Women's Critical Health Issues

Hormones, Obesity and Screenings

Ten years ago, Healthy Living magazine's first Physicians Roundtable discussed hormone replacement therapy in post menopausal women. Healthy Living recently assembled a group of Eisenhower physicians to discuss today's views regarding hormone replacement therapy and issues affecting women's health in general. Participants included Eisenhower gynecologists Lisa Lindley, MD, and Jeralyn Brossfield, MD, who specialize in women's health issues. The session was moderated by Eisenhower Cardiologist Philip Shaver, MD, whose patients include a large number of postmenopausal women with cardiac disease.

Dr. Shaver: Dr. Lindley, what do you think has been the most significant advance during your practice of medicine?
Dr. Lindley: I think one of the most significant achievements is the HPV (human papiloma virus) vaccine. Now we can vaccinate [against] a virus that causes cancer; not only cervical cancer in women but esophageal, throat and other head and neck cancers.

Dr. Shaver: There is a time that [the vaccine] is appropriate before first sexual contact, or should it be any time in a woman's active sexual life? Dr. Lindley: The goal is to vaccinate young women, and now also young men, before their first sexual encounter. Then we know they have never been exposed to the virus. It is still worthwhile to vaccinate those who are already sexually active. Most people who are infected have been infected with only one strain of the virus, and therefore may receive protection from the other strains in the vaccine. There are currently two FDA approved vaccines which offer protection against up to four of the most worrisome strains of HPV.
Dr. Brossfield I think that's probably the greatest change, because it also starts to affect the way we practice with PAP smears. With HPV testing, there are new guidelines coming, and PAP smears will not have to be done as frequently. We both hasten to add to our patients that that doesn't mean they need fewer visits; they still need to see a gynecologist or have their family physician do a pelvic exam once a year, but the PAP smear itself is undergoing changes.

Dr. Shaver: Even before the vaccine, there were some guidelines regarding the woman who had a negative PAP smear and was a certain age, and wouldn't need them anymore. Is that still valid?
Dr. Brossfield: I think that is still more related to that person's lifestyle. I frequently say to my patients, if there is no new partner, and no history of cervical cancer, you don't need to continue having a yearly PAP smear. However, I still do yearly PAP smears in my 80 year old patients, if they have a new partner.

Dr. Shaver: How about someone who is no longer sexually active. Is there an age at which they don't need to have a pelvic exam, with or without a hysterectomy?
Dr. Lindley: ACOG [American Congress of Obstetricians and Gynecologists] says it is reasonable to stop PAP smears after the age of 70 if these patients have had three normal PAP smears in a row and no abnormal results in the past ten years. But I agree with Dr. Brossfield, that older patients with a new partner may have a new exposure. It is important to stress that even though a woman may skip her PAP smear, she still needs a yearly pelvic exam. We screen these patients for much more than just cervical cancers. We are looking for masses in the pelvis, as well as vulvar, vaginal and skin cancers.

Dr. Shaver: There are still a number of women who have had a hysterectomy for fibroid tumors and have intact ovaries.
Dr. Lindley: Absolutely. She still needs her annual pelvic exam even if she's had a hysterectomy (removal of the uterus), and especially if she still has her ovaries.

Dr. Shaver: Because you take care of the whole patient, women's health guidelines for screening come up frequently. I am interested in when you initiate breast cancer screening in someone who does not have a positive family history of premature ovarian or breast cancer. What do you recommend?
Dr. Lindley: We both are still following the American Cancer Society guidelines which say start annually at the age of 40. I just read an article that said an annual mammogram between the ages of 40 and 50 reduced the risk of mastectomy by 50 percent.
Dr. Brossfield: ACOG actually just issued a supplemental guide reiterating their support for annual [mammograms]starting at 40, which…reverses a little bit of their position that they had had a year or two ago.

Dr. Shaver: What do you see as the greatest challenge to the future of your specialty? Let me propose this as the greatest challenge to all of us, and that is the growing incidence of obesity. Two out of three women over 20 are either overweight or obese in this country, and we're seeing an epidemic of diabetes. Because of the trend of obesity, we may be seeing a reversal of the protection younger women have demonstrated. Have you had any luck in convincing people about lifestyle changes?
Dr. Brossfield: This year obesity-related disease surpassed lung cancer as the number one preventable cause of death.
Dr. Lindley: Obesity is the single greatest health issue in our country right now, and the greatest challenge. If we can encourage patients to lose weight, make lifestyle changes and stop smoking, these interventions will have a larger impact on their health than any pill we can give them. Obesity is directly linked to heart disease, diabetes, breast cancer, and overall cancer risk.

Dr. Shaver: So what has worked?
Dr. Lindley: We have used several different diet programs. We begin by assessing the patient, helping them choose a program and then educating them. For instance, if they choose a meal come off of that program. Education and accountability are the keys to long-term success.
Dr. Brossfield: The things that have really created the most success in my patients include commitment to a program, whether it's a meal replacement program, which happens to be the one I'm seeing the best success with, or another type of program or a nutritionist, combined with a person of accountability. I have now started training lay persons…to be buddies or coaches to other people through a system that Johns Hopkins has used for the last 15 years. This is a program of accountability with a buddy and a psychological/educational program, a curriculum that shows them what it takes to make continual healthy choices that are optimal for them. I believe it is essential to combine those three features: education, a coach for accountability and a dietary regimen. I have now seen 260 people over the past year that have used that successfully and maintained their weight loss through a one year period of time.
Dr. Lindley: There was a study that showed if patients kept a journal of what they ate, creating personal accountability, those patients lost more weight and were more likely to keep it off. Dr. Brossfield: Johns Hopkins' preliminary data was released and it showed that people who put themselves in the position of being accountable to another person are five times more successful at maintaining their weight loss.

