The Swinging Pendulum in Menopause Management

Heather Hirsch, MD, MS, NCMP
Assistant Professor, Clinical Internal Medicine
Division of General Internal Medicine
& Center for Women's Health
Director of Women's Health Education at the
Center for Women's Health
The Ohio State University Wexner Medical Center

Objectives

- Hormone Therapy (HT) is safe and effective
- Studies that prove efficacy and safety
- Understand importance of the timing of Hormone Therapy
- Treatment options for symptoms

Relevance

- QOL
  - Vasomotor symptoms (VMS)/Genitourinary Syndrome of Menopause (GSM)
  - Sleep disturbances besides night sweats
  - Cognitive concerns (memory, concentration)
  - Psychological symptoms (depression, anxiety, moodiness)
  - General health decline.
- Financial
  - Income lost from days off work
  - Indirect/direct increase in health care cost
- Lives lost from estrogen avoidance

Common patient experiences

- Hot flashes
- Insomnia
- Dyspareunia
- Palpitations
- Weight gain
- Joint pains/myalgia
- Urinary tract infections
Likelihood of prescribing hormone therapy

• US OB/GYNs & PCPs: 15 – 20 minute Internet based Survey.¹
• Assessed knowledge via 9 true-false statements about HT and 6 clinical vignettes
• Primary analysis -> correlation between HT trial knowledge and likelihood of prescribing HT.
• N = 501 Physicians.
• Mean score of OB/GYNs was 4.5/9.

• Mean score of PCP was 2.1/9
• Overall mean was 3.8.
• Physicians more knowledgeable about large, published HT trials more likely to prescribe HT.


Menopause

• Menopause is a normal, natural event, defined as the final menstrual period, confirmed after 1 year of no menstrual bleeding.
• Loss of ovarian follicular function.
• Prematurely from medical intervention. (bilateral oophorectomy, chemotherapy, autoimmune)

Clinical Importance:

• By 2020 - 50 million postmenopausal women in the US.
• Will spend 1/3rd of their lives in menopause.
• Vasomotor symptoms (VMS)/Genitourinary Syndrome of Menopause (GSM) are most debilitating symptoms
  • 60 – 90% of women.
• Hot flashes can last on average for up to 7.4 years or more
  • Interfering with daily activity and sleep.
• ¼ women find these symptoms unbearable.
1. Hormone therapy is safe and effective

Back to the future

• 1980s- Observational studies and meta-analyses suggested that HT after menopause was beneficial in preventing osteoporosis, cardiovascular disease, dementia and decreased all-cause mortality.
• Late 1990s/early 2000s - randomized trials.
• 2002 - Almost immediately after the Women’s Health Initiative, HT stopped being prescribed.

Women’s Health Initiative (WHI)

WHI Background

• Two arms –
  • Intact Uterus
    • 16,608 women in 0.625 mg conjugated equine estrogen (CEE) + 2.5 mg medroxyprogesterone acetate (MPA)
    • s/p hysterectomy
      • 11,739 in 0.625 CEE arm.
  • Planned duration of 8.5 years, stopped after 5.3 years in CEE+ MPA arm.

References:
1. Writing Group for the Women’s Health Initiative Investigators. Risks and Benefits of Estrogen Plus Progestin in Healthy Postmenopausal Women: Principal Results From the Women’s Health Initiative Randomized Controlled Trial. JAMA. 2002;288:321-333
**WHI Objectives**

- Randomized controlled primary prevention trial:
  - Coronary heart disease
  - Nonfatal MI
  - Coronary heart disease death.

- The WHI trials were **not designed to study the control of menopausal symptoms** and only a fraction of the women enrolled in the WHI were symptomatic.


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**Women’s Health Initiative: CEE+ MPA ENDS EARLY**

- 2002 – Ended early due to an apparent increased risk of invasive breast cancer and also an increased risk of VTE or stroke in the treatment estrogen plus medroxyprogesterone acetate (MPA) arm.

