


“Elixir of youth” or “Cancer potion”?

The battle for the purse of the middle-aged woman and the role of the media in reporting themes in medical science.

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Assignment in partial fulfillment of the requirements for the degree of Masters of Philosophy (Journalism) at the University of Stellenbosch.

The crest of the University of Stellenbosch is centered behind the text. It features a shield with a red and white design, topped with a crown and a red banner. The shield is flanked by two figures, and the word 'recti' is visible at the bottom of the shield.

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**DECLARATION**

I, the undersigned, hereby declare that the work contained in this Assignment is my original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

## **ABSTRACT**

The popular media ("Media" here referring to newspapers, magazines, television, internet) adds to confusion and panic when reporting on the risks and benefits of Hormone Replacement Therapy for women (HRT).

Most reports show bias, cast scientists as villains, or leave the reader more confused than before about terminology.

The Southern African media does in general aspire to objectivity towards both the pharmaceutical and natural health industry.

However, shallow or inept reporting, the need to generalise complicated findings and dramatise what's regarded as cold scientific news, create this bias and confusion.

Misleading health reporting, in South Africa as much as anywhere else in the world, can change health behaviour and can even cost lives.

Ethical health reporting can therefore be described as a matter of life and death.

This paper aims to analyse the media for biased, confusing and alarmist reporting. It then aims to explain reasons for the bias or confusion.

Fourteen reports are analysed. One Time magazine report, and 13 reports selected from the Southern African media.

## OPSOMMING

Berigte oor Hormoonvervangingsterapie (HVT) vir vroue in die media (“Media”) hier verwys na koerante, tydskrifte, televisie, internet) dra by tot verwarring en paniek.

Die meerderheid berigte is bevooroordeeld, in die sin dat medici as booswigte uitgebeeld word. Indien hulle nie bevooroordeeld is nie, is berigte verwarrend, soms *juis* in ‘n poging om konsepte te vereenvoudig.

Die media in Suider Afrika aspireer wel tot objektiwiteit, teenoor beide die farmaseutiese sowel as die holistiese (kruie) industrie.

Nietemin, oppervlakkige/oningelige verslaggewing en die behoefte om ingewikkelde navorsing te vereenvoudig/interessant te maak, dra by tot vooroordeel en verwarring.

Misleidende mediese beriggewing in Suid Afrika, net soos in die res van die wêreld, kan mense noop om besluite te neem wat hul gesondheid kan skaad.

Die belang van etiese verslaggewing kan dus as ‘n kwessie van lewe en dood beskryf word.

Hierdie studie ontleed berigte en ondersoek vooroordeel, verwarring of sensasionalisering.

Redes vir bogenoemde word dan bespreek.

Veertien berigte word ontleed. (een berig uit die Amerikaanse tydskrif *Time*, en 13 uit die Suider Afrikaanse media)



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## CHAPTER 1

There are only two kinds of medical reporting: New Hope and No Hope.

(Victor Cohn's "First law of medical reporting")

### 1.1 Introduction

Media coverage is an important source of medical information for South Africans. Misleading reporting can be risky. People may experience undue hope or fear. They may even start, or stop, treatment.

Coverage is often alarmist, reflecting misunderstanding *or* popular social beliefs.

Nelkin (1995: viii) writes in *Selling Science: How the press covers science and technology*:

“The increased scale of science has raised questions of social priorities and research costs; the growing importance of research in human biology has raised concerns about ethical implications; the many reports of scientific fraud have increased public mistrust; and the continuing incidents of technological risk have turned individual events into generic problems. The coverage of science in the 1990s has also been influenced by the growing competition in the media: events are dramatized and public figures villainized in the endless quest for *news*.”

Cohn (1989: 5) the former science editor of the Washington Post, stresses in *News and Numbers*, how health reporters may make the public quake when they write *danger*, or may falsely re-assure the public if they write *no danger*. He also notes that it is not *what* we write; it is what we *emphasise* that can influence healthy or unhealthy lifestyle choices.

HRT has been in the news since 1963 when the press proclaimed its extraordinary benefits and promised miracles. Typical headlines read: "Preventing Menopause," "Science Paints Bright Picture For Older Women".