Dr. Shaver: What kind of research do you see in the next five years that will change your practice?
Dr. Lindley: I see treatments targeted towards genetics, whether that's a cure for cancer or disease prevention. I believe we will be able to offer different treatments based on a patient's genetic make-up.
Dr. Brossfield: I still really hope for hormone research, because there's a lot of controversy, but we see women day in and day out where the use of hormones has made such drastic changes for that person in their lifelong health, that I hope for that data at least.

Dr. Shaver: The three most recognizable symptoms of menopause are hot flashes or flushes, night sweats and vaginal dryness. You mentioned the importance of pelvic exams. If women aren't having pelvic exams, they may be ignoring something that is a problem — vaginal dryness, painful intercourse, more frequent urinary tract infections, and you can potentially do something about that.
Dr. Brossfield: Regarding vaginal dryness, over the last two years there have been a couple of major studies that show that using a vaginal estrogen does not raise systemic levels to the degree of having any risk even for a post breast cancer patient, which allows us to treat vaginal atrophy effectively and make people comfortable without a systemic level of hormone. Vaginal dryness is a pretty limiting description in that the collagen elasticity is maintained by estrogen and does not get affected by a lubricant or a moisturizer. It really is an elasticity issue and the estrogen can restore that, even years after menopause.

Dr. Shaver: If a patient came to you and just said I've gone through menopause and I feel fine, is there any reason to put her on estrogen? Dr. Brossfield: The age of the patient is really a key factor. If a person under the age of 60 was symptomatic with menopausal symptoms, we would likely recommend an estrogen as a first line of therapy, unless she had an MI [myocardial infarction or heart attack] or had breast cancer. Of patients who are over the age of 60, it's rare that [Dr. Lindley] and I would initiate estrogen. I have done it, but it's been with a really specific need, where we've detailed out that there weren't other risk factors.

Dr. Shaver: Both [the American College of Cardiology and ACOG] agree estrogen should not be employed to prevent cardiovascular disease. The patient has to be part of the answer and understand they are taking some responsibility. We are going to tell patients the benefits and risks of this.
Dr. Lindley: It is critical to accurately educate patients as to the true risks and benefits of any therapy, and nothing is risk-free. Unfortunately, since the WHI [Women's Health Initiative] study, the risks of hormone therapy have been overstated, while the benefits are often lost [in translation]. We should not ignore more than 40 years of observational studies which have shown numerous benefits in current and past users of hormone therapy. Having said that, there are patients in whom the risks outweigh the benefits. The point is that it's a complex decision, requiring assessment and education in each individual case.

Dr. Shaver : I have seen patients who use a number of nonhormonal treatments for symptoms: acupuncture, soy and phytoestrogens had their day. Will you use any of these with your patients?
Dr. Lindley: Currently any studies on these therapies have shown them to be equal or less than placebo. However, the placebo effect can be quite large. Roughly 30 to 40 percent of patients respond to placebos. So if a patient is taking a non-hormonal remedy, and she feels better, that's fine. It is important to review those remedies or supplements with your doctor as they also have side effects and can interact with other medications.
Dr. Brossfield : There was just an article about a study that determined exercise by itself was equally beneficial as anything else that's been tried, and they had done an analysis comparing it to other treatments. I often will say to people the best way you're going to be able to go through menopause is to help your body be as healthy as possible as you enter that time of your life.

Dr. Shaver : I think, if I were a young woman going through menopause, with hot flashes, and I had very few risk factors for cardiac disease, I would certainly take estrogens. I would do it with the understanding that I would hope that this would not be a lifelong thing, and in two or three years, I would come off of it and see if I didn't have hot flashes anymore. Dr. Lindley: There was no increase in any risk with less than five years of hormone use in the WHI study. But I recently read another article that stated you need to take them for seven years to get the benefits of bone health. You may decrease certain risks when you stop therapy, but you also lose the

benefits. Again, it's a risk/benefit ratio.

Dr. Brossfield : Most of the reported and published studies over the last nine years have been rewrites of some sections of the WHI study. It's not new data. It's just a re-write and a new presentation of the same data, [but] women come in thinking something new has been found and it's the same data.

Dr. Shaver : I've always said that the patient will never have a better advocate than themselves, and an educated patient, a patient who goes to recommended Web sites and comes to us with questions is going to be the best advised. We will tell them the pros and cons.

Dr. Lindley: My goal is to educate patients so they understand all these things that they're being bombarded with in the media, and help them sort through that data, to understand their own risk and make a decision that is best for them.

Dr. Brossfield : My favorite slide last year at the North American Menopause Society meeting was a slide of a woman's brain during a hot flash. It literally demonstrated between a 75 to 80 percent reduction of blood flow to the brain tissue on a PET type scan during a hot flash, and to me, that is evidence that you can't say women ought to be able to function through hot flashes and ignore them.

Resources

Dr. Lindley and Dr. Brossfield are among several gynecologists available for patient care. For a physician referral call 760-568-1234.

www.menopause.org The North American Menopause Society www.nlm.nih.gov/medlineplus/menopause.html

www.nof.org National Osteoporosis Foundation: information, education, and support for people with osteoporosis in the United States.

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