Northwest Gynecological Oncology

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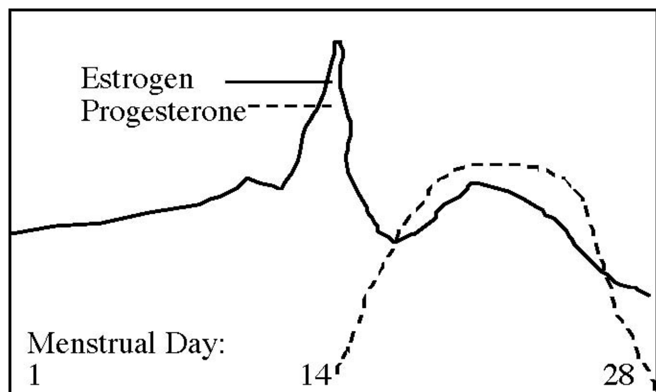
SURGICAL AND NATURAL MENOPAUSE

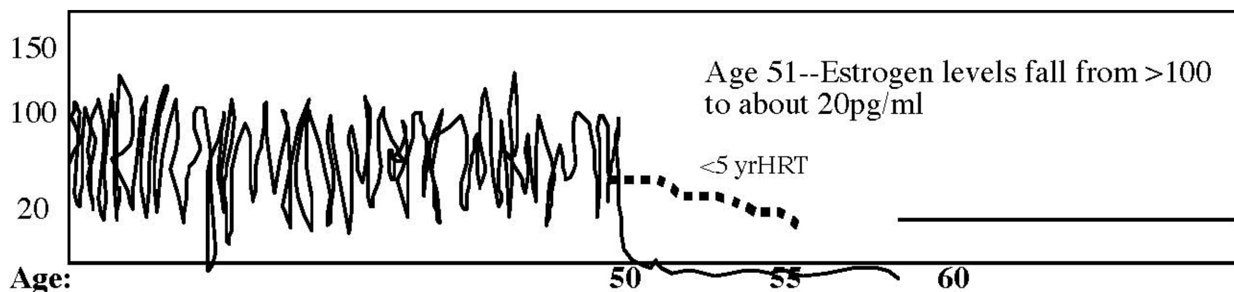
After 50 years of hormone use, our field of medicine has finally produced the most definitive and reliable data for women over age 50 making decisions about use of estrogen and/or estrogen with progestins. We now have information for women having bothersome menopausal symptoms, whether they have had a hysterectomy and need only estrogen, or have their uterus and need the two hormones.

BASIC OVARIAN FUNCTION

During the reproductive years, estrogen is produced in varying amounts on a continuous basis by the cells surrounding the egg follicles in the ovary. **Estrogen** released into the blood stimulates the cells in the uterine lining and the breast ducts to grow. Once ovulation has occurred, usually around post-menstrual day 14, the same follicle then secretes progesterone for about two weeks.



Around day 28 of the cycle, the lining of the uterus sheds as a menstrual period. Physiologically, menopause begins when the ovaries run out of eggs resulting in very low levels of estrogen (20pg/dl), and no more ovulations. The sudden large drop of estrogen, at the average age of 51, can result in hot flashes, insomnia, night sweats, and dry vagina. Many women elect to soften this sudden decrease by using low doses of estrogen for a short while, 'til symptoms resolve and do not recur. They use lower doses as they age till they have tapered off completely, with no symptoms.



It is important to appreciate that estrogen and progesterone have many other actions besides the cyclic transformations of the uterine lining and breast ducts. Estrogen supports the lining of the upper vagina and maintains a lush wall of tissue to allow secretion of lubrication during sexual excitement. Estrogen effect in the vagina, along with testosterone, is responsible for libido in women. It also supports the back wall of the bladder and urethra and helping to maintain strength and continence, preventing bladder infections. Estrogen promotes bone maintenance by inhibiting of calcium absorption from the bone.

MENOPAUSE DEFINED

Menopause is defined as the time after menses have ceased for at least 12 months. Women can enter this period with many different patterns of cessation of hormone secretion. The most common are 1) a gradual tapering off of the two hormones and decrease in menstrual flow and frequency or 2) an abrupt cessation of secretion of both hormones which is frequently associated with hot flashes, insomnia, and sometimes changes in mood, and 3) the confusing picture with loss of one hormone while the other continues. Some women will enter menopause with a decrease in secretion of estrogens while still ovulating. This results in the often-confusing profile of hot flashes while the menses continue on a regular basis. The most troublesome pattern occurs when progesterone secretion decreases while estrogen secretion continues. This pattern usually causes irregular, painless and occasionally profuse bleeding from the buildup of the uterine lining without progesterone cycling. These women are at higher than average risk for cancer of the uterine lining.

