

EDITORIAL

Concern about US Preventive Services Task Force recommendation on hormone therapy for the primary prevention of chronic conditions in postmenopausal women

We are concerned that the US Preventive Services Task Force (USPSTF) recommendation against the use of menopausal hormone therapy (HT) for prevention of chronic conditions recently published in *JAMA*¹ will be misinterpreted as advising against the use of HT for any purpose, including treatment of distressing menopausal symptoms. Although the authors mention briefly that the report's guidance does not apply to HT use for symptom management, this critically important distinction was not given adequate attention. As a result, the report may exacerbate the confusion and fear surrounding HT decision-making, leading to even fewer women receiving appropriate treatment for symptoms that impair quality of life.

Recent guidance from The North American Menopause Society (NAMS)² clarifies that initiation of HT is appropriate for symptomatic women in early menopause (eg, below age 60 or within 10 years of menopause onset) and free of contraindications to treatment. At a time when such women are already undertreated,^{2,3} the USPSTF recommendation may have a chilling effect by perpetuating fear of HT and further discouraging appropriate use. Clinicians may be deterred from providing evidence-based, individualized guidance to their patients regarding HT use. Given the extremely low prevalence of use of HT for "prevention of chronic conditions," what was the impetus for an update on this topic (so soon after the last statement with the same recommendation)?

Convergent evidence from randomized clinical trials, and also preclinical, clinical, and epidemiologic studies, documents the low absolute risks and favorable benefit:risk profile for HT use in symptomatic women in early menopause.²⁻⁵ Moreover, a variety of US Food and Drug Administration (FDA)-approved HT formulations are now available, including lower doses, nonprogestin therapy for women with a uterus, and transdermal routes of delivery. Although conclusive evidence on risks versus benefits of these alternative formulations is not available from randomized trials, observational studies have suggested lower risks of venous thromboembolism with transdermal compared with oral estrogen.^{2,4}

Special populations not addressed by the USPSTF include women with premature or early menopause, those with persistent (long-duration) vasomotor symptoms, and women at elevated risk of osteoporotic fracture requiring complex and

individualized decision-making. In addition, the prevalent condition of genitourinary syndrome of menopause warrants consideration.

Our understanding of the benefits and risks of HT has evolved dramatically over the past two decades. Importantly, guidance to clinicians and women should reflect these refinements and emphasize individualized care and shared decision-making to allow sound decisions regarding use of HT.

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