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The North American Menopause Society (NAMS) Continuing Medical Education Activity

The 2017 hormone therapy position statement of The North American Menopause Society

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ACCREDITATION AND CME INFORMATION

The North American Menopause Society (NAMS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

NAMS designates this journal-based CME activity for a maximum of 2.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Participants who are not physicians will be issued a certificate of participation. NAMS has determined that this activity includes 2.0 hours of pharmacotherapeutics education.

In order to earn CME credit or obtain your certificate of participation for this activity, please read the position statement that follows, reflect on how the information applies to your clinical practice, and complete the CME self-assessment and evaluation found on page 754.

LEARNING OBJECTIVES

By participating in this journal-based CME activity, the learner will be able to

- Provide evidence-based and current best clinical practice recommendations for the use of hormone therapy for the treatment of menopause-related symptoms
- Understand the effects of hormone therapy on various health conditions at different stages of a woman's life
- Apply the basic concepts of relative risk and absolute risk when communicating the potential benefits and risk of hormone therapy and other therapies.

TARGET AUDIENCE

This educational activity has been developed to meet the educational needs of physicians, nurses, physician assistants, pharmacists, and other healthcare providers who treat or counsel women at midlife and beyond.

SUPPORT

This activity is made possible by donations to the NAMS Education & Research Fund and has received no commercial support.

ACKNOWLEDGMENTS AND DISCLOSURES

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Acknowledgments: The NAMS 2017 Hormone Therapy Position Statement Advisory Panel: *Chair*, JoAnn V. Pinkerton, MD, NCMP, NAMS Executive Director; Professor of Obstetrics and Gynecology; Division Director, Midlife Health Center; University of Virginia Health System, Charlottesville, Virginia. Dr. Fernando Sánchez Aguirre, Asociación Mexicana para erl Estudio del Climaterio A.C.; Mexico City, Mexico. Jennifer Blake, MD, MSc, FRCS, Chief Executive Officer, the Society of Obstetricians and Gynaecologists of Canada, Ottawa, Ontario, Canada. Felicia Cosman, MD, Professor of Medicine, Columbia University College of Physicians and Surgeons; Medical Director, Clinical Research Center; Helen Hayes Hospital, West Haverstraw, New York. Howard N. Hodis, MD, Harry J. Bauer and Dorothy Bauer Rawlins Professor of Cardiology; Professor of Medicine and Preventive Medicine; Professor of Molecular Pharmacology and Toxicology; Director of the Atherosclerosis Research Unit, Division of Cardiovascular Medicine; Kent School of Medicine; University of Southern California, Los Angeles, California. Susan Hoffstetter, PhD, WHNP-BC, FAANP, Associate Professor, St. Louis University School of Medicine; Department of Obstetrics, Gynecology, and Women's Health; Division of Uro-Gynecology; St. Louis, Missouri. Andrew M. Kaunitz, MD, NCMP, University of Florida Research Foundation Professor and Associate Chair, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Jacksonville; Medical Director and Director, Menopause and Gynecologic Ultrasound Services, UF Southside Women's Health, Jacksonville, Florida. Sheryl A. Kingsberg, PhD, Chief, Division of Behavioral Medicine; University Hospitals Cleveland Medical Center; MacDonald Women's Hospital; Professor, Departments of Reproductive Biology and Psychiatry; Case Western Reserve University School of Medicine; Cleveland, Ohio. Pauline M. Maki, PhD, Associate Professor of Psychiatry and Psychology; Director, Women's Mental Health Research; University of Illinois at Chicago College of Medicine; Chicago, Illinois. JoAnn E. Manson, MD, DrPH, NCMP, Chief, Division of Preventive Medicine; Brigham and Women's Hospital; Professor of Medicine and the Michael and Lee Bell Professor of Women's Health; Harvard Medical School; Boston, Massachusetts. Polly Marchbanks, PhD, MSN, Captain, USPHS (Retired); Epidemiologist; Atlanta, Georgia. Michael R. McClung, MD, Founding Director, Oregon Osteoporosis Center, Portland, Oregon. Lila E. Nachtigall, MD, NCMP, Professor of Obstetrics and Gynecology; New York University School of

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NAMS CME Activity Self-Assessment Examination

Designated Article:
The 2017 hormone therapy position statement of The North American Menopause Society

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1. Vasomotor symptoms of menopause include which of these?
   ___A. Brain fog and moodiness
   ___B. Migraine headaches
   ___C. Hot flashes and sleep disturbances
   ___D. Low libido

2. FDA has approved hormone therapy for which of these indications?
   ___A. Prevention of heart disease
   ___B. Prevention of bone loss
   ___C. Breast cancer treatment
   ___D. Sexual dysfunction