Early symptoms: Many women will have multiple symptoms at the start of menopause but a few have none at all. Early symptoms result from the sudden drop in estrogen and may include traditional hot flashes, palpitations, and psychological alterations in mood, such as irritability and depression (which may be related to sleep loss due to nighttime hot flashes). These acute symptoms usually abate in most women after one to five years; however, some women will continue to have hot flashes throughout their lives after menopause. For some women these symptoms are mild and not bothersome, but for other women, they can be distracting to intolerable, disrupting their lives and requiring treatment for as long as the symptoms are bothersome.

Later symptoms: Other symptoms that usually occur later in the menopause from prolonged low estrogen levels in the pelvis include vaginal dryness, painful sexuality, and urinary incontinence, urinary urgency or bladder infections. Restoring estrogen to the pelvic tissues can restore libido, improve sexual experience, reduce urinary tract infections, reduce urinary leakage, and improve vaginal lubrication and odor.

Fortunately, there are multiple hormonal and non-hormonal modalities available to help menopausal women maintain normal, functional, comfortable lives after their ovaries have stopped secreting hormones. That is the goal: normal, functional living, as naturally as possible.

HRT does not replace a healthy lifestyle. Heart disease almost never occurs as a surprise. It usually occurs after twenty or more years of poor lifestyle, and/or elevated risk factors. About 45% of women die of heart disease, which is largely preventable by lifestyle changes. When estrogen levels drop, the cholesterol profile can worsen some, as it can also due to natural aging, lack of exercise, poor diet and obesity. Originally it was thought that estrogens would prevent heart disease because they cause a small improvement in the cholesterol profile. Although estrogen can reduce the LDL and raise the HDL by a small amount for most women (The Writing Group for the PEPI Trial, 1995), four major prospective studies have clearly demonstrated that estrogen offers no protection to healthy women (WHI data June 2001), or to women with heart disease, even when they are used for the long-term. (HERS Study, Hulley, et al JAMA, 1998, ERA Study, Herrington et al, NEJM, 2000, Nurses Health Study, Grodstien, Ann Int Med, 2001). Estrogen alone might someday be shown to reduce heart attack if it is started and continued throughout the menopause, but it appears that estrogens with progestins cause some deleterious effects on inflammatory markers and may increase risk of heart attacks, strokes and blood clots by a very tiny amount. Thus, combination hormone replacement therapy is not a “heart attack preventative.” Hormones will never replace a **healthy lifestyle and diet**. Exercise, healthy eating and maintaining a healthy weight, alone reduce heart disease by 40-50%, improve blood pressure, triglyceride levels and diabetes, with no side effects. Women with unfavorable cholesterol profiles should have consultation with a specialist in cardiac disease prevention and be encouraged to follow all of the current recommendations for cardiac disease risk reduction: low fat diet, exercise, weight optimization, management of blood glucose, blood pressure and cholesterol.

It has been shown from WHI that HRT does not slow progression of Alzheimer’s disease in women over age 65.

Estrogen is one of four therapies that stop bone loss and can be useful for women with very low bone density, called osteoporosis. Estrogen and any of four other drugs are used to effectively halt progression of measured bone density loss in women who have mild bone loss, called osteopenia, to prevent further loss into the lower osteoporotic range. Every woman should have bone density testing after she quits taking estrogen or if she becomes menopausal and does not need to take any estrogen, in order to see if she has early thinning of the bones and needs heightened prevention or has advanced thinning and needs medical therapy.

Healthy without Hormones: Women of every age should be painstakingly counseled by every one of their physicians that:

1. The evidence is strong that exercise, defined as 30-minute segments (60minutes if weight is not optimal), 4 times weekly, resulting in a 1.3-2.0-fold increase in resting heart rate, reduces the risk of coronary vascular disease and osteoporosis and many cancers. Weight-bearing exercise is a standard in prevention of osteoporosis and heart disease, as well as colon and breast cancer.

2. Cessation of smoking reduces risk for heart diseases, osteoporosis and cancers.

3. While one alcoholic beverage a day may be beneficial in preventing cardiac disease, more than one alcoholic beverage daily will increase risk of cancers and osteoporosis (and overweight, too!).

4. Monitoring blood pressure, blood sugar and cholesterol and maintaining an optimal weight (BMI< 25) will reduce risk of heart disease and stroke. Preventing excess gastric acid with H-2 inhibitors (antacid medications) reduces intestinal cancers.

5. Maintaining a Body Mass Index (BMI) under 25 will reduce risk of heart disease and stroke. BMI = (Your weight in pounds) x 703, divided by your height in inches twice. 20 to 25 ideal, 25-30 overweight, and 30+ is obese. Lowering your BMI reduces heart attacks, cancers, and early death.