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**Estrogen Therapy is Dangerous and Harmful**

- As a result, an idea became deeply rooted - that estrogen is dangerous and harmful.
- The idea still persists among doctors and the public in spite of the plethora of scientific evidence to the contrary.
- Information and evidence has so far been unable to ward off the idea.

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**Annual Number of U.S. Prescriptions for All Forms of Hormone Therapy: 1995-2003**

*Hersh et al. JAMA 2004;291:47-53*
Consequences of hormone therapy drop-off

- Due to patient and physician confusion over the results, the usage of hormone therapy (HT) dropped off precipitously.
- 60% increase in anti-depressant scripts written during that time.
- Compounded non-FDA approved postmenopausal hormone prescriptions increased.

Women still want treatment

Compounded non-FDA hormone therapy

- Data estimate the number of prescriptions for compounded non-FDA menopause hormone therapy written on an annual basis:
  - 26 to 33 million prescriptions worth over a billion dollars per year.
  (Estimating $49 dollars per prescription).

Studies that prove efficacy and safety:

- CARIOVASCULAR DISEASE IN WOMEN
  - Long term WHI data
  - DOPS Trial
  - KEEPS Trial
  - Elite Trial
Hormone Therapy and Cardiovascular disease

Timing Hypothesis

- Post-hoc analysis of the WHI has showed several benefits especially within ten years of menopause
  - ‘timing hypothesis’
  - Long term data from the WHI discloses that women on hormone therapy 50 – 59 or within 10 yrs of menopause:1,2
  - Decreased coronary heart disease
  - Decreased all cause mortality
  - Others - reduction in menopausal symptoms, improved quality of life, osteoporosis prevention, & prevention of new onset diabetes mellitus

Long term WHI data 10/2013

- WHI conjugated equine estrogen only
  - Total mortality HR of 0.73 (0.47-1.13)
- In analysis that combined estrogen/MPA and estrogen therapy
  - Hormone therapy was associated with a significant 30% reduction in mortality among women in their 50s
  - No effect on women in 60s
  - Increased mortality on women in 70s.

1. Manson J. et al. Menopausal hormone therapy and health outcomes during the intervention and extended post-stopping phases of the Women’s Health Initiative Randomized Trials. JAMA 2013;310:1353-1368.
Game Changer: DOPS Oct 2012

- 10 year randomized clinical trial of Danish women
- younger symptomatic (age 50)
- Followed for ten years
- **Oral EPT (estrogen-progestin therapy) – estradiol + norithindrone**
  - Significantly reduced:
    - Risk of mortality
    - Heart Failure
    - Myocardial infarction
  - Without any apparent increase in risk of:
    - Cancer
    - Venous thromboembolism
    - Stroke


Newer Research: KEEPS trial

- Ave age 52.
- 3 arms: Placebo, oCE, tE2 with cyclic micronized progesterone Days 1-12.
- Both treatment arms:
  - Improved bone density
  - Improved cardiovascular markers (did NOT include BP)
  - Improved vasomotor symptoms
  - Improved insulin resistance
  - Improved genitourinary syndrome of menopause and lubrication
  - No adverse affect on cognitive function

Elite Trial: NEJM 2016

- Oral estrogen + vaginal progesterone in women < 6 years or > 10 years after menopause.
- Measure coronary calcium and carotid intimal thickening.
  - Oral E was associated with less progression of subclinical atherosclerosis (measured as carotid intimal media thickness) vs. placebo when started by 6 years of menopause, but not when started 10 years or more after menopause.
- Study confirmed the timing hypothesis -10 year window in which prescribing hormone therapy is beneficial to cardiovascular health, and likely not harmful.


