

2. Principles of Practice

Keywords Menopause • Transdermal estrogen • Hormone therapy prescription • Hormone therapy routes of administration

For decades, menopausal-range women have been treated as a homogenous subgroup, with HT seen as a one-size-fits-all prescription. Hormone therapy can no longer be expected to be the automatic prescription and “cure” for female aging that clinicians only a few years ago desired it to be. Today, HT and menopause management demand a focus on managing individual symptoms, paying close attention to what the patient reports, understanding the science, and helping patients demystify the many confusing popular reports they may have heard about menopause and about hormone therapies. The menopausal-range years offer a window of therapeutic opportunity, in which clinicians can help women move from their years of reproductive potential, to the postmenopausal period, with concern for symptomatic relief and general good health.

Principle of practice: Menopause is not a disease, and should not be regarded as a pathophysiologic process. If a woman presents with symptoms, these are treatable as such. There’s no need to suffer through hot flashes, night sweats, cognitive problems, sleep disturbance, vaginal dryness, urinary incontinence, and other results of fluctuating levels of sex steroids. Conversely, women of menopausal age who don’t have severe symptoms and who are doing just fine don’t need HT just because they’re in perimenopause or menopause.

Principle of practice: The term “hormone therapy” is in many ways a misnomer, as is its implication that all estrogens are interchangeable. Broad generalizations about hormone actions, efficacy, and safety greatly simplify a complex and nuanced body of knowledge.

“Hormone therapy” is used to encompass all:

- Families of hormones, including estrogens (estradiol, estrone, and estriol), progesterone, and progestins (such as medroxyprogesterone acetate) and testosterone
- Types of estrogens, ranging from conjugated equine estrogens and plant-derived esterified to bioidentical
- Types of progesterone and progestins, including, among others, medroxyprogesterone acetate, NETA, and oral micronized progesterone
- Routes of administration, including oral, transdermal, intravaginal, local topical and coming, injections subdermal pellets and soon, inhalations
- Dosing regimens, including daily and cyclic
- Broad statements about hormone safety and efficacy greatly simplify a complex and nuanced area

Principle of practice: The perimenopausal transition is not equivalent to estrogen deficiency but involves changes in other sex steroids including progesterone, testosterone, and their ratios. In some women, estradiol levels may be higher in perimenopausal cycles compared to their premenopausal cycles. It is essential that clinicians recognize that the symptoms arise from changes in sex hormones, not just deficiency. These changes include a steady decrease in progesterone production and an increase in the estradiol to progesterone ratio until the last cessation of cycles.

Principle of practice: Women experience the menopausal years as individuals, and require individualized medical care and hormone therapy. Women have varied perimenopausal symptoms that may occur as early as their late thirties and postmenopausal symptoms that can occur as late as their sixties. These require varied treatment. Even women of similar age respond differently to various formulations, dosing regimens, and routes of administration. Necessary for effective hormone therapy is a focus on treating individuals, not populations. Currently, there are few specific guidelines for prescribing hormones, and there are none that instruct how to individualize the care that perimenopausal and postmenopausal women receive. This handbook rectifies that knowledge gap with easy to access information about dosage, drugs, routes of administration, and decision-making based on symptoms. The one-time practice of a standardized and uniform approach to menopause treatment is outdated. Women experience symptoms differently and must be treated accordingly.

Below are additional principles of practice for perimenopause and postmenopausal management and HT prescription:

- HT should not be used to “treat” or prevent other disease associated with aging, including heart disease and cancer risk.
- HT should be used specifically to alleviate symptoms of perimenopause and menopause, including hot flashes and night sweats, cognitive “fuzziness”, urogenital symptoms, and sleep disturbance.
- The well-publicized dangers of a prior generation of hormone replacement therapy in terms of raised risks of breast cancer and heart disease were based on the use of a specific formulation of oral conjugated equine estrogens and medroxyprogesterone acetate. Not only were the conclusions based upon two popular regimens, but the negative findings of increased incidence of breast cancer and coronary artery disease were not detected in women who started hormones in their 40s and 50s. The new favored prescription practice is transdermal application, either through patch, cream, or gel.
- Women understandably may be very skeptical about using hormones given the amount of controversial and often conflicting media attention accorded to the WHI findings. Women may require a great deal of explanation about risks and benefits. The important principle is to work in partnership with patients, giving them enough information so that they can make informed decisions about this controversial area.
- Many clinicians have been reluctant to prescribe hormones due to a pronounced lack of coverage given to the WHI findings of safety and benefits in younger women.
- Women in the menopausal range have a huge amount of information at their fingertips due to the popularity of books by Dr. Susan Love and celebrity Suzanne Somers about aging and about designer bioidentical hormones. The medical information in Somers’s books is relatively sound, even if in our opinion and in most cases the designer estrogen phenomenon is not more effective than the new HT practice. The most important thing we practitioners need to do and know is to be respectful of the information about bioidentical hormones that our female patients are bringing into our offices, and work with them from that basis as we provide sound medical guidance for prescribing and monitoring HT use.

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