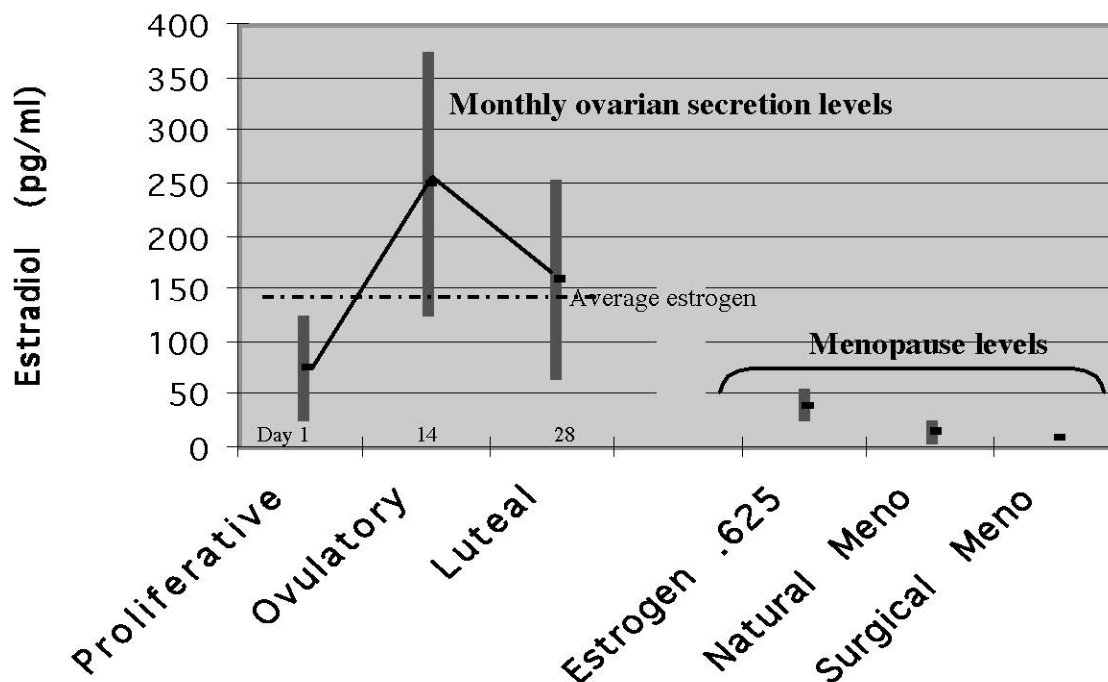
6. A low-fat, high-fiber, predominantly vegetarian diet is the most cardiac wise, most cancer-protective, and most osteoporosis-preventive. Get selenium, Vitamin A, B, C, D and E in foods and supplements. Low-dose aspirin or NSAID reduces heart disease, stroke and colon cancer.

7. High calcium intake (calcium carbonate or citrate well-tolerated by most) from both dietary sources and supplements reduces risk of osteoporosis, colon cancer and hypertension. Total intake from both sources should be at least 1000 mg of elemental calcium for women with either endogenous or exogenous estrogen, and 1500 mg for women who do not have or take estrogens.

SO…WHO NEEDS ESTROGEN THERAPY?

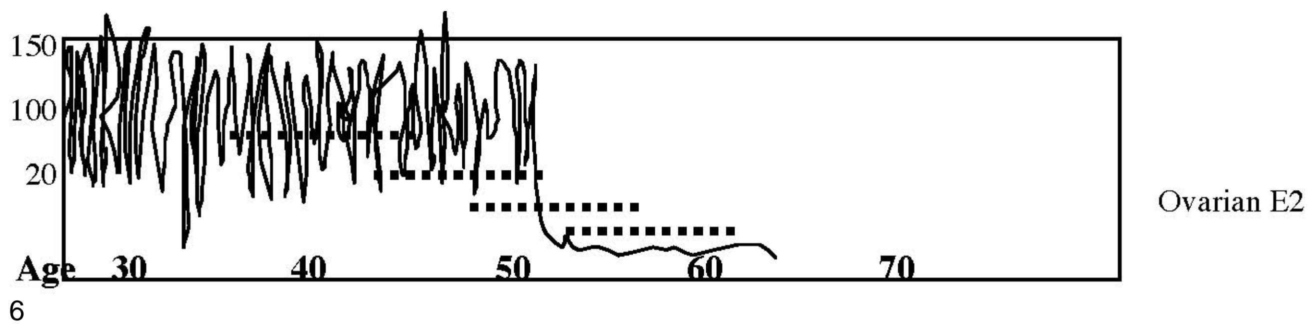
Surgical menopause symptom amelioration. It is not controversial to prescribe hormone therapy to younger women (under age 51) entering the menopause, whose ovaries either naturally stopped or were surgically removed with her uterus. In fact, if the ovaries are removed or shut down for over ten years before age 50 and low-dose hormones are taken to prevent hot flashes, the breast cancer risk is reduced by 50% for life! Even in women who have the Breast/Ovary Cancer gene (BrCa 1,2), removing the ovaries and taking low dose HRT causes a 50% reduction in breast cancer risk. From the chart below, notice that the ovaries secrete a continually much higher level of estrogen than the levels attained by any of the replacement regimens. Normal ovarian secretion needs to be high to stimulate a thick uterine lining for possible pregnancy implantation. Such high levels also stimulate endometrial plaques outside of the uterus (endometriosis) to grow as well. Hot flashes and insomnia can be resolved with much lower doses. This is why women who have their ovaries removed at an early age have a lower risk of breast cancer, even if they use low doses to estrogen to prevent hot flashes, and even if they are BrCa 1 or 2 positive. Breast and ovary cancer, and gallstone risk is not elevated by hormone therapy in women under age 51, (the

