if there were no negative consequences to long-term testosterone. However, the data simply [do] not exist...

## September/October 1996

### **The Antioxidant Issue**

...Approximately 50 years ago, at the height of the poliomyelitis epidemic, a popular belief existed that wearing garlic around the neck reduced the risk of developing the feared disease. Perhaps the odor of the garlic kept people at a distance, reducing the opportunity for transmission. In this decade, due to epidemiologic studies reporting lower rates of cancer and/or cardiovascular disease by eating a healthy diet preponderant in fruits, grains, and vegetables, the "garlic" of the era has been hailed as beta carotene. Indeed, both the popular media and scientific literature [have] so popularized this issue that an entire industry has developed and millions of individuals consume beta carotene supplements.

Unfortunately, like garlic did not prevent polio, definitive reports now prove that current formulated beta carotene supplements do not reduce the risks of heart disease or cancer...

## November/December 1996

### **Long-Term Estrogen Therapy and Alzheimer's Disease**

One of the biggest concerns facing healthcare planners, policy makers, and individuals alike, is the fact that an increase in life expectancy has not been paralleled by a reduction in the time of disability before death. Indeed, the enlarging elderly population spends a greater proportion of their lives with some disability. In this context, particularly the female population with a greater life expectancy than men, Alzheimer's disease (AD) represents a major health problem...

As the first investigator to report the ERT brain effect on mood elevation in 1972, I would certainly be more than thrilled to see confirmation of an even greater neurological action. Regrettably, until we have better information, we cannot claim the prevention and treatment of AD as a significant benefit of estrogen usage.

## May/June 1997

### **Menopause and HRT—Science, Politics and Pseudoscience**

Many clinicians are currently being asked if they are "for or against" HRT, as if this were a political issue on which it was necessary to take sides. Regrettably, the written and visual media persist in focusing on this question in the same way, present-

ing a picture of us engaged in some form of modern medical warfare...

The truth, need I repeat at the risk of "crying Wulf," is that genuine medical science is a search for facts. In the absence of definitive data, the objective is to "do no harm," that is, to carefully balance potential risks and potential benefits on a case-by-case basis. Under these circumstances, there is no side to take—only the best care for each woman...

## July/August 1997

### **Is "Natural" Natural?**

Over the past few years, we have witnessed increasing confusion over defining products as pharmaceuticals or foods...

Clearly, there is an astounding degree of hypocrisy in all of this. Estrogens can't be declared to be the cause or accelerator of breast cancer if "synthetic," yet anti-cancerous if "natural." Nor can there be calls for more research on pharmaceutical ERT/HRT products amidst proclamations of the safety and effectiveness of "natural" estrogen or progesterone in the absence of long-term studies...

It is my hope that the FDA will soon identify this entire "natural" remedy arena as one in need of its scrutiny. Until that time, the public at-large needs to be made aware of the fact that "natural" is not necessarily natural.

## September/October 1997

### **Has Gender Bias Affected Menopause Management?**

While listening to a presentation on gender bias in biomedical research, the question of whether gender bias might have affected menopause-related research and management crossed my mind. On the surface this might sound like a ridiculous concept—menopause is specific to women, making gender bias apparently irrelevant—but it struck me that much of what we say or do with regard to management of postmenopausal women might well have been influenced by gender bias...

## November/December 1998

### **HRT and the HERS Findings—Has the Ground Shifted?**

...There is a clear lesson to be learned. Observational studies are of value in indicating trends. Randomized studies are necessary to test these observations.

*But these studies need to be based and planned on what the observational studies suggest, not what we hope a different treatment or drug combination would produce. Progress is only made one step at a time.*

### March/April 1999

#### **The FDA, Soy Protein and Coronary Heart Disease**

*As you read this editorial, the FDA is proposing to authorize the use on food labels and in food labeling of health claims on the association between soy protein and reduced risk of coronary heart disease (CHD)...*

*Given that the FDA approval is likely to be for soy protein "included in a diet low in saturated fat and cholesterol," might it be irrelevant what is added for a protective effect to be exhibited? Thus, the FDA might just as well approve fish, or bananas, or low-fat yogurt, provided they complement a healthy diet.*