It turned into a feminist debate with some women accusing pharmaceutical companies of pushing the false quest towards eternal youth to enrich them. On the other hand,



many women felt they had a right to the choice of eternal youth and was not going to be made feel guilty about vanity and accepting their "lot".

Nelkin (1995: 41) asks:

"Who were the experts cited by reporters promoting ET? The major source of information was Dr. Robert A. Wilson, a gynaecologist, an active promoter of oestrogen treatment, and the director of the Wilson research Foundation. Funded by three drug firms, his foundation existed to publish and distribute recommendations about specific products. Wilson has published a popular book called *Feminine Forever*".

Clearly the discovery of a pill that would keep women young forever was a newsworthy event: Reports of this discovery not only touched on a subject of wide interest, but also conveyed a message readers wanted to hear. The problem with this promotional reporting was that it ignored or underplayed the growing evidence indicating ET's potential risks.

"Media interest in promoting a treatment to keep women *lovely and young* gave way to 1980s feminist sensibilities and the desire to be politically correct. But in the 1990s, as a baby boom generation reaches their fifties and public attention has turned to women's health, ERT again hit the news -- despite the fact that there is little new to report on the costs and benefits of a medication sustained as much by ideology as by definitive research."

Jenni Murray (Murray: 2003: 2), author of several articles and a book on menopause, writes in a column in *The Guardian* newspaper:

"There is evidence that the promotion of HRT, and our willingness to embrace it, was indeed the result of a male conspiracy born out of loathing and suspicion of the ageing female. Medical literature of the 18<sup>th</sup> century refers to the menopause as a catastrophic tragedy, and post-menopausal women were described as dull and unattractive. The worst offender arrived in the mid-20<sup>th</sup> century. Robert Wilson, an American doctor, published his book *Feminine Forever* in 1966. He



described menopausal women as castrated by the menopause. He promoted HRT as the long-sought elixir of life”.

For feminists this has sparked many years of bitter debate:

“In the blue corner are women such as former MP Teresa Gorman who, at 70, gaily reports that she feels and looks as well as she did in her 40s, and claims that if she were diagnosed with breast cancer tomorrow, she would be grateful for the years of well-being she attributes to the treatment. In the red corner we have women such as (well-known feminist author and activist) Germaine Greer, who in *The Change*, saw the medicalisation of the menopause as a male conspiracy that poisoned women and recommended that we embrace our old crone-ness”.

Murray agrees that many women have been told lies by the medical establishment.

However, she warns against a modern backlash. She advises a golden mean:

“There is no reason to become a casualty in this war. We can inform ourselves of the sexual politics and the procedures on offer, balance the risks and decide what kind of older women we want to be”.

She admits that she chose the treatment, after informed consultation with her doctor.

The media should try interpret medical evidence without being swayed by reigning socio-political beliefs. Reporters should not be afraid of either the medical establishment *or* by what their audiences feel is politically correct to hear.

While it's true that there are capitalist motives to sell a product, the benefits of HRT and ET also certainly hold water. The risks are not to be ignored, but crying wolf might in the end desensitise the public to dangers. The media should supply *informed* reports on the pros and cons.

The current *Zeitgeist* is distrustful of everything “unnatural”.

It seems to have caused a backlash against hormonal supplements. This is often disproportionate, and can cause action that may be equally detrimental to women's

health. In many countries, the natural health industry is, if not fanning the flames of a backlash, certainly cashing in on the trend against "big bad chemical drug pushers".

Much publicity has been given to the fact that the chemical industry has indeed used strategies to counter its negative image. Companies *have* used the media to provide "facts". Public relations campaigns have been launched against what is known as "cancer phobia" and "chemo phobia".

Nelkin (1995: 139) writes:

“By 1992 Wyeth-Ayerst Laboratories was spending over 9 million US dollar to advertise their product in women's magazines that, appealing to their ageing readership, often feature articles and news reports on the effect of HRT on the symptoms of growing old”.

Now in the 21<sup>st</sup> century, women feel hoodwinked, while scientists feel a storm in a teacup is being used to push the herbal industry.

