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Misinformation. Misinterpretation. Missed opportunity.

Distressed symptomatic menopausal women are being denied, or are choosing to avoid, hormone therapy because of recent and misleading media coverage

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Recent media accounts implicating menopausal hormone therapy as a causative factor for breast cancer have fuelled a pre-existing misperception about personal levels of risk related to hormone therapy use. Reports from the most recent North American Menopause Society meeting in Chicago indicate that there was a statistically significant reduction in mortality and a positive benefit to risk ratio for women started on hormone therapy in the first decade after onset of menopause when data from the two Women's Health Initiative hormone therapy trials were pooled. These findings only related to hard clinical endpoints and do not address the well established quality of life benefits for symptomatic women. Rather than reporting this important observation, the media has latched on to a recent publication which cites a slightly increased risk of breast cancer detection and mortality in women assigned to combined estrogen and progestin therapy. The increased detection of breast cancer in women on combined estrogen and progestin therapy (but not estrogen alone where breast cancers were fewer in women compliant with estrogen therapy) has been known since 2002. The level of increase with combined estrogen /progestin therapy was small (defined as a "rare" risk according to the World Health Organizations CIOMS classification of adverse events) with 8 additional cases of breast cancer detected among 10,000 women using combined hormone therapy. Approximately 25-30% of women with a breast cancer diagnosis will succumb to the disease. The most recent report from the WHI states that breast cancer accounted for 2.6 deaths /10,000 combined hormone users and 1.3 of 10,000 women assigned to placebo. The actual difference was 1.3 additional deaths per 10,000 women.

The SOGC supports efforts to reduce breast cancer and has advocated for this cause for years. Unfortunately it is becoming increasingly clear that effective advocacy programs combined with a media focus on breast cancer has distorted women's perception of their true risk for this disease.

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Marg Helgenberger, actress on the TV series CSI, recently did a short clip for breast cancer awareness during the ads on 60 Minutes (October 24, 2010) in which she stated*: I'll tell you what is a crime; 1 in 8 women will get breast cancer* ***this year****.* Nothing could be further from the truth! Unfortunately, this 1 in 8 number has been misused so much that people forget that it represents a cumulative lifetime risk to age 85 if a woman does not succumb to other diseases first.

Cardiovascular diseases are much more likely to account for death and disease. For example, in the decade between age 50 and 59, deaths from breast cancer affect 5 women of 1000 while 55 will die from other causes; between 60 and 69, breast cancer deaths affect 7 of 1000 while 126 die from other causes. This disparity is further accentuated in succeeding decades (70-79: per 1000 women, 9 deaths due to breast cancer versus 309 from other causes; 80-89: per 1000 women, 11 deaths due to breast cancer versus 670 from other causes). Survey data show that women consistently overestimate their personal breast cancer risk and underestimate the impact of cardiovascular disease.

To keep the true risks of breast cancer in perspective women and their health-care providers need to consider several things.

First, the increased risk for detection of breast cancer in users of combined hormone therapy is approximately the same as the risk of breast cancer that women accept when they consume alcohol, fail to exercise regularly, or become overweight after menopause. The risk associated with combined hormone therapy is actually lower than the breast cancer risk that results from a late first pregnancy (after age 30) or failure to breastfeed.

Secondly, when considering the usefulness of any medical treatment, it is essential to have an informed consideration of both the benefits and the risks of treatment. Aspirin, which is widely used for prevention and treatment of coronary artery disease, is thought to have a positive benefit to risk profile even though it is estimated to account for 2 cases of hemorrhagic stroke/10,000 users (of whom 1/3 will die) and gastrointestinal bleeding in 500-1000 of every 10,000 users (with 150-200 cases where bleeding is life threatening).

Thirdly, unbalanced information in the media about hormone therapy has led many health-care providers to abandon this approach to management of menopausal symptoms in favour of untested and largely ineffective complementary and alternative therapies. Symptomatic women have, for the most part, remained dissatisfied and prescriptions for selective serotonin reuptake inhibitors in Canada have soared as hormone therapy prescriptions fell after 2002.

Where do we stand as 2010 draws to a close? Women and their physicians have been made fearful of menopausal hormone therapy to the extent that many distressed symptomatic menopausal women are being denied, or are choosing to avoid, a safe and effective therapy for which the overall benefits exceed the risk. The SOGC is promoting high quality reproductive health care for Canadian women and remains committed to careful and ongoing evaluation of research evidence upon which prudent clinical decisions can be made.

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