*Which brings us to the major question. How effective might soy protein be in the absence of a healthy diet? Here, it appears, the studies are essentially as observational as are many of those on estrogen use...*

### May/June 1999

#### **The Trojan Horse of Menopause Marketing**

*Remember the story of the Trojan horse? In Greek mythology a huge, hollow wooden horse, in which attacking Greek troops hid, was left at the entrance to Troy as the attacking Greeks surreptitiously feigned departure and hid. The Trojans, sensing victory and believing the horse to be a departing gift, moved it through the gateway into the walled city, and unsuspectingly allowed the Greeks to capture the city of Troy; thus, ending the Trojan war.*

*Well, I am deeply disturbed by a similar phenomenon by which our once proud medical profession is being "sprung by the same trap," and is inadvertently doing the same to its patients. In this instance the Trojan horse comes in different guises, frequently appearing as slickly marketed packages of ostensibly independent CME. But the "troops in the horse" are aggressive marketers of questionable "menopausal products," and the "inhabitants of Troy" are the menopausal women and their pocketbooks.*

*It truly troubles me to note once proud names in medicine who, often for no more than the price of a fancy weekend in a plush resort, will allow the use of their names, faces or institutions on glossy packets of "educational" material, the hidden agenda of which is only to market products...*

### September/October 1999

#### **Is There an "Alternate" Menopause Management?**

*Ever since 1994, when the "natural products" industry was granted what amounts to a license to steal by the US Congress, I have watched with wonder and bemusement as products that are quite obviously pharmaceuticals are labeled "dietary supplements" and, with the FDA sidelined, have been ever more aggressively marketed, and accepted by a seemingly gullible public. I have also been fascinated—and frankly, often disgusted—by the obscene haste with which some health care professionals have jumped onto this bandwagon...*

*Logically, therefore, traditional and alternative therapies will, when subjected to scrutiny, either pass or fail the test for effectiveness. But the playing field needs to be leveled; the intensity of scrutiny needs to be the same. Under these circumstances the public will be protected from ineffective alternatives, and the therapies that are actually effective will be recognized as such. There is no "alternative" medicine, only good medicine.*

### March/April 2000

#### **Hormone Replacement Therapy and Risk of Venous Thrombosis**

*Current thinking on the risk of venous thrombosis in association with postmenopausal hormone replacement therapy has undergone a radical shift...*

### September/October 2000

#### **Thoughts on the NIH Consensus Development Conference on Osteoporosis Prevention, Diagnosis and Therapy**

*...I feel that this consensus statement warrants criticism; in its attempt to be "all things to all people," it presents general statements that fail to reach concrete solutions...Finally, was the question, "What [is] the optimal evaluation and treatment of osteoporosis and fractures?" answered by this panel? Quite frankly, no.*

### November/December 2000

#### **Hormone Replacement Therapy and Coronary Heart Disease—Where Now?**

...The overall conclusion at this time, pending the outcome of more definitive studies in progress (e.g., WHI, RUTH), is that prevention is easier than cure. Thus, clinicians should encourage women with no history of heart disease to make healthy lifestyle choices by quitting smoking, improving diet, exercising and considering the use of HRT. Once active atherosclerosis is present it is unclear whether HRT will have an impact on long-term outcome.

### September/October 2001

#### **Precisely Defining the Effects of Long-Term HRT—The Ultimate Catch-22**

Remember Joseph Heller's 1961 novel *Catch-22*? "There was only one catch and that was Catch-22, which specified that a concern for one's safety in the face of dangers that were real and immediate was the process of a rational mind. Orr was crazy and could be grounded. All that he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to..."

Attempts to precisely define the true benefits and risks of long-term hormone replacement therapy (LTHRT) after menopause pose an exquisite dilemma, perhaps the ultimate *Catch-22*...

Obtaining this information necessitates enrolling large numbers of women in studies that, of necessity, take many years to plan, complete and report. But by the time such randomized, controlled, blinded long-term studies are completed, the drugs, doses, regimens and combinations will almost certainly have changed...

