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I wish you a Merry Christmas

and

a Happy New Year

Case Discussion

Mrs JNS is 56 years of age. Her last period was at the age of 51. She has been on combined HRT for 5 years. She started combined HRT because of hot flushes, loss of memory and feeling tired and they are now well controlled on HRT. She had no gynaecological problems since her menopause. She heard about the risks associated with HRT from the media and she came to you for advice

- **Should you apologize that you have not sent her a letter to advise her to stop HRT?**
- **Should you dismiss the media coverage of the recent papers on HRT?**

* The results from the recent HRT studies (WHI and Million Women Study) do not necessitate any immediate changes to women's HRT treatment. However, women on HRT should have their therapy and health regularly reviewed (especially with long term use).
* Combination HRT is **only** indicated for the treatment of menopausal symptoms and prevention of osteoporosis (**but it should not be the first choice medication**). HRT should **not be** initiated or continued for the primary prevention of CHD
* For management of menopausal symptoms HRT may be used for 1-2 years after the menopause.
* The absolute risks from HRT were small and that the overall rates of deaths and all cancers were not increased with combined HRT.
* Initiation of HRT should be based on review of the risks and benefits of treatment for the **individual woman**. **The risks for cardiovascular disease and breast cancer must be weighed against the benefit for fracture in selecting from the available agents to prevent osteoporosis**. In general terms; over 1 year, 10 000 women taking continuous combined oral HRT compared with placebo might experience 7 more coronary heart disease events, 8 more strokes, 8 more pulmonary embolisms, 8 more invasive breast cancers, 6 fewer colorectal cancers, and 5 fewer hip fractures.

The patient decided to stop HRT, as she is worried about what she has heard.

- **What advice would you give her?**
- **She heard about natural progesterone to be a safe alternative to HRT. What advice would you give her about its safety?**
- **Her main worry is the possibility that the hot flushes may return. What methods other than HRT you can recommend to manage the hot flushes? When do you start her on these alternatives?**

* Lifestyle counselling is important because good health habits can reduce the incidence of chronic health problems and reduce the menopausal symptoms. Critical components of a healthful lifestyle include good nutrition, exercise and smoking cessation.
* **There is a double increase of breast cancer risk with all types of progestogen-only preparations.**
* Alternative medications for controlling hot flushes should only be started if the hot flushes are severe enough and the patient cannot cope with them. Most of the hot flushes that develop after cessation of HRT are temporary in nature and the patient should be encouraged to use general measures before the use of any medication (None of the medication has been licensed for the management of hot flushes):
    * Avoid common triggers include a warm environment by turning down the thermostat, sleeping with fewer blankets, and wearing layered clothing
    * Avoid stress, alcohol, caffeine, and spicy foods.
    * Regular aerobic exercise
    * Vitamin E (400 to 1,200 IU daily), Evening primrose oil, Reflexology, Acupuncture
    * Clonidine hydrochloride
    * Antidepressant: Venlafaxine 37.5 mg to be increased to 75mg daily, Paroxetine 10 mg increased to 20mg daily bedtime, Fluoxetine 20 mg/day
    * Gabapentin increasing in dose over 3 weeks from 300 mg to 600 mg to 900 mg daily.
    * Soy and Isoflavones (50 grams of soy protein per day) (soybeans) for < 2 years, Black cohosh for < 6 months.

She stopped HRT for six months and came back with the complaint of loss of libido

- **What questions would you like to ask the patient before deciding on the management?**
- **Would you like to carry on any examination or investigation?**
- **Would you start her back on HRT?**
- **Would you refer her for androgen therapy?**