average age of menopause), or on estrogen-only regimens (for women who have had their uterus removed). ESTROGEN LEVELS ARE LOWER ON REPLACEMENT ESTROGEN AFTER REMOVAL OF OVARIES. Here is why: Say a woman age 41 has severe endometriosis and needs a hysterectomy and removal of both of her ovaries. Her ovaries normally always maintained an average of 150pg/dl estrogen in the blood, with spikes to 300 at ovulation. After removal of the ovaries, the estrogen levels would drop to 20 or so, but to prevent her from having hot flashes and insomnia with such a low estrogen level, she starts estrogen pills, patch or ring, which will keep her blood levels of estrogen at about 60-80pg/dl. This much lower level is just enough to make her feel normal, but still much lower than her natural ovaries were producing before on a monthly basis to make the uterus ready for a pregnancy (and cultivate painful endometriosis).



See the diagram: estrogen level by pill, patch or ring provides a much lower level of estrogen than the average woman's fluctuating levels with active ovaries. So the plan for a woman under 50 havoing ovaries removed would be to take the estrogen pill or patch until she turns 50 or so and then to taper down and later go off estrogen, just like other women when their ovaries naturally quit at age 51. If she takes estrogen after age 51, keeping a level of 60, then her estrogen levels will then be higher than the average (not taking hormones) woman's level of 20 in this age group. Research tells us that a woman who has her ovaries removed at age 30 and takes estrogens for 21 years until age 51 has only a 6% lifetime chance of breast cancer, half of the regular risk of 12%.

Thus, starting at age 51, she should see if the estrogen is still needed and go off her estrogen once a year, resume it at any time that the hot flashes, night sweats, or insomnia recur. If they don't recur, then there is no further need for taking estrogen.



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Natural menopause symptom amelioration. Most women will develop some hot flashes and some sleep difficulties when their ovaries quit secreting estrogen around the age of 51. Some women develop hot flashes while they are still having periods; they usually benefit from very small doses of supplemental estrogens to ameliorate their hot flashes until their menses stop. Half the menopausal doses of estrogen will not affect the menstrual cycle, but relieve the symptoms. Some women simply stop their bleeding and have no bothersome symptoms at all. Women do not need any hormones if they have no bothersome symptoms.

Treatment of surgical menopause. When the ovaries are removed at any age, some hot flashes can occur. If the uterus has been removed only estrogen is needed to treat these mild hot flashes. The pattern of natural menopause is the same, in that the lowest dose of estrogen is used in tapering doses over time, and finally discontinued when there are no more symptoms. Women try the nest lower dose every year or so, and if they feel normal, then they stay on that dose until they can decrease again, finally to go completely off, with no hot flashes or insomnia.

SYSTEMIC ESTROGEN THERAPY: LOWEST EFFECTIVE DOSE

The drop in estrogen levels from normal ovarian secretion levels of 150-300 down to menopausal levels around 20 can cause significant symptoms. Most women will develop symptoms in the early menopause and will want some form of hormonal therapy just for while the symptoms are disruptive to their lives. Hot flashes can be debilitating and un-restful sleep can cause depression. But fortunately, these symptoms will abate with the usually prescribed very-low doses of estrogen, with levels at 40-80. After the body gets used to the lower levels for a few years, the HRT dose can be further lowered or discontinued without return of symptoms for many women. It is thought that the symptoms go away either because the body accommodates to lower levels of estrogen, or because when discontinuing the replacement hormones, the drop is so much smaller than the original plummet from the active ovarian secretion levels of 150.

Bothersome systemic symptoms (hot flashes, night sweats, insomnia, loss of mental focus) that resolve with hormone therapy should be treated with the lowest effective dose for as long as they continue in a bothersome manner. For some 10% of women, this may mean lifelong HRT so that they can feel normal.

YOU HELP ADJUST THE DOSE: Too high or too low? For systemic symptoms (hot flashes or insomnia, loss of acuity), estrogen pills, or continuous release patch .05 mg, or vaginal ring are highly effective. “Pill or Patch or Ring” is simply based on your preference and skin type: you decide; all doses are available. Can you remember to take the pill? Would your skin break out with a patch? Will it stick? Will it bother you? Can you insert and remove a ring in your vagina? Estrogen is given continuously without stopping at the end of the month or while taking progesterones (if your uterus is present). You should feel perfectly normal on the ERT, or the dose needs to be adjusted.
The goal is to keep you on the lowest dose of estrogen that abates your symptoms and makes you feel perfectly normal. A few women will have symptoms that don’t resolve quickly, but this may be due variations in saturations of the tissues during the first month or so. Before considering a higher oral dose, try waiting one month.