3. Of what does conjugated equine estrogen consist?
   ___A. Synthetic and bioidentical estrogens
   ___B. Micronized 17β-estradiol and ethinyl estradiol
   ___C. An estrogen isolated from the urine of pregnant mares, estrone sulfate, and more than 10 different minor forms of estrogen
   ___D. A combination of estrogen and the selective estrogen-receptor modulator bazedoxifene

4. Why would a progestogen be added to estrogen in a woman with a uterus using hormone therapy?
   ___A. It makes the estrogen more efficient in managing vasomotor symptoms
   ___B. It lowers the risk of breast cancer
   ___C. It prevents endometrial overgrowth and increased risk of endometrial cancer
   ___D. It controls unscheduled bleeding that occurs with estrogen therapy

5. What is not a contraindication for hormone therapy use?
   ___A. Prior estrogen-sensitive breast or endometrial cancer
   ___B. Coronary heart disease
   ___C. Dementia
   ___D. Chronic urinary tract infections

6. In the Women's Health Initiative, conjugated equine estrogen plus medroxyprogesterone acetate doubled the risk of which of these cognitive conditions?
   ___A. Dementia in women aged older than 65 years
   ___B. Clinical depression at any age
   ___C. Alzheimer disease
   ___D. Cognitive function

7. The benefit-risk profile of hormone therapy is most favorable when
   ___A. It is not prescribed for more than 30 days
   ___B. It is given to a woman aged older than 65 years for dementia
   ___C. It is initiated by women aged younger than 60 years or within 10 years of menopause onset for treatment of vasomotor symptoms or risk of bone loss or fracture
   ___D. It is prescribed for cardioprotection

8. What is true about compounded bioidentical hormone therapy?
   ___A. It is preferred over FDA-approved therapies because it is all natural
   ___B. It has no risk of overdosing or underdosing
   ___C. It has shown great efficacy and carries little risk
   ___D. It should be avoided, given concerns about safety and the lack of product labeling detailing risks

9. For a healthy woman with vasomotor symptoms who initiates hormone therapy aged younger than 60 years or within 10 years of menopause onset, which of these is true?
   ___A. Hormone therapy is indicated for primary or secondary cardioprotection
   ___B. Hormone therapy puts them at higher risk of stroke and venous thromboembolism
   ___C. Clinical trials report a significant reduction in all-cause mortality with hormone therapy in this population
   ___D. There is an increased risk of fractures the longer hormone therapy is used

10. In a woman aged older than 65 years with an elevated risk of fracture who has been using systemic hormone therapy for osteoporosis prevention, the use of hormone therapy

___A. Does not need to be routinely discontinued in this age group and can be considered for continuation after appropriate counseling and evaluation of risks and benefits
___B. Should be stopped as soon as possible because it is dangerous to use in women aged older than 65 years, according to the Beers criteria
___C. Can continue as long as only local vaginal estrogen is used for genitourinary symptoms
___D. Should not have continued to be used in the first place once this women reached 60 years old

EVALUATION

What changes will you make in your approach to hormone therapy prescribing practices as a result of reading and studying this position statement? (Check all that apply)

____Suggest to women aged younger than 60 years or within 10 years of menopause onset that hormone therapy is the most effective treatment for vasomotor symptoms and symptoms of the genitourinary syndrome of menopause. Suggest a trial of systemic hormone therapy for relief of bothersome menopause symptoms if nonhormone therapies have not been successful, after taking all health contraindications into consideration.

____Counsel women who are reluctant to try hormone therapy of all the benefits and risks involved for their particular situation and medical history and recommend hormone therapy to those who would get the most benefit from it.

____Select the most appropriate type, dose, duration of use, route of administration, and timing of initiation and decide whether a progestogen is needed for the individual woman on the basis of her age, time since menopause onset, general health, and whether she has a uterus.

____Encourage women who are survivors of estrogen-dependent cancers to try for symptom relief using nonhormone therapies. If these are not successful, make decisions regarding hormone therapy use in conjunction with their oncologists.

____Reassure women aged older than 65 years who desire to stay on hormone therapy that they may continue taking it at their age and beyond after careful reevaluation of their health and risks for returning vasomotor symptoms, developing osteoporosis, or a poorer quality of life if they stop.

____None. I already do these in my practice.

What barriers do you face in implementing the position statement's recommendations in your practice?

_____
_____
_____
_____
_____

Was this activity fair, balanced, and free of commercial bias?
Yes No
If you answered no, please explain.

_____
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What are other topics for which NAMS should develop position statements?

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_____
_____
_____
_____

To Apply for CME Credit

To receive CME credit or a certificate of participation for this activity, this 2-page form must be mailed, faxed, or emailed by July 1, 2019.

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