The Women's Health Initiative (WHI) is a perfect example of this problem. WHI was planned in the 1990s, is being executed over the course of a decade as one of the most expensive clinical research projects ever supported by the NIH, and findings will be reported in detail later this decade. By that time, at the very least, the preferred doses and, almost certainly, the preferred progestogen, will have changed...

### November/December 2001

#### **HRT and Cancer**

Are estrogenic steroids carcinogenic? Attempts to answer this perplexing question are beginning to resemble those around the question, "When does life begin?"...

### January/February 2002

#### **Thoughts on Fear and Anxiety**

The horrific news of September 11, and after, has already affected all of our lives in more ways and to a far greater extent than anything we might have initially expected...

What has all of this to do with Menopause Management? Everything and nothing. The majority of women, as demonstrated in NAMS Gallup Surveys, do not have these thoughts and fears as they go through the menopause transition, but many women do. Our role as healthcare providers has never been more important. We need to step up to the plate as role models and leaders. The remedies for the fear created by terrorism are much the same as those for almost any transitional situation in life...

I take every opportunity to counsel women that the best response to fear, whether of terrorism or of potential future health problems, is to continue doing what they do best—only more so. Work just that much harder. Love your loved ones and offer friendship and charity that much more. Do not give fear and terrorism the negative response they seek. I suppose that my message to you is the same, from one healthcare provider to many; do the same for your patients—and yourself!

### March/April 2002

#### **Bone Mineral Density Testing: Storm Clouds Rising**

The use and potential for abuse of bone mineral density (BMD) testing are escalating rapidly. BMD testing is increasingly being promoted as a universal requirement, with BMD being measured centrally or peripherally and the tests being advertised, publicized and charged for. In short, BMD testing has become big business. But much of this enthusiasm might well rest on a shaky foundation. My concern relates not to the use of BMD in research, but to its application to the individual patient...

### July/August 2002

#### **Managing Menopause After HERS II and WHI: Coping With the Aftermath**

...Barely was the long-awaited follow-up of the HERS study published, than the National Institutes of Health (NIH) dropped its bombshell of discontinuing the trial of estrogen plus progestin (E+P Trial) in women with an intact uterus in the Women's Health Initiative (WHI). Since then, there has been much water under the bridge, but let's try to consider "Where to now?"...

While the merits and demerits of the data and the wisdom of the decision to terminate this arm of the WHI study will be debated for years, the manner in which the study was terminated was poorly planned, abrupt and inhumane...

### September/October 2002

#### **The Neglected Symptom: Vaginal Dryness**

Other than the cessation of menstruation itself, the two most specific early symptoms associated with menopause are hot flashes and vaginal dryness. The former are the usual reason for women to seek help during the perimenopause; vaginal dryness, on the other hand, is frequently not addressed...

The bottom line is to query all patients about vaginal symptoms, including those on ET/HT. Vaginal dryness and dyspareunia should be regular components of a comprehensive gynecological history.

### November/December 2002

#### **Weight, Menopause and Hormones**

One of the frequent questions raised in clinical discussions is whether menopause of itself influences body weight or body mass index (BMI), or if sex hormone therapy can cause an increase in body weight...

What then is the message regarding sex hormones, menopause and BMI? While they are probably not related, in that neither menopause nor ET/HT appears to be associated with weight gain and BMI does not determine symptomatic response to therapy, BMI is nonetheless an important component of menopause management. Of itself, elevated body weight is a negative factor for morbidity and mortality. It should therefore be raised as an item for health-related discussion every time an overweight patient is seen.

### January/February 2003

#### **Clinical Practice Six Months After the WHI EPT Arm Termination**

There is probably one fact all parties impacted by WHI can agree on: Life has been very hectic and confusing since the termination of the EPT arm of the WHI study...

It cannot be overemphasized that WHI is a prevention project, and that hormones can be prescribed for preventive or clinical indications, or both. But both the consumer and the provider must clearly understand why hormones are being considered and prescribed.

What does this mean in practical terms? The NAMS Advisory Panel provides some guidance in this respect...