The medical fraternity's general view about the WHI furore is summed up in the following quote. Calling it a “backlash”, Dr John Stevenson of London's Imperial College (Endocrinology and Metabolic Medicine), writes in the *Irish Medical News* (2004: 2)

“You get the feeling that there's an orchestrated campaign against HRT. Is it due to an industry that thinks if they could destroy HRT it would increase the market for a particular product?”

The HRT debate has since the 60s been one of the media's favourite headlines.

News about Hormone Replacement Therapy sells well today.

Apart from the politics of feminism, it contains attention-grabbing elements that make publications fly off the shelves -- death, sex and ageing.

## **1.2 Explanation of terms**



Menopause is a natural progression in a woman's reproductive cycle. Levels of circulating female hormones, oestrogen and progesterone, drop.

This normally starts happening between ages 45 and 50.

Odendaal (Odendaal et al, 2000: 335) describes this period in a woman's life, the climacterium, as manifesting the following possible symptoms:

Physical -- night sweats, hot flushes, vaginal dryness, loss of libido, insomnia, fatigue, skin changes and a depletion of calcium, resulting in "brittle bones" or osteoporosis. This increases the risk of bone fractures. Some women also report emotional symptoms -- anxiety, mood swings, depression, and memory loss.

Hormone Replacement Therapy (HRT) is a combination of oestrogen and progesterone used by women who have started to experience discomforting symptoms of menopause, and who have not had hysterectomies. Women who still have their uterus intact run the risk of uterus cancer when taking unopposed; oestrogen only supplements.

Progesterone offsets the risk of uterine cancer.

Oestrogens are manufactured from the urine of pregnant mares *and* synthesised from plants. Most medical experts agree that the body does not differentiate between natural ("natural" meaning produced by the ovaries) and synthetic hormones.

HRT is used to alleviate menopausal symptoms, and prevention and treatment of osteoporosis.

Some women say it makes them look younger by improving skin elasticity.

For the purposes of this paper, when referring to oestrogen only supplements, I will stick to the American-used abbreviation ET.

**Phyto oestrogens** are the "plant-based" oestrogens that are not used in HRT.

HRT oestrogens are either animal products or synthetic.

### 1.3 Background to the WHI study and summary of findings

The WHI randomly assigned 16 608 postmenopausal women 50 to 79 years of age (mean 63) with an intact uterus to HRT, or a placebo. The WHI study was supposed to last 8 years and examined various health factors connected to HRT. It was stopped three years short because of a small but statistically significant risk observed for breast cancer in the HRT group after five years. The study also did not find HRT use added any significant “lifestyle” benefits (whether women slept better or were less depressed). It did find a statistically significant reduction in the colon cancer and hip fracture risk category.

The WHI was what Cohn (1989: 38) describes as medicine's "gold standard", a controlled, randomised clinical trial.

“At its best, the investigator tests a treatment or drug or some other intervention by randomly selecting at least two comparable groups, the experimental group and a control group that is observed for comparison. True clinical trials are expensive and difficult. It has been estimated that of 100 scheduled trials, 60 are abandoned, not implemented, or not completed, whether for lack of funds, difficulty in recruiting or keeping patients, toxicity or other problems, or, sometimes, rapid evidence of a difference in effect (making continued denial or effective treatment to a control group unethical).”

That's exactly what happened with the WHI trial.

The British Menopause Society ( Newsletter, 2003: 2) summarises how the WHI was begun in 1991 by the National Institutes of Health:

“More than 160 000 post-menopausal women, ages 50 to 79, were recruited for various trials designed to find the best ways to prevent heart disease, breast and colorectal cancers, and osteoporosis. Final results were due out in 2005. One part of the study, involving 16 000 women was halted in May 2002. Half of the 16 000 were randomly assigned to receive HRT and the other half were given a placebo, or dummy pill. Neither the women nor their doctors knew who was taking the HRT. It was halted because the number of breast cancer cases had reached a pre-specified safety limit. The study had not shown any benefit for cardiovascular



diseases, including heart attacks and strokes, although it had shown some other benefits for hip fractures and bowel cancer. Superficially, the percentage increases in breast cancer and cardiovascular disease look alarming, but this will depend on the way that the results are expressed, namely as **relative risk or as absolute risk.**”

The fact that the study was halted early and the fact that details were released early, added to a sense of alarm.