ESTROGEN TOO LOW: The major symptoms of too low estrogens are hot flashes and insomnia. If these persist more than a month after starting ERT, the dose needs to be increased. If you have low-estrogen

symptoms but are on a dose that seems right, it may become useful to check a blood level to see if you aren't absorbing it well. You may need a higher dose or different route.

ESTROGEN TOO HIGH: If you have tender breasts or feel bloaty on estrogens alone, the dose is probably too high and needs to be reduced. Estrogen therapy alone mimics day 10 or so, when you feel most normal and have no pain or moodiness or tender breasts.

PROGESTERONE + ESTROGEN THERAPY: Unfortunately, if you used to get "Pre-Menstrual Syndrome" (PMS) tender breasts and moodiness just before your periods during your menstruating years, you may also experience any of the familiar PMS symptoms during the progesterone phases of your therapy as the combination of estrogen and progesterone in your blood mimics the time in the menstrual cycle during which PMS develops.

No systemic symptoms, no systemic therapy! If no hot flashes or low-estrogen symptoms, then no therapy needed. (systemic means whole body doses)

LOCAL ESTROGEN: WHEN NO SYSTEMIC SYMPTOMS, LOWEST EFFECTIVE DOSE

Urinary symptoms and Vaginal Dryness: Use only local estrogens. Vaginal dryness may not be adequately treated with systemic (pill, patch, ring) estrogen. In fact, many women near age 50 whose ovaries are still working or, whose ovaries have quit and are now on estrogen, will still notice vaginal dryness because the levels of systemic estrogen (systemic--in your blood, travels over the entire body) are much lower near menopause and on ERT in comparison with younger-age cyclic ovarian secretion. Vaginal estrogens are often necessary in the late 40's and later on ERT to keep the vagina moist and comfortable. They are inserted as vaginal cream, pills or rings, and provide very low doses of estrogen into the vaginal fluid, but none into the systemic blood, conferring no risk of cancer, according to abundant research. (Note: if you have breast cancer, it is still okay to use these vaginal-only doses every day. Ask to see the research papers proving this in my office.)

For all perimenopausal and post-menopausal women with symptoms of bladder irritation, urinary frequency, urinary leakage, vaginal irritation, or vaginal dryness, a low-dose local regimen of estrogen cream, pills or ring is safe and effective. A 1.0 gm estrogen cream (1/4 applicator) or a tiny estrogen vaginal pill can be inserted daily for two weeks, then twice weekly thereafter; or vaginal ring to be replaced every 10-12 weeks, will relieve frequent urinary tract infections, mild incontinence or interstitial cystitis, painful vagina, without increasing the blood levels of estradiol.

Multiple studies have shown that even after daily and prolonged use, such low doses of "topical" (applied to the skin) estrogen are not associated with systemic elevations of serum estrogens or reflective of systemic estrogenic activity and do not stimulate the endometrium, as it is one eighth of the usual oral dose. Many women prefer the ring because the silastic ring can be left in the vagina, even during sex, for up to 3 months, with no cleansing required, then replaced with a new ring. Other women prefer the tablet because it does not add to their natural vaginal discharge. Other women prefer the cream because it provides a small amount of additional lubrication. All have been well researched and are safe for women with breast cancer, for whom many think that systemic estrogens should be avoided.

Discontinuing estrogen. Most women will notice that their hot flashes disappear after a 2-5 years in menopause, either because they forget to take their hormones for a few weeks and feel fine, or they simply forego them for a few weeks and notice no difference. They should stay off the estrogen if the hormones make no noticeable difference. In fact, all women on estrogen after age 51 should try discontinuing it every year for a few weeks just to see if they still need it. If their symptoms of hot flashes, loss of focus, or insomnia recur, restart the estrogen. If no significant differences are noted off of estrogen for more than a month, then it is time to discontinue it. Get a baseline bone density at this time to see if extra prevention of osteoporosis by medication should be employed, because the estrogens have been conferring protection up until this point.

RISKS OF SYSTEMIC HORMONE USE

Women with a uterus: estrogen + progestin: The WHI data was released after 5.2 years of double blind testing of women ages 50-70, average 63 years, with combination daily estrogen (CEE) and progestin, (MPA). The evidence indicates an increased risk for breast cancer from .30% to .38%, increased risk of pulmonary embolism from .16% to .34%, increased risk of stroke from .22% to .28% and increased risk of heart attack from .30% to .38%, among women ages 50-79 taking combination hormones versus placebo. This same regimen also reduced risk for colon cancer from .14% to .09%, and hip fracture from .13% to .08%.

Heart attacks in women ages 50-59 increased a very tiny amount from .17% to.22%, or an increase of half a percent on combination HRT. For women ages 60-69, risk was higher at .34% increasing to .35%. For women ages 70-79, heart attack rates increased from .55 to .78% (Manson et al NEJM 8/2003). Combination HRT increased risk of declining mental testing scores from 2.5% to 2.8% and of entry into dementia from .9% to 1.8%. (Rapp, JAMA 2003).