Pathophysiology Continued

- Timing Hypothesis:
  - In earlier stages of atherosclerosis, estrogen may have beneficial effects on lipids and endothelial function.
  - In advanced atherosclerosis, estrogen may trigger acute coronary events through prothrombotic and inflammatory mechanisms.
Hormone therapy and cardiovascular disease after stopping therapy

• Recently published large observational study from Finland reported increased cardiovascular mortality during the year following discontinuation of HT.1

• Post WHI trial analysis showed mortality was increased within the 3 years of cessation of the E+MPA arm relative to those who were assigned to placebo (hazard ratio [HR]=1.15; 95% confidence interval [CI], 0.95-1.39).2


Back to the Future

The Future is Now

• Observation Vs. Randomized Controlled Trials.

• Data show that in primary prevention, HT reduced coronary heart disease and all cause mortality in women who initiate HT before age 60/ten years of menopause.

• Data are consistent across observational studies, randomized clinical trials and meta-analyses.

Timing Hypothesis & Coronary Heart Disease

• HT appears to REDUCE coronary heart disease risk when initiated in younger and more recently postmenopausal women.

• Longer HT duration associated with REDUCED coronary heart disease risk and mortality.

• Evidence of lower coronary heart disease risk in women who used HT ≥ 5 yr exists in WHI.

Hormone therapy & hot flashes, mood and quality of life

NAMS 2017 position statement
HT & Vasomotor Symptoms

- Treatment of moderate to severe vasomotor symptoms remains primary indication for systemic HT.
- Every systemic product in the US/Canada is approved for this.
- Significant data support its use in women to treat
  - Menopausal symptoms
  - Prevent osteoporosis in women at high risk for fracture.

HT and improvement in mood & quality of life

- KEEPS trial
- Oral - improvement in mood.
  - Improved significantly on measures of depression-dejection and anxiety-tension.
  - Showed a trend in improvement on measures of anger-hostility
  - Improvement in memory recall
- Transdermal-
  - Improved arousal and desire
  - Insulin sensitivity

Hormone therapy & insulin sensitivity

HT & Insulin Sensitivity

- PM women on HT have higher glucose utilization and improved insulin sensitivity than women not on HT. ¹
- Kaiser data: shows a 30% reduction in risk of diabetes in women on HT.
- WHI Data
- In diabetics - Transdermal ET may have advantages over oral estrogen.
- Inadequate evidence to recommend HT for sole or primary indication for diabetes mellitus prevention.

In the E+MPA arm of the WHI, there was a statistically significant decrease in the incidence of colorectal cancer.¹
Hormone therapy & Osteoporosis

Osteoporosis
- In the WHI, HT reduced the risk of hip fracture by 50%.
- In the conjugated equine estrogen arm fracture reduction was seen at all sites.¹
- In the E +MAP arm, after approximately 5 years there was²³
  - 33% reduction in hip fractures.
  - 24% reduction in all fractures.
- A meta-analysis of 22 trials of estrogen for the prevention of fractures⁴
  - 33% reduction in non-vertebral fractures in women under age 60
  - 12% reduction in women over 60.

HT & Osteoporosis
- HT proven to reduce postmenopausal osteoporotic fractures.
- Most systemic HT is approved for the prevention of post-menopausal osteoporosis through long-term treatment.
- Extended use of HT is option for women with low bone mass, regardless of menopause symptoms, when alternate therapies not appropriate.


NAMS position statement 2017
**HT & Breast Cancer: Estrogen Only**

- **WHI** - At end of intervention of 7.1 years, fewer invasive breast cancers in the estrogen alone group
  - HR 0.80, CI 0.62-1.04

- After longer follow-up 12 years, statistically significant lower incidence of invasive breast cancer emerged in the estrogen alone arm
  - HR 0.77, CI 0.62-0.95
  - Effect is seen during and after intervention.

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**HT & Breast Cancer: Estrogen Only**

**Estrogen Only**

- Women receiving ET who did develop breast cancer, had a 63% reduction in deaths from the disease (6 deaths) versus those in the placebo group (16 deaths).