#### **1.4 How it broke - embargoes and ethics**

**Scientists are to reporters what rats are to scientists. Would scientists allow their subjects to check the interpretation of their behaviour?**

**(Victor Cohn)**

Nelkin (1995: 152) explains what's known as the Ingelfinger rule:

“In 1968 Franz J. Ingelfinger, then editor of the *New England Journal of Medicine*, decided that he would not publish a scientific article if the details had been previously reported in another journal or the press. He wanted the Journal to remain newsworthy. His successor Arnold Relman, perpetuated the rule. He argued that prior disclosure places a burden on physicians, who should have the opportunity to read about research in an authoritative source before being besieged by patients clutching a newspaper article.

However, journalists are appalled by the Ingelfinger rule, arguing that it violates the public's right to know.”

Findings of the WHI study were leaked to the public media before the peer review report. The reporter who wrote the story had interviewed one of the WHI physician investigators. Breaking the embargo for the sake of a scoop sparked severe criticism from medical circles. The way it was broken is believed to have caused undue public alarm.

Findings first appeared in the *Detroit Free Press* newspaper in the United States. An extensive report was then published as cover article in the respected *Time Magazine*.

The WHI study embargo break illustrates how interpretations of urgency can vary. Scientists try and control press coverage by refusing interviews unless they can review and correct the copy prior to publication. Reporters, fearing censorship by vested interests, are reluctant to show their articles to sources.

Here it helps to apply the **SAD formula for moral reasoning**, devised by Louis A. Day (Day, 2000: 65-67):

**Situation definition:** Describe facts, identify values, and state the ethical issue/question.

**Analysis:** Weigh competing values, consider external factors, examine duties of various parties, and discuss ethical theories.

**Decision:** Render moral agent's (editor's) decision. Defend that decision based on moral theory.

The issue here is whether it was in the public interest to know the facts before publication in a medical journal. Is there a need to know or is it just nice to know?

**Cons:** It might spark undue panic/alarm.

**Pros:** It will certainly sell and there is after all a newspaper's need to survive economically and a duty to shareholders.

But did the WHI findings warrant an embargo breach? The public was going to be informed anyway.

The moral agents (editors) had a duty to:

1. The public.
2. The doctor interviewed who leaked the findings before embargo time.
3. Competitive interests.

The paper decided to go public.

Therefore, results of the study were first run by the Detroit Free Press on Monday July the 8<sup>th</sup> 2002.



So detail of the study became public before it was published in any medical journal. The story was picked up by other news agencies.

The Journal of the American Medical Association (JAMA) felt that the embargo breach created unnecessary confusion and exaggerated importance of the findings. The JAMA expressly asked the reporter who broke the story to refrain from publishing it in the popular press before it was published in the journal.

The JAMA felt that honouring embargoes of this nature helped foster responsible reporting. Doctors who were inundated with calls from anxious patients were unprepared to deal with queries since they had not read the findings. (JAMA, June 2002)

It is difficult to judge when best to release information to the press when scientific research bears on health.

Nelkin (1995: 155) quotes Barry R. Bloom of the U.S.-based Albert Einstein College of Medicine:

“Until data are interpreted and validated, until the experimental design and significance are reviewed, and until all currently available data on the incidence in exposed human populations can be integrated, the rush to the press is mindless, if not unethical”.

However, she mentions that total adherence to such constraints would be impractical; the press would wait indefinitely for medically related science news.

Johan Retief (Retief, 2002: 38) has a word of caution for such situations:

“The conviction that the public has a right to know is of the utmost importance to the freedom of the media and indeed also to the upholding of democracy. However, journalists often make the mistake of pointing out to their sources that they (the media) have a right to know. The media are far from being that special. Remember that the media are only vehicles through which the public can be informed. It is in the first instance not the media, but the public, who has the right to know. It is the individual’s right to know that gives the media a reason for their

existence. It is only on this basis that the media can function as watchdogs and that they need ethical guidelines to fulfill their function properly.”