WHI: Estrogen + Progestin, (women with uterus) ages 50-79: +.08% +.08% +.18% +.07% -.05% -.05% (all under .2%)

The risk of developing invasive breast cancer went up by less than one half per cent from 1.85% to 2.33% over 5.2 years. The types and grades of the cancers were similar, but the size was 1/12 inch larger for HRT women, and the chance of metastatic spread was increased by one third of one per cent from .296% to .592%. (Cheblowski JAMA 2003).

These facts are not clinically worrisome. What this tells us is that women who need to stay on their combination HRT to feel like their normal selves can understand that the very small risk they take is just that: very small. The study confirms that hormones are not any way to prevent Alzheimer's dementia, heart disease, stroke or blood clots.

Women over 50 without a uterus: Estrogen only: We know, finally, from the WHI Study, that for women age 50-59 without a uterus, needing estrogen therapy for their symptoms, there is **virtually no risk** to taking estrogen alone for many years: no increase in breast cancer, heart attack, stroke, or blood clot. For women over age 60 still needing estrogen for their symptoms, some unfavorable risks appear: the rate of stroke increases from 0.33% to 0.44%, an increase of .12%. Also, the risk of blood clots in the legs increased from 0.15% to 0.21%, an increase of .06%. The risk of heart attack decreases from 0.24% to 0.14%, and breast cancer risk decreases from 0.29% to 0.21%. All of these changes are teeny-weeny and frankly ignorable for the woman with significant symptoms who needs to feel like her normal self. The WHI suggests that estrogen should be used like any medication: whenever it has proven benefits (hot flashes) which outweigh the risks (individualize). It is recommended that women take menopausal hormone regimens for as long as they need them, discontinue using them when no benefit is appreciated or predicted by research, and receive appropriate follow-up surveillance testing once the hormones are discontinued. (Anderson et al JAMA, 2004)

Increased Risk of Gall Stones, and Serum Triglyceride: Menopausal estrogens also result in a higher concentration of saturated cholesterols in the bile, which favors stone formation, multiplying the lifetime risk for gallstones from 2-4% to 4-8%.

Women with Previous Breast and Endometrial Cancers: A history of breast or endometrial cancer or pulmonary embolus has been viewed as a contraindication to administration of systemic estrogens. The chemotherapy for breast cancer usually results in ovarian failure and sudden severe menopausal symptoms. Consequently, these women are at risk for premature bone loss; however they usually seek treatment for relief of their hot flashes, painful sexual activity from a dry vagina, and insomnia. Concerns about estrogen receptors in the remaining normal breast tissue, as well as potential nests of persistent or metastatic breast or endometrial cancer has brought about the widespread refusal to prescribe any estrogen regimen to young women (age < 51) who have menopausal symptoms after breast or endometrial cancer therapy. Six studies on over 10,000 women with breast cancer have been conducted to

show that pregnancy with its extremely high levels of hormones confers no reduction in survival. (Partridge, Oncology, 2005) There are many significant case control and cohort studies documenting the safety of administering replacement hormones to women with prior breast or endometrial cancer showing no adverse effects to estrogen alone. (von Schoultz, Lancet, 2004) The Women's Health Initiative showed that women ages 50-60 did not have a higher risk of breast cancer using estrogen alone for over 8 years. The Women's

Health Initiative also showed that women ages 50-60 with their uterus intact, taking estrogen with progestin, for 5 years had an increased risk of breast cancer by .08%, from .30% to .38%. The HABITS study showed that women with breast cancer on estrogen alone did not have an increased risk of recurrent breast cancer. Women using estrogen and progestins in the HABITS had an increased risk of breast cancer recurrence. Large studies of women having hysterectomy and removal of the ovaries show that breast cancer risk if halved when the ovaries are removed premenopausally, even if estrogen is given for hot flashes. Thus hysterectomy/ovariectomy for young women with breast cancer and then subsequent low dose pure estrogen therapy is safe. For more information and to see the studies, go to my website (ohanlan.com) and look at the many links there, including the extensive research link. Vaginal estrogen is not contraindicated in even active breast cancer therapy because the doses do not provide hormone into the blood. Vaginal estrogen is considered "topical." Many gynecologic oncologists are currently prescribing systemic estrogen (pill, patch, ring) to select breast and endometrial cancer patients with severe menopausal symptoms. Although the few published accounts suggest no adverse effects, very few doctors have familiarized themselves with the actual data and are willing to risk medico-legal responsibility. Women with breast cancer have fallen into a gap between specialists, because their medical oncologists rarely read the gynecologic hormone literature, and gynecologists rarely read breast cancer literature. Gynecologic Oncologists now prescribe estrogens to symptomatic women who have had surgical staging and hysterectomy for low risk endometrial carcinoma. The belief is that if no cancer cells remain, then estrogens will not cause harm. If cancer cells are present, then estrogens may result in a slightly earlier but still inevitable re-presentation of the cancer.

