

Mass Media Markets Mistrust to Women, or How Women Learned to Hate Their Hormones

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A veritable firestorm of fear and mistrust has erupted all over America following the sensational release of the Women's Health Initiative. The study of the effects of Prempro as compared to placebo in menopausal women hit the press on July 9, 2002, with a bang. Unlike any previous publication of data from a large research trial, the WHI continues to create intense fear and arguments in public and professional sectors. Described by its investigators as "the end-all-be-all study," the HRT trial and its results became public knowledge in a most remarkable and ultimately socially destructive manner. Disagreements among medical experts regarding study design and utilization of conclusions continue to appear in the press, fueling growing public mistrust of doctors (who in the press seem to know nothing and take patient risks too lightly) and of the medical establishment itself. Dramatic TV, magazine and newspaper stories have women by the thousands throwing out not only their HRT prescriptions but also any "misplaced trust" they might have held for their doctors. How can the results of the WHI be so contrary and terrifying? And what was so enormously powerful about the data

from the trial such that it "revolutionized" the approach to HRT?

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risk between women who did and did not take Prempro was exceedingly small—8 in 10,000 women per year, *equaling 0.08 percent or eight-hundredths of 1 percent!*

This was also documented in many previous studies, but here was headlined as "Study halted over rise seen in cancer risk." The fact that virtually every study around the globe shows that HRT users compared to non-users diagnosed with breast cancer have better outcomes and live longer was not mentioned. Names of trials such as HERS, ERA and the Nurses Health Study were not previously household words. Yet the data was clearly available and used responsibly by most physicians who prescribed HRT appropriately to

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doctors. But in actuality, the study did not tell us much that was new. Reduction of some risks, colon cancer and hip fractures, was confirmed. And slight increased risks of hyper-coagulation-related events (stroke, MI, DVT) were also confirmed. The small increase risk of being diagnosed with a breast cancer if on HRT was represented as a huge excess of breast cancers (26 percent increased risk) in Prempro users. The actual difference in

millions of symptomatic women. Another problem has been created by the lack of discussion in the media regarding differences between Prempro and bio-identical estrogen and progesterone. This reflects outmoded "one size fits all" HRT prescribing patterns, which was the old standard of care. Large volumes of positive data with lower physiologic doses of estrogen and non-oral routes of delivery are also woefully missing from media

coverage . Women have been robbed of any confidence they might have had in the innate wisdom of their bodies, with their hormones viewed as killers, not friends.

Demographic data reveal that the opportunity to experience menopausal hormone changes is a relatively new gift of longevity, mostly brought to us by public health measures (such as clean water, control of sewage, immunizations for high-mortality infectious diseases, treatment for TB, etc.). The average life expectancy for women in the U.S. after the Revolutionary War was 32 years and rose slowly to 49 by 1900, and now approaches 80 years of age in 2000. When women express anger over our lack of good solid data regarding optimal management of menopause they can be assured that this is a relatively new phenomenon in the eons of time for biologic evolution and our understanding of it. For a variety of reasons, some of them not so politically correct, gender-based research trials are a new kid on the block. It has taken many decades to raise concerns about the disenfranchisement of women from traditional Western medical research trials. For the very reasons biology between men and women differ, women were historically excluded from trials so as to not confound the data. This is not current-day consciousness or wisdom and we have to do better.

The reproductive constraints of menstrual cycling are essential to women's physiology and have profound biologic implications. Menopause imitates the endocrine state of postpartum lactation in many essential aspects. The low-estrogen state of menopause (cessation of ovarian hormone production) causes an inexorable mobilization of calcium from bone and fats from fat stores. Evolutionary biology would favor this particular physiology only during lactation to enrich milk for nursing offspring, enhancing successful survival of the species. There does not appear to be a significant evolutionary biologic pressure to support

longevity, with a paucity of mammals ever living past menopause. Thus the Darwinian view of menopause (with low estrogen levels leading to mobilization of calcium and fat) explains women's dilemma as a biologic constraint of reproduction unique to the female of the species. This may also provide a helpful perspective from which to counsel confused patients, friends and family members.

Men are blessed to maintain a serum estrogen level of 40 pgm/ml from boyhood until they are 70. Girls share this low level of estrogen until they begin menses after which it rises to the hundreds with ovulation, with an abrupt fall below 30 after menopause. This small but crucial level serves to slow the loss of bone and leads to a later onset and slower ascent in the curve of acquired dementias. Of interest, women who take estrogen from onset of menopause and continue longest have the lowest rates of dementia, mirroring men, as compared to those who never took it or started HRT late (as in the WHI population). Women are not created equal! We have to reconcile ourselves with an adverse biology that may in fact not serve us optimally after menopause. This is not a politically correct thing to say in some circles. But it is the brutal biologic truth.

The baby boomers are truly the first generation of women who have a significant opportunity to prevent disease and enhance their chances for independent living into very old age with a good quality of life. Over the past 50 years a steady and rather consistent picture has emerged: There is no pill that can overcome the negative health impacts of a bad lifestyle. Obesity, inactivity, untreated hypertension, hyperlipidemia and hyperglycemia all lead to significantly higher disease risks, morbidity and earlier mortality.

The negative impact of the sensational and highly polarizing release of the NIH trial continues to manifest in

myriad discussions among confused and insecure consumers and physicians alike. We all see newspaper and magazine headlines and gripping television programs, featuring angry and frightened women who feel "duped and discouraged." Physicians are faced with the day-to-day office demands of reassuring patients about that which we *think* is still true about the use of hormones to control symptoms versus the peculiarities of the specific population of women who compose the WHI study group. But what is really going on with our "system" of health information across this media-rich country of ours?

From the WHI we have learned one thing if we have learned anything: The system of dissemination of medical information is broken and needs inspired repair.