### March/April 2003

#### **Integrity of Scientific Clinical Publications and Media Reporting—Credible Information or Imaginative Marketing?**

In this new century it is virtually impossible to avoid being a cynic or a total doubter. The media feed us daily avalanches of mixed messages: bad news, cautions, warnings, exposures of "evil doers," and unbelievable promises of technological advances or medical breakthroughs. We hear stories of greedy and conniving CEOs, disgraced politicians, fallen priests, a pharmaceutical industry force-feeding products via direct-to-consumer advertisements and a rampant health profession placing profits ahead of patient care...

How can we in the health profession deal with the challenge of differentiating scientific credibility from imaginative marketing? There is no clear answer. Transparency is obviously essential. Therefore, Menopause Management will immediately introduce a policy of full disclosure from authors of future articles appearing in this publication that discuss any product or service...

### July/August 2003

#### **Apples are not Oranges—Prevention and Treatment are Different!**

The aftermath of the abrupt termination of the estrogen-progestogen (EPT) arm of the Women's Health Initiative (WHI) in July 2002, as well as the recent publication of its substudies, has produced at least one major benefit—women are having

more interactive discussions with their health providers about their overall care...

However, the issue I intend to focus on is that prevention of potential future disease is not equivalent to treatment of an existing problem! Let me repeat that. Prevention and treatment are very different issues...

### November/December 2003

#### **Does “Statistically Significant” Always Equate to “Clinically Relevant?”**

There is a widening chasm between the points of view of epidemiologist/research investigators and practicing clinicians regarding the appropriate interpretation of major randomized trials and observational studies...

Clinical practitioners should not despair. Nor should they grant excess credence to any one research report, meta-analysis, or focused review. Instead, they should consider all facts relevant to each individual patient. The unique profile inevitably requires a unique clinical opinion. Provided that a patient is given an understandable summary of the balance of risk and benefit, that discussion is documented, and that appropriate follow-up is planned, you are practicing good medicine. Ultimately, whether “statistically significant” is “clinically relevant” still has to be decided between the woman and her health provider, and that remains the challenge of the “practice of medicine!”

### March/April 2004

#### **Thoughts on Suffering and Dying—Or, is “Disease A” Really Equivalent to “Disease B”?**

Most healthcare researchers, epidemiologists and clinicians tend to consider morbidity and mortality in cold, professional terms until they, themselves, become victims of illnesses involving disability and dying...

Clearly, the primary objective of medical research and subsequent healthcare delivery is to enhance quality and duration of life...

This entire concept has been largely ignored in the current debate over the use of postmenopausal pharmacotherapy...

I cannot emphasize strongly enough that this criticism of current affairs must not be taken as a recommendation for or against the use of HT. The QoL and cost-effectiveness analyses are simply

lacking. Rather, this is an urgent appeal for a more precise and humanitarian approach to data evaluation, so that advice given to women facing severe medical problems or making difficult medical decisions can be truly “quality”- and “caring”-based. For the clinician helping women to enhance QoL, the challenge remains to recognize that each woman has a unique profile that needs to be recognized and utilized in medical management.

### May/June 2004

#### **Women and Prostate Cancer**

This editorial is one I wish I had not been inspired to write since much of it relates to a recent personal experience...

But this is not an editorial on prostate cancer; it is a call to healthcare providers to recognize that this diagnosis has an impact on the life of the spouse/partner that is almost as severe as the impact on the individual who has been diagnosed...

### July/August 2004

#### **Women’s Health Initiative Round 2—Is this the Opportunity to Clear the Air on Postmenopausal Hormone Use?**

The dogmatic pronouncements of the demise of postmenopausal hormone therapies (the “last nail in the coffin”) since the termination of the estrogen and progestogen therapy (EPT) arm of the Women’s Health Initiative (WHI) in July 2002 appear to have been premature. The latest data reported with the termination of the estrogen-only arm of the WHI have given postmenopausal estrogen therapy (ET) serious revitalization...

It is clear that, at this time, there have been few winners. My hope is that we can utilize the latest WHI estrogen-only data in a more responsible fashion to truly reopen the debate, reduce the confusion and fear in our real constituency (women with legitimate health concerns and needs) and banish the acrimonious and biased opinions that, until now, have pervaded the subject, to the garbage heap of medical history.