Women with Prior Pulmonary Embolus: Women with a history of pulmonary embolus should not use oral estrogens. Every study of clotting effects of transdermal estrogens (patch or vaginal ring) has shown that clotting is not increased over placebo, but it is with oral estrogens. Even it the prior pulmonary embolus was on oral contraceptive pills (OCP's), transdermal (patch, gel, lotion or vaginal ring) estrogen is safe because the dose is about one sixth that of OCP's and the route of administration does not increase any of the clotting agents in the blood since it does not have a "first pass" high dosing on the liver, where the clotting agents are made and secreted.

ALTERNATIVES TO ESTROGENS

Many regimens for abating the various bothersome symptoms are available and safe, and offer partial amelioration of symptoms. Research trials show they do not work predictably or in everyone, but can be tried safely to see if they work. Some patients report that vitamin E (alpha-tocopherol) at 1,000-2,000 I. U. ameliorates their flashes. Soy Bean Extracts, called isoflavones (Promensil 40-80mg or any isoflavone with other name brands, 40-80 mg), or soy itself in quantities up to 80 grams have relieved hot flashes for some. Black Cohosh in the dried rhizome form at 300-2000 three times daily in a tea or as a tablet in 20-80 mg may help. Use of Tamoxifen or raloxifene can abate some hot flashes in older women, but may cause them in younger women. A trial of natural progesterone cream has benefited some. Low-dose Clonidine patches or 12 oral tablets may be employed, with the limiting side effect of low blood pressure. Bellergal has been shown to reduce frequency of hot flashes as well. Effexor and Prosac are antidepressants that can significantly reduce hot flashes, and may be a great choice if depression is present. Troublesome insomnia can be treated with over-the-counter Tylenol PM. Depression is a reasonable temporary response to life's issues, including developing cancer or sustaining a rapid drop in estrogen levels, but persistent or prolonged depression may also be a result of insomnia or hormone loss and may require a trial of estrogen reinstitution and/or psychological counseling and possible pharmacological therapy. Physicians must keep an open mind to experimenting with some or all of these regimens, and be open to their exceptional patients bringing in ideas and regimens of their own.

LOW LIBIDO

This can be for lots of reasons: too hectic a schedule, tension between partners, tiredness from childrearing or work, depression, or because they are tired of having sex that was never really rewarding to them before. The remedy for the first three causes is to fix your schedule and keep your relationship in good repair, perhaps with counseling for either or both of you. Many women have trouble reaching orgasms in partner sex, and 10% simply never do have orgasms. While some 25% can achieve orgasm from vaginal thrusting activity, over 75% of women require direct clitoral stimulation by fingers or mouth to achieve orgasms. The average time for a woman to reach orgasm is over 20 minutes with direct clitoral stimulation. Women secrete less lubrication and take longer to climax as we age. Ask yourself: are you getting enough quality stimulation? Many are afraid to require our partners to take the time we women naturally need for an orgasm. If you don't like your partner or spouse any more, you won't have much libido within your relationship. Lack of orgasms can also reduce drive for sex. Lack of orgasms can come from never receiving what one needs to have an orgasm, feeling unable to communicate to our partner what we need done to us to have an orgasm, or having a partner that is unable to learn to do what is needed to generate orgasms in us. In these situations the remedy is to learn what makes an orgasm happen in yourself by practicing it on yourself (Yes, Joycelyn Elders was right on!) and then communicating this information to your partner. While many partners think they are great at giving sexual pleasure, they may not know what you love the most to have done to you, and they may need to hear that from you. There are great books in bookstores for teaching yourself to become grandly sexual, and for teaching your partner what you need to become jointly grandly sexual.

Low libido is also caused by poor fitness and by low body-self-concept. We are under constant influences in our society that tell us we should look like a playboy bunny, when none of us do. So get content with your aging body. Maybe in therapy. Also, get fit in your body by exercising, stretching and making that place where you live a proud and fun place to play in. Do whatever it takes to feel physically great, starting with exercise and stretching. Exercising with your partner has the best effects on libido. If you are menopausal, with no hot flashes, and have low libido and dry vagina, consider vaginal estrogens to make certain that your vagina feels fresh, resilient, moist and happy to play. If your ovaries are working regularly with regular ovulations, then your drop in libido is not because of hormones, so consider other life influences. Most women retain their normal libido on oral estrogen alone, but some may benefit from transdermal estrogen (patch or ring) as these routes do not bind the available testosterone. Some women may also need a little added testosterone to get their sexual urges back to their normal. In such cases, testosterone in intermittent and very low doses can help restore libido. A few women will notice mild hot flashes or new onset of mild acne as a side effect of the androgen dose and may want to alternate with a plain estrogen tablet (without androgen) every other day or every two days. If there is no acne, however, then worries about androgen-induced excess facial and body hair, lowering of the voice, balding or clitoromegaly are entirely unfounded. Some women have found improved libido from applying an androgen cream to their clitoris nightly. A 2% testosterone cream can be compounded by local pharmacies. Let me know if we need to talk about this…It is healthy to have healthy great sex, so go for it.

