Hormone therapy to treat menopause-related symptoms or to reduce the risk of certain disorders in postmenopausal women is associated with a favorable risk-benefit ratio when initiated around the time of menopause, but the benefits diminish as the duration of time since menopause increases and among older women, according to the 2010 position statement published by the North American Menopause Society.

The new document updates the organization’s 2008 position statement on the role of estrogen and progestogen hormone therapy (HT) by including consensus recommendations derived from key data published since the earlier statement, the authors wrote, noting that the revised statement includes new sections on ovarian and lung cancer, as well as updates to the sections on breast cancer, cognitive aging and decline, dementia, coronary heart disease, stroke, and discontinuation (Menopause 2010;17:242-55).

“Recent data support the initiation of hormone therapy around the time of menopause” to treat menopause-related vasomotor symptoms, sleep disturbance, vaginal atrophy, dyspareunia, or diminished libido and to reduce the risk of osteoporosis and fractures in some women, the authors wrote.

Specifically, findings from the Women’s Health Initiative (WHI) trial of estrogen therapy showed that 0.625 mg/day of oral conjugated estrogen effectively treats menopause-related symptoms with low absolute risks. Similarly, in the WHI trial of combined estrogen-progestogen therapy, most risks were deemed rare—except for stroke, which was above the rare category—based on the criteria of the Council for International Organizations of Medical Sciences, the authors wrote.

They noted, however, that “there is a growing body of evidence that each type of estrogen and progesterone, route of administration, and timing of therapy has distinct beneficial and adverse effects.” As such, more research is needed before the risks and benefits of HT can be generalized, and “it cannot be assumed that benefits and risks of [HT] apply to all age ranges and durations of therapy,” they wrote.

The most notable changes in the NAMS 2010 position statement on postmenopausal HT are the two new sections on ovarian cancer and lung cancer, which were not included in the 2008 position statement, as well as the assertion that HT is not recommended in women with a history of endometrial cancer (Menopause 2010;17:244-55).

“I think the biggest changes pertain to ovarian, lung, and endometrial cancer,” Dr. Margery L.S. Gass, executive director of NAMS, commented in an interview.

“The new statement also reflects the latest research on the effect of age on the risk-benefit ratio of postmenopausal HT. The current understanding is that the risk-benefit ratio is greatest among women who start HT close to the time of menopause and decreases with time since menopause should make clinicians and women more comfortable using HT right at the time of menopause and more cautious about using it later in life for the prevention of osteoporosis. Most of the side effects associated with HT become more common with aging, even without the use of HT. Therefore, rather than recommending oral or transdermal estrogen therapy for all problems as vaginal dryness and painful intercourse, a local/topical estrogen should be used,” said Dr. Gass, also a consultant to the Cleveland Clinic Center for Specialized Women’s Health, Mayfield Heights, Ohio.

Regarding the association between hormone therapy and cancer, the data are conflicting, according to the NAMS statement authors. “Unopposed systemic estrogen therapy in postmenopausal women with an intact uterus is associated with increased endometrial cancer risk related to the [estrogen therapy] dose and duration,” wrote Dr. Gass, but did not mention that the diagnosis of breast cancer increases with estrogen-progestogen use beyond 3-5 years. However, a reanalysis of WHI data suggested that women who started estrogen-progestogen shortly after menopause experienced an increased breast cancer risk over the next 5 years, while those with a gap of more than 5 years between menopause and treatment did not, the authors explained.

Among breast cancer survivors, estrogen-progestogen therapy has not been proved safe and may be associated with an increased risk of recurrence, as indicated in one randomized, controlled trial that “showed a statistically significant 2.4-fold increase in new breast cancer events,” the authors wrote.

Individualize Hormone Therapy

In general, the 2010 NAMS position statement on postmenopausal hormone therapy is in line with clinical practice; however, many doctors are not prescribing hormones, even when supported by the science, because of bad publicity and a lack of interest combined with fear of litigation.

It is pretty clear that hormone therapy should be used for patients with a clear indication, and the statement outlines what the relevant indications are. The data coming from the Women’s Health Initiative seem to be reversed on the cardiovascular issue. Some of the subanalyses suggest that hormone therapy is associated with a cardiovascular benefit in women close to the age of menopause, while other studies from the same group suggest that this isn’t so. Obviously, the science is evolving, and we are only beginning to understand the mechanism of cardiovascular risks and benefits. With this said, the statement is pretty clear that we should not use hormones to prevent cardiovascular disease.

In all cases, the decision to initiate hormone therapy has to be individualized to each patient. There is not a one-size-fits-all solution. The main issue is determining what is the safest drug for a woman at a particular time in her life.

Disclosures: Dr. Gass and Dr. Stuenkel reported having no financial conflicts.

The position statement can be found on the NAMS Web site at www.menopause.org/PSh10.pdf.