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IWH: an Initiative for Women's Health with a better quality of life

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Ever since pioneers, like Robert B. Greenblatt and Robert Wilson (both from the USA), Wulf Utian and Morris Notelovitz (both originally from South Africa), started using estrogens for the relief of menopausal symptoms, there has been a rapid and growing interest from the pharmaceutical industry in this treatment (Organon, from the Netherlands, Schering from Germany, Ayerst from the USA).

It was the talent and merit of the late Pieter van Keep (at the time Director of Medical Services at Organon, Netherlands) that created the International Health Foundation (a branch of Organon Marketing Services) and the International Menopause Society. Both organizations concentrated their efforts on the hormonal treatments for menopausal women. Peter created the expression HRT (hormone replacement therapy), a misnomer loaded with a marketing occulted message: 'If you do not replace to the premenopausal plasma levels, you will be deprived….'.

I have published several papers about this subject and made remarks about what seemed to me to be wrong in the literature (see references 1–10). First of all, HRT is for me a misnomer. Instead, I was the first to propose HT (hormonal treatment).

Second, rather than reporting the results of epidemiological studies in terms of absolute risks (AR) or relative risks (RR), I prefer NNT/NNH (number needed to treat or number needed to harm, reciprocals of the absolute benefit or risk) in order to help clinicians to interpret better what these numbers mean. So, if an AR is, for example, 0.05, that means that five out of 100 subjects will be harmed. If a RR is, for example, 0.30, it does not mean that 30% of the subjects will be harmed, but it means only that there is a 30% increase in the AR (in our example, a rise to 6.5/100 subjects, or 1.5 additional subjects/100!).

Third, we are all physicians, no matter what our specialty is (gynecologists, endocrinologists, rheumatologists, cardiologists, etc). Our mission, when we are consulted by mid-aged women, is, above all, to keep them in good health, preventing or treating diseases, identifying and eliminating risk factors, so that they may enjoy a good quality of life for many years to come, 'adding more life to their years and more years to their lives'. Therefore, the prescription of HT, when indicated for the relief of menopausal symptoms, is only but one single duty of the attending physician.

Women will not necessarily die because they are menopausal and hypoestrogenic, although this may accelerate the aging process. Most will die from cardiovascular diseases ten times more than from breast or other cancers. Many will break their femurs and some will die from it, too.

What are we doing when we are consulted by a symptomatic, menopausal woman? Are we only prescribing HT? Are we checking whether she has other diseases or preventable risk factors? Are we eliminating these risks? Are we checking her blood lipids, PTH, Ca^{2+}, C-reactive protein, vitamin D3 (normal levels can prevent many breast and colon cancers)? Are we recommending a colonoscopy, abdominal echography, X-ray of the thorax? Do we know their body mass index or percentage of fat? Did we measure the circumference of their waist, so well-related to insulin resistance?

What are we telling them about the benefits of physical exercise and of a well-balanced diet (recent studies have shown that these are beneficial for the increase of telomere length of the chromosomes[11], a sign of longevity and good health)? Do we tell them something about the merits of a relaxation response, as advocated by Dr Henry Benson[12]? Is it not our duty to screen? Treatments may not be in our hands but a good screening is certainly our duty.

After all, what is a menopausal woman? She is a woman in distress caused by symptoms and psycho-sociocultural influences. She is a woman who is growing in age and is becoming hypoestrogenic. Therefore, we must try to decrease her biological age vs. her chronological age.

If she wants to increase her longevity, she must adopt maintenance strategies and regenerative attitudes, as she would do for her 50-year-old Rolls Royce automobile. She must follow the new lifestyle medicine; 90% of people die due to errors in lifestyle! Lifestyle medicine can prevent many risk factors.

In my 50 years of practice, I have found many silent and asymptomatic diseases, like colon cancers, breast cancers, uterine and ovarian cancers, lung metastases, occult vertebral fractures, real depressions other than depressive moods (depression affects components of the immune function related to cancer), several sexual dysfunctions which were not revealed

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during the consultation (unless I asked), aortic aneurysm, coronary disease, etc., etc., etc. Why? Because the consultation of a menopausal woman is not centered only on a discussion of the benefits and risks of treatments with hormonal sex steroids!

Efforts are being made by many scientific menopause societies to tell physicians that hormone treatments are only one but a *small* aspect of the good care of these women. But the lesson is often forgotten. Either one sees those who *only* prescribe hormones or, on the contrary, those who refuse to prescribe those dangerous hormones! This is why I was the proponent of World Menopause Day.

The aim is the compression of morbidity[13]. The time has come to slow down and to meditate about the good practice of modern medicine. The best attitude is to adopt a holistic approach in the care of a menopausal woman: to cure her physically and to cure the *whole* person. 'It is much more important to know what sort of patient has the disease than what sort of disease a patient has' (Sir William Osler).

The Women's Health Initiative (WHI) has limited value for our daily medical practice because it did not reflect good medical practice. It was a clinical trial that, despite its internal validity, lacked external validity. The WHI was even unethical because it could easily be predicted that older women who participated in the study would not tolerate the doses given to the younger ones and would have side-effects due to overdosing! The Nurses' Health Study, although with lesser internal validity, has a greater external validity, thus permitting a better extrapolation to clinical practice.

Hormones are medicines like many other drugs. They have indications and contraindications. If one practices good medicine, it becomes obvious that they may only be but a component of many other treatments required by mid-aged women. The WHI has caused great harm to these women, all over the world, mainly because the medical professionals did not interpret well what was reported! Had they done it well, they would have anticipated the successive reinterpretations of the WHI study published, ever since, by their authors.

The ongoing Kronos Early Estrogen Prevention Study (KEEPS) study will soon be reported[14]. I anticipate that the results will be in line with our pre-WHI practice and flash a green light to HT. I foresee that again the results may be wrongly interpreted due a lack of knowledge of epidemiology and result in another explosion, this time of uncontrolled optimism by doctors, the industry and women themselves. That would be again very wrong!

No matter what the future will be, I dare to sing with Frank Sinatra: '*This is my way*!' because 'A woman in the autumn of her life deserves an Indian summer rather than a winter of discontent' (Robert B. Greenblatt).

Added in proof: Two very important studies were presented in September and October 2012[14,15]. Recently menopausal women to whom HT was administered over a period of 10 years had a 50% reduction of cardiac diseases. There was no increased incidence of breast cancer. Both studies concluded that HT is safe.

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