PROGESTINS FOR ALL WOMEN WHO HAVE A UTERUS

All women who have a uterus should be given cyclic or continuous progesterone to prevent endometrial overgrowth into hyperplasia and cancer, which occurs in one-third of cases when prescribed estrogens are not balanced by adequate progestins. Endometrial cancer is epidemic in menopausal women with the strongest risk factors being obesity and age. This is because menopausal women make no progesterones, but their fat cells do make estrogens. The more fat cells, the higher the risk and earlier age of endometrial cancer. Obese women have a 25-40% lifetime risk of developing endometrial cancer, even without prescribed estrogens, unless cycles of progesterone are taken to prevent buildup of the uterine lining. Both women on estrogen and obese women need a protective 14-day cycle of progesterone on a quarterly basis. This is the only way that endometrial cancer can be prevented in this high-risk group of women; that is, besides weight loss, the most important disease preventative. Most women have no side effects from the cyclic or continuous oral or vaginal progesterone, but some will describe PMS type symptoms such as flattening of the mood to frank depression, requiring experimenting with various doses, cycles and routes of progestins. Natural progesterone is much less likely to cause PMS like symptoms than

medroxyprogesterone acetate (MPA), the most commonly used synthetic regimen, and the one used in the WHI, showing increased risks of breast cancer, heart disease, and venous thromboembolism. While natural progesterone may have similar effects if tested over the long term, it appears that it might be better for the cholesterol profile than MPA. Natural progesterone is a natural sedative and may cause sleepiness, so it should be taken last thing at night. A very few women may choose cessation of all progestins followed by yearly biopsy to check for pathological uterine changes, but hysterectomy should really be considered here, as the rate of pre-cancer or cancer of the uterine lining on estrogen-only regimens is 33% (PEPI Trial data). It is important to keep in mind that the commonly used progestins will all reduce some of the benefit of estrogen on the cholesterol profile. While estrogen-only regimens improve the HDL by 11%, addition of natural progesterone to estrogen increases the good HDL by 8%, and addition of MPA increases HDL by 3%. Natural progesterone also does not blunt the benefit of estrogen on the prevention of plaque buildup in the arteries, according to research done on monkeys who have similar cholesterol profiles as humans. Thus, women who have a uterus and who have an abnormal lipid profile, or are obese or have a history of coronary vascular disease should use natural progesterone to optimize the cardiovascular benefit of the hormone replacement therapy. Additionally, it should be noted that four recent articles, (Ross, JNCI, Feb, 2000, and Schairer, JAMA, Feb, 2000, Colditz, NEJM, 1995, WHI, JAMA, 2002) have shown that progesterone contributes to the risk of breast cancer. Thus, combination HRT should only be taken for reduction of hot flashes.

Continuous Regimens. Most women with a uterus will prefer a continuous regimen because it is usually associated with no bleeding on any scheduled basis. Half of women, however, will develop the most common side effect of this regimen—unscheduled bleeding, which may require a biopsy of the uterine lining. Use of 2.5 mg MPA or 100 mg natural progesterone daily can result in regression of the uterine lining to such extent that spotting occurs and may require temporary or permanent use of the cyclic regimen for over half of women. Obese women should try 200 mg natural progesterone for continuous treatment.

Cyclic progestin regimens. Cyclic regimens are the easiest to employ in the beginning of menopause, as they are associated with the lowest rates of unscheduled bleeding. The only detriment of this regimen is that most women will have a shedding of the uterine lining on a regular basis. Use of natural progesterone (Prometrium), 200 (300 if obese) mg/day, or less preferably MPA, 5-10 mg/day, for a minimum of 12 days per month, or 10 mg/day MPA or 200 mg natural progesterone for 14 days every two or three months is sufficient to prevent hyperplasia in most women.(Ettinger, Selby, Citron et al., 1994) Obese women should use the higher doses in the preceding monthly guidelines, and may require 20 mg/day of MPA or 300 mg/day NP if they wish to cycle every two to three months. A withdrawal bleed usually occurs one to three days before or after completion of the progestin cycle, but this is most often scant and gradually decreases to spotting with time. Some women on natural progesterone don't bleed at all. Great! It is reasonable to stretch out the interval for women on monthly cycles who have only spotting or who do not have any withdrawal bleed to cycle every two to three months. Should bleeding or spotting occur during the prolonged interval, then the interval should be shortened to that length which prevents spotting. A biopsy should be performed in these women if they have not had one in the preceding year.

CONCLUSIONS

All during a woman's life, good health habits should be cultivated and practiced. This requires a specific focus from the caring physician and a motivated patient, with attention to the variability and individuality of each woman's presenting concerns, as well as to the larger picture of each woman's cardiac and bone health as well as cancer risks. It requires a strong effort on the part of every woman to learn, grow and change; always becoming her better and her best. Interestingly, focus on each of these issues helps reduce cancer rates, heart disease, lung disease, and stroke, the four most common causes of death in women past the menopause. Nuthin a woman can't do after forty.