### January/February 2005

#### **Osteoporosis-Related Events Negatively Impact Quality of Life, But Does Quality of Life Impact the Outcome of Osteoporosis?**

There is an escalating awareness in clinical medicine that self-perceived quality of life (QOL) can be

a key outcome measure of quality of health care. There is considerable evidence that the complications of osteoporosis will have a negative impact on QOL. But less well recognized and of enormous potential clinical relevance is the question of whether perceived overall QOL will actually have an impact on osteoporosis and its complications...

### March/April 2005

#### **Pregnancy After Menopause and The North American Menopause Society (NAMS)**

It was really inevitable. Given the remarkable sequential breakthroughs in reproductive technologies over the past three decades, it was only a matter of time before women could begin to consider the option of salvaging fertility, and be[ing] able to achieve pregnancy with their own eggs after menopause. Who would have thought that pregnancy and menopause would need to be considered a single area of health care?...

### May/June 2005

#### **The What and the Who of Contemporary Menopause Management**

We ask a lot of 'what's?' in clinical practice. Consider the most recent new patient you have just seen in your office. The front office staff had already asked innumerable questions, like "What is your name?" "What is your age and date of birth?" "What medical insurance do you have?" So, by the time she entered your consulting room you had a pretty good idea of the patient's demographics.

Chances are that you started the conversation, after the preliminary courtesies, by asking, "What is your main complaint?", and then proceeded to ask a series of other "what's", such as those about previous medical history, family history, personal habits, exercise and diet patterns, and so forth.

But did you ever get around to asking the woman, "WHO are you?"...

### July/August 2005

#### **The True Symptoms Associated with Menopause Confirmed after 33 Years: Better Late than Never, But Let's Move on NOW!**

It is quite extraordinary how frequently in medicine a finding published three, four, or more decades ago languishes in obscurity until, voila!—

the observation is rediscovered and that idea then becomes the newly accepted dogma...

### September/October 2005

#### **Selling Menopause**

The days when the definition of "menopause" was a one-liner in medical textbooks ("Menopause is physiological amenorrhea") are long gone. Gone too are the days when the word "menopause" was not mentioned in public by any self-respecting woman. Nowadays, the "M word" is a healthcare subject that is inspiring musicals, and a 'title' launching a thousand opinion-based books and magazine articles. Above all, the word "menopause" has, unfortunately, become a selling tool. In simple terms, menopause has regrettably graduated into an industry!

This observation may seem to be particularly hypercritical, coming from someone such as myself, who has made a major part of my medical career out of the educational, research and clinical issues regarding menopause, and perhaps in my capacity as Executive Director of The North American Menopause Society (NAMS), an organization whose very existence is based on menopause. But there is indeed a significant difference that needs to be highlighted. It is one thing to attempt to bring scientific clarification to all issues about menopause, or to attempt to deliver state-of-the-science, high quality preventive and therapeutic health care to all women going through (and beyond) the menopause transition. It is quite another thing to use menopausal women as a "market" and to knowingly and consciously attempt to industrialize, commercialize, and sell inappropriate "remedies" purely for the sake of gathering the almighty dollar...

### November/December 2005

#### **Domestic Violence and Menopause**

A patient of mine committed suicide in the early 1970s...

My primary objective in writing this editorial is to trigger awareness of [intimate partner violence] IPV and [domestic violence] DV, and to remind you that these issues might lie behind an unusual or persistent presentation in some of your patients. We are the front line and often the only defense for victims of abuse. I strongly recommend that you access

the resources referred to in this editorial. I certainly wish that all those years ago I had an awareness of DV and IPV and that these resources were available to me. Perhaps the outcome for my own patient might have been better.

### March/April 2006

#### **The Psychosocial and Socioeconomic Burden of Menopausal Vasomotor Symptoms**

We are constantly informed of the high socioeconomic impact of a number of diseases, from osteoporotic fractures, to heart attacks, to various cancers. But disruptive symptoms like headache, backache—and yes, hot flushes—are also a source of considerable medical cost and socioeconomic impact. I recently reviewed the psychosocial and socioeconomic burden of menopausal vasomotor symptoms (VMS) elsewhere, but in this column would like to draw your attention to some of the most significant conclusions of that review...