- Use of estrogen alone did not substantially interfere with breast cancer detection by mammography.

**Combined Estrogen + MPA**

- WHI - Associated with a 24% increased risk of invasive breast cancer.

- The RR of 1.26 with E/MPA translates to an excess risk of 4 per 1,000 women taking hormone replacement therapy for a 5 year time period.

- Epidemiologic data have linked alcohol consumption to risk of breast cancer
  - An approximate 11-50% increase in breast cancer risk from 15-30 grams/day of alcohol consumption.

**Combined Estrogen + Progestin**

- Post-menopausal primate model using estradiol + MPA versus estradiol + micronized progesterone

- MPA significantly increased breast cancer cell proliferation whereas micronized progesterone did not

- Analysis from French prospective cohort study

- No increased risk of invasive breast cancer in users of synthetic progesterone

- Increased risk in estrogen + compounded progestin's (MPA, cyproterone, promesgestone, nomesgestrol, medrogestone)


**Hormone therapy and cognitive function**
**Women’s Health Initiative Memory Study (WHIMS)**

- HT not recommended at any age for the sole or primary indication of preventing cognitive aging or dementia.\(^1\,\text{,}\,^2\)
- HT seems to increase dementia incidence when initiated at ≥ 65
  - Increase stroke risk.
- WHIMS did not look at women < age 65

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**Hormone therapy and venous thromboembolism risk**

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**HT & Venous Thromboembolism**

- Oral HT increases venous thromboembolism risk in postmenopausal women
- Similar deep venous thrombosis risk with SERMs
- Venous thromboembolism risk emerges soon after HT initiation
  - Peaks at 6 months
  - Decreases over time.
- Lower venous thromboembolism risk with in women <60 yrs
- Lower venous thromboembolism risk risk with transdermal than with oral (ET-ESTER study)
- Lower HT doses may be safer than higher doses

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**HT vs hormone contraceptives**

- Venous thromboembolism major issue with both:
  - 2-4 fold increase with HT
  - 3-6 fold increase for hormone contraceptives
- Transdermal hormone contraceptives
  - Higher venous thromboembolism risk compared to transdermal HT.

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Absolute benefits / Risks 13+ years

Absolute benefits and risks from the 13 year follow up study from the hormone trials of WHI: Conjugated Estrogens (CEE) alone trial and the trial with CEE combined with medroxyprogesterone acetate (MPA). Data on the initiation of HRT in women 35-50 years of age or < 10 years from the onset of menopause: number of events per 10,000 women per year. * The only statistically significant adverse outcome. Adapted from Manson JE et al. N Engl J Med 2016; 803–806

The Morbidity & Mortality Toll of Estrogen Avoidance

- Over a 10-year span, starting in 2002, a minimum of 18,601 and as many as 91,610 PM women died prematurely because of the avoidance of estrogen therapy (ET). 1,2
- Substantial increase in hip fractures due to HT discontinuation rates.


NAMS position statement 2017

Incremental Direct and Indirect Costs of Untreated Vasomotor Symptoms

- Employer-based Insurance Records
- U.S Fortune 500 companies.
- Case Cohorts: Untreated vasomotor symptoms vs. vasomotor symptoms (control).
  - N=252,273; mean age = 56
- Number of health care visits & cost of lost work for 12 months.
  - 1.5 million more outpatient visits (per year) by women with untreated vasomotor symptoms.
  - (PerPtPerYr) = $2,000.00 more for women with untreated vasomotor symptoms.
- Total cohort cost (252,273 women in each group): Nearly $400,000,000 more for women with untreated vasomotor symptoms.

Length of treatment

- The American College of Obstetricians and Gynecologists and NAMS have expanded their treatment definition to state that women on HT do not need to stop treatment at the age of 65.
- Often, symptoms return.
- Consider lower doses with aging due to decreased metabolism.