* The loss of libido is not necessarily hormonal of origin in all cases. The premenopausal sexuality of the couple and current marital issues should be evaluated first. Physical and psychological disorders should be excluded. Superficial dyspareunia due to atrophic vulval and vaginal changes may be a major contributing that can adversely influence sexual function.
* Clinical studies have not supported the effect of androgen therapy on loss of libido in ladies with normal androgen levels. There is no available androgen preparation that is licensed to use in females as none can achieve physiologic replacement levels of testosterone in females. A matrix testosterone patch is under development for women that can achieve physiologic testosterone levels. Androgen therapy is only indicated if there is subnormal level of androgen (Testosterone or dehydroepiandrosterone sulphate). If androgen is given continuing monitoring of side effects and liver function will be indicated. Side effects include virilization, with unwanted acne, seborrhoea, facial and body hair, alopecia (male boldness), clitoral hypertrophy, and even voice change. It also includes somatic effects e.g. fluid retention and bloating. Potentially more serious side effects include hepatocellular dysfunction, cardiovascular disease and cancer risks.
* Androgens are not currently approved for the treatment of sexual dysfunction in females. The American College of Obstetricians and Gynaecologists announced that there is insufficient data on the safety and efficacy of androgen therapy to recommend this treatment for sexual dysfunction
* The initiation or restarting of HRT should be based on review of the risks and benefits of treatment for the **individual woman.**
* Patient with local vaginal dryness can use Replens a nonprescription nonhormonal bioadhesive vaginal moisturizer that is shown to restore vaginal moisture and increase vaginal elasticity. Local oestrogen can be also used for 3-4 months course. **There is no increase of breast cancer risk with the vaginal HRT.**

Mrs JNS decided to go back on HRT as her problem of loss of libido persisted and she now developed hot flushes which is not under control with other methods

- **Would you welcome her decision?**
- **Would you ask her to transfer her care to another GP?**
- **Would you refer her for a gynaecologist?**
- **If you accept her decision what form of HRT would you recommend and why?**

* The initiation or restarting of HRT should be based on review of the risks and benefits of treatment for the individual woman. Specialist advice is required if the further analysis of benefits and risks is required
* According to the available data oestrogen only HRT is generally safer that combined preparations**.** For example the absolute increase of breast cancer per 1000 cases are 1·5 (oestrogen only HRT) and 6 (combined HRT) for 5 years' use, and 5 (oestrogen only HRT) and 19 (combined HRT) for 10 years' use. Furthermore the results of WHI trial from oestrogen only HRT will be reported 2005 (the trial for oestrogen only is still active however WHI trial for combined HRT had been stopped prematurely due to an increased risk of cancer and stroke with these preparations). Therefore insertion of Mirena device and giving oestrogen-only HRT is currently considered safer than combined HRT.

During Mrs JNS last visit she mentioned that her sister has been diagnosed to have an ovarian cancer. She is understandably worried about her own risk to develop ovarian cancer and would like to be screened for the disease

- **What is the risk that Mrs JNS may develop the disease if her sister is the only member of the family who developed ovarian cancer?**
- **Would you arrange her screening test for ovarian cancer? If yes what are the tests?**
- **Would you refer her for a gynaecologist?**

The risk of ovarian cancer is 1%, 5%, 15% and 50% for patients who have a family history of 0, 1, 2 and > 2 first degree relative(s) with ovarian cancer respectively.

Ovarian screening is of unproven benefit and has a high false positive rate (resulting in unnecessary intervention in many women), it is, therefore, not offered to women with only one affected first-degree relative. Women at "higher risk" may be eligible for screening and genetic testing and if they fall into one of the following groups, may be referred to the UK Familial Ovarian Cancer Screening Study (UKFOCSS). Women at "higher risk" are those with:

1. TWO or more first-degree relatives (a parent, sibling or child) with ovarian cancer.
2. One first-degree relative with ovarian cancer and one first-degree relative with breast cancer diagnosed less than 50 years of age.
3. One ovarian cancer and two breast cancers diagnosed less than 60 years in first-degree relatives.
4. Known BRCA-1 or BRCA-2 mutations in the family **or**
5. 3 colorectal cancers, at least one diagnosed less than 50 years of age, and one ovarian cancer, all first-degree relatives of each other.

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