### July/August 2006

#### **Reconsidering Postmenopausal Estrogen Therapy and Breast Cancer**

...My personal opinion is that from a breast perspective, women—certainly those with previous hysterectomy—and practitioners can breathe more easily. While the outcome for women with an intact uterus requiring endometrial protection or observation is less certain, the symptomatic perimenopausal woman should feel more secure in her short- to medium-term prescription of estrogen-alone therapy. Certainly, CEE treatment alone does increase the need for more frequent mammography screening. Whatever the decision, I am convinced that there is a need to reduce exposure to progestin. As always, constant vigilance remains mandatory.

### September/October 2006

#### **Is Evidence-Based Medicine a Pipe Dream?**

Sir William Osler (1849-1919) was credited with presenting the following observation during a commencement speech at Johns Hopkins Medical School: "As you complete your rigorous studies and graduate today, unfortunately I must inform you that half of what we have taught you is wrong. Even more unfortunately, we cannot tell you which half!"

In the concerted effort to enhance the quality and outcomes of contemporary health care, clinicians, other health providers, medical societies, reimbursers, and the rest, have all scrambled to develop guidelines, clinical care paths, protocols, "best practice of medicine" rules, and position statements. One of the most emphasized and current of these methodologies is the so-called practice of "evidence-based medicine."

The question I pose is this: Is evidence-based medicine really wishful thinking—a fanciful attempt at determining clinical practice on an Osler-defined shaky foundation?...

### January/February 2007

#### **Feminine Forever Round II:**

##### **The Bioidentical Cult**

George Santayana's admonition that "those who cannot learn from history are doomed to repeat it" is a warning and not a cliché. *Feminine Forever: Revolutionary—The Amazing New Breakthrough in the Sex Life of Women*, by Robert Wilson, MD, was published in 1966. He claimed that "for the first time, a leading doctor in the field of menopause prevention explains why no woman—no matter what her age—need ever feel a day over forty."...

...the 2002 WHI termination of the estrogen-progestogen therapy (EPT) arm of the Women's Health Initiative (WHI) was a major speed bump on the road of menopause history. But the subsequent massive backlash against use of FDA-approved hormonal therapies has had an unanticipated and unfortunate outcome—a shot in the arm for a new school of "natural" therapies.

We are now in the era of *Ageless: The Naked Truth about Bioidentical Hormones*. Written and mega-marketed by former actress Suzanne Somers, who has no medical training or college degree, the book claims a foundation of "16 interviews from cutting-edge doctors on how to slow the aging process, for women and men."...

There should be an explanatory patient package insert in all hormone prescriptions, whether commercial or compounded, that clearly explains to women the benefits and risks associated with the product. Nonetheless, you are the advocate for your patients and for safe and effective women's

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arthritis will, it is hoped, lead to more effective preventive measures and better therapies. ■

**Anne K. Rosenthal, MD, is Professor of Medicine, Division of Rheumatology, Department of Medicine, Medical College of Wisconsin, and the Zablocki Veterans Affairs Medical Center, Milwaukee, WI.**

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#### From the Editor

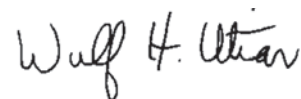
*(continued from page 19)*

*health care. The responsibility to counsel women about risks and benefits of all pharmacotherapies is yours. You sign the prescription, you carry the liability. It is time to tell women, "Buyers beware!"*

A bird's-eye view over 20 years truly makes me wonder whether life goes in circles. The immediate access to our comments and writings brought about by the new technology age should make all of us think twice before committing the thought to the document. I cer-

tainly do, and fortunately have little regret for what I have said thus far.

If you want copies of any of the complete editorials, please contact the NAMS office ([info@menopause.org](mailto:info@menopause.org)).



Wulf H. Utian, MD, PhD

*Executive Director, NAMS  
Consultant in Women's Health  
The Cleveland Clinic Foundation*