Is it HOT in Here? The TRUTH about Hormone Therapy

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"Help, I'm having a meltdown!"

This seems to be a mantra of some women in their 40s and 50s. Hot flashes and night sweats are just some of the symptoms women experience when their ovaries begin producing less estrogen and may occur for months or even years before a woman's last menstrual period.

The exact cause of hot flashes (or flushes) is unclear. What is clear is that diminishing estrogen levels causes a deregulation of the body's temperature control mechanism, allowing an increase in peripheral and core body temperature. Hence, hot flashes are a result of an actual increase in body heat.

Night and daytime hot flashes can interrupt sleep and cause other quality of life issues, such as daytime drowsiness and fatigue.

Many women seek "non-hormonal" remedies for hot flashes such as soy, black cohash, red clover and other supplements. Although some women find relief with these products, there is little scientific evidence to support their effectiveness. Certain antidepressant drugs have proven helpful for some women to control menopausal symptoms, specifically women who cannot take hormone therapy.

Hormone Therapy – what you need to know

The most effective therapy currently available to treat hot flashes is hormone therapy (HT). In recent years, the practice of hormone therapy has gotten negative publicity due to the 2002 release of the Women's Health Initiative (WHI), a study that showed an increased risk for heart disease among HT users. The results of this study led to a media frenzy and, based on pharmacy records, hundreds of thousands of women stopped using prescribed hormone therapy.

However, in the final analysis as well as in spin-off studies, it was found that women who started HT early in menopause (as opposed to the women in the WHI study who were 15-20 years postmenopausal) actually tended to have a reduced risk of heart disease. The increased breast cancer risk was only 1:10,000 higher than that of the placebo group and not considered statistically significant. Additionally, WHI showed a decreased risk of colon/rectal cancer, hip fracture and new-onset diabetes among HT users.

Physicians still find that HT is the most effective therapy for menopausal symptoms and that it is safe for most women.

Is it necessary to test for menopause?

Laboratory testing for hormone levels is generally not helpful due to the normally wide fluctuations in female hormones, and there is no scientific evidence that "saliva testing" for female hormone levels is biologically meaningful. (Millions of dollars are spent every year for saliva testing and compounded hormones. These are advertised as being more natural and safer. This is actually not true and could even be more dangerous.) In addition, centers that offer saliva testing advertise "customizing hormones" for individual women. Hormone therapy (estrogen and progesterone) does not need this individualized dosing since there is a wide range in therapeutic levels and toxic concentrations are extremely unlikely. Therefore, testing isn't only unnecessary; it's unreliable. I prefer to treat patients based on symptoms of estrogen deficiency, which include hot flashes, night sweats, mood swings and cognitive issues.

While hormone replacement is the safest and most effective treatment for menopausal symptoms, it's important to know what your options are.

Bioidentical Hormones

Compounded and FDA-approved bioidentical hormones have the exact molecular structure as those made in the human body. All hormones outside the human body have to be made in a laboratory/pharmaceutical setting (there are no natural occurring sources of estrogen or progesterone outside the human body) and are formulated to be metabolized exactly as the body would metabolize estrogen or progesterone from the ovary itself.

Compounded bioidentical hormones are prepared, mixed and assembled by a pharmacist under a prescriber's orders. Most compounded products have not undergone rigorous testing for safety, effectiveness, purity, potency and quality. There is no scientific evidence to support the claims made of increased safety with use of these products.

There are many bioidentical hormones that are FDA-approved, including various patches, creams and gels that are manufactured using the same plant-derived hormones as compounded products. However, FDA-approved bioidentical hormones must pass stringent quality control standards and therefore lack the intrinsic risk of compounded products. I recommend the FDA-approved "patch" for estrogen replacement because it is bioidentical to the estrogen produced by the human ovary, it maintains very steady delivery of estrogen, preventing highs and lows in symptoms, and is very friendly to cholesterols – lowering the bad, raising the good – and does not increase triglycerides.

There is one FDA-approved bioidentical hormone patch that contains both estrogen and progestin in the same patch (it must be changed twice weekly). There's also a vaginal ring that delivers systemic estrogen levels and is changed every three months. Some oral estrogen products are bioidentical; some are not. The estrogen used in the WHI was Premarin, the first estrogen for hormone therapy in the United States (derived from pregnant mares' urine). Many of the compounds in Premarin are not utilized in the human female and are simply excreted in the urine. Today, although still frequently prescribed, Premarin has for the most part been replaced by the newer estrogen formulations.

Women who have a uterus must also take a progestogen, as taking estrogen without progestogen increases the risk of endometrial cancer four to five fold. Natural micronized progesterone is available in an FDA-approved product called Prometrium. Other synthetic progestens are available but are not bioidentical.

Also, "compounded" topical progesterones lack absorption so they are not adequate to protect the endometrium.

Overall, for healthy women who are newly menopausal (natural or surgical) with symptoms associated with menopause, the benefits of hormone therapy most likely outweigh the risks. Women who are candidates for HT, but are concerned about possible risks, can be assured that the women enrolled in the WHI were on average 15-20 years postmenopausal and not the typical symptomatic menopausal women seen in clinical practice today. Talk to your healthcare provider or a specialist in gynecology/women's health regarding the right kind of therapy for you.

REFERENCES:
North American Menopause Society: www.menopause.org
The Endocrine Society: www.endo-society.org
American College of Obstetricians and Gynecologists: www.acog.org
Red Hot Mammas: http:///www.redhotmamas.org

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