NAMS position statement 2017

New Paradigm
“Designer” Estrogens
SERMs/ERAAs

Estrogen Agonists/Estrogen Antagonists

The ideal SERM/ERAA

ERAA: Bazedoxifene/conjugated equine estrogen: Duavee

- SERM/ERAA
- 20 mg Bazedoxifene with 0.45 conjugated equine estrogen
- SMART Trials:
  - Effective and safe treatment for menopausal symptoms in women with intact uterus.
  - FDA Approved to treat vasomotor symptoms.
  - FDA approved to prevent osteoporosis.
  - No increase in uterine cancer.
  - Bazedoxifene competitively inhibits binding of 17-B estradiol – antagonist at uterus.
- Carries similar risk of deep venous thrombosis as HT

ERAAs and their respective benefits

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Non-Hormonal Option for Menopause Symptoms

- FDA Approved:
  - Brisdelle 7.5 mg at night (Paroxetine)
  - 7.5 mg low dose not associated with weight gain or sexual dysfunction

- Several off label options for vasomotor symptoms:
  - Desvenlafaxine
  - Venlafaxine
  - Gabapentin

- Insomnia:
  - sleeping agents
NAMS 2015: Lifestyle Symptom Management

- Recommended:
  - CBT
  - Hypnosis (to lesser extent)
- Recommend with caution:
  - Weight loss
  - Mindful stress reduction
  - Soy isoflavones
- Not Recommended
  - Exercise, yoga
  - OTC supplements and herbals
  - Acupuncture
  - Chiropractic interventions.

Genitourinary Syndrome of Menopause

GSM

- Symptoms:
  - Vaginal dryness
  - Vulvo-vaginal irritation/itching
  - Dyspareunia
  - Frequent bladder infections
  - Urinary incontinence, dysuria, urethral symptoms
  - Experienced in most postmenopausal women, yet only 25% of these women seek treatment.

- Unlike vasomotor symptoms, vaginal atrophy is progressive and unlikely to resolve on its own

Genitourinary Syndrome of Menopause Treatment

- NAMS position statement:
  - non-hormonal lubricants
  - moisturizers in combination
  - regular sexual activity considered first line.

- This is often, if not usually, inadequate

- Local vaginal ET more effective

- Systemic HT may be needed to treat genitourinary syndrome of menopause.
### Vaginal Estrogen

- **Creams**
- **Vaginal Rings**
- **Vaginal tablet**

### Prasterone

- FDA - Approved Prasterone for Dyspareunia in Postmenopausal Women.
- Once-daily vaginal insert
- The first FDA-approved product containing the active ingredient prasterone, dehydroepiandrosterone (DHEA)
- Efficacy established in 2 - 12 week clinical trials of 406 women with dyspareunia.
  - Reduced pain with intercourse
  - Safety established in 52 week trial

### Summary: Explaining HT Risk

- Potential absolute risks with the use of HT are very low
  - Especially for ET in hysterectomized women
  - Especially for younger women closer to menopause
- GOLD standard for vasomotor symptoms, genitourinary syndrome of menopause, and osteoporosis prevention
- Greatest risk of HT related to venous thromboembolism (same for ERAA/SERMs and hormone contraceptives)

### Summary: Benefits >> Risks

- Benefits outweigh risks
- Each regimen, route, and timing of therapy has distinct beneficial and adverse effects.
- Each woman must be informed of her known risks/benefits and alternatives.
  - Acceptance of HT risk balanced with understanding risks in not treating
  - And compared to risks similar to other agents commonly used (eg Statins, ERAAs/SERMS, diabetic agents, aspirin others)
Lastly: Individualized Treatment Needed

- An individual risk profile is essential when contemplating HT.
- Late HT initiation in older women-with no indication is less favorable
- Women with premature menopause have increased symptoms and risks-TREAT or REFER
- Recommendations are DIFFERENT for first users versus previous users in their 60s - REFER

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