The WHI study reports had global implications on markets. News that the United States government halted an HRT study involving the pharmaceutical product Prempro (the estrogen/progestin combination used in the WHI study) hit share markets the following day.

On July the 9<sup>th</sup> drug maker Wyeth's shares tumbled over 19 per cent. Prempro is a member of Wyeth's Premarin family of hormone replacement therapies, and accounts for 14 per cent of the company's sales.

Britain's AstraZeneca shares were hit the next day. And the FTSE 100 index closed sharply lower.

(Business Report: July 9 2002)

The Southern African media picked up the story. Debate flared with contradicting headlines and reporting.

Thousands of women jammed call-in lines, wanting to quit their medication cold.

My mother, in her seventies, has been on ET for about 30 years.

After a full hysterectomy (ovaries, tubes and uterus removed) in her early 40s -- she's taken ET (oestrogen only therapy) every day of her life.

She goes for a mammogram once a year and has her cholesterol levels checked.

She has never has osteoporosis-related problems and leads a high-energy life.

When asked to show ID to prove she qualifies for the "over 60" benefits in public places, she feels flattered. My dad, the same age, is annoyed when strangers think she's his daughter.

Maybe she simply has good genes, and she's never had unhealthy habits.



Maybe she is indeed a poster girl for the "elixir of youth" oestrogen-related treatment was punted to be decades ago.

The media reports alarmed her since they did not make clear to the layperson the distinction between oestrogen replacement and combination oestrogen/progesterone Treatment. After several days of worry, she was convinced *not* to quit cold. She consulted with her physician and exercised her informed choice to stay on the drug. Unlike other women who *did* quit.

In *The Guardian* article, Murray tells of an elderly relative who took HRT with no ill effects for more than 20 years and stopped suddenly in her 70s because of fears of breast cancer as a result of continued and confusing media debate.

“Shortly after quitting, she had a full house of typical symptoms and has so far suffered two broken hips as a result of the drop in bone density”.

## CHAPTER TWO

### 2.1 Methodology

This paper covers the period from publication of principal results from an American Women's Health Initiative randomised control trial on HRT in July 2002.

My goal was to compare references to the WHI study in medical journals (The Journal of the American Medical Association JAMA, New England Journal of Medicine NEJM, the South African Journal of Medicine SAJM, and Medscape), with reports in the popular southern African media.

Thirteen print reports (including a Time magazine report) and one television report from between July 2002 and October 2003 were used.

Quotes commented on are in *italics*. All Reports analysed are in the Appendix.

I scanned text for the following five points:

#### 1. Anti or Pro-HRT bias

## 2. The medical fraternity cast as villain

### 3. The natural health industry pitted against the pharmaceutical industry

I grouped under the following categories the most **common errors/omissions** that contributed, intentionally or unintentionally, to the above:

**Incorrect reference to WHI study, Selectivity, Use of headlines and photos, Use of statistics, (Relative Risk and Absolute Risk) Generalisation, Dramatisation, Quoting extreme opposite views, Confusing reporting.**

4. I checked whether reports mentioned **confounding factors** such as:

\* **Flaws** in the study (The women in the WHI HRT study were all over 60, high above the age at which most women use HRT. Women in their 60s are usually post menopause or had hysterectomies, and would be on oestrogen replacement (ET) only. Some of the women were obese and some used to be smokers. These may have contributed to negative coronary and breast cancer risk factors.).

\* The fact that only one HRT brand -- *Prempro*, was used in the WHI study. and whether reports mentioned that other HRT brands might not have the same effect.

\* The **difference between oestrogen only (ET) and oestrogen/progestin (HRT).**

\* Whether it was pointed out that the **period of use** might play a role in risk and result.

## 5. Type of media used

I hypothesised that magazine features have the best "chance" (more space and more time) to be accurate and give the full picture, with newspapers and television coming second and third in terms of quality and depth of reporting.

I checked whether the use of **by-lines** made a difference to quality/depth of reporting.

Chapter three is a discussion of the common errors and omissions.

I found that bias or alarm was sparked more by "well-meaning" but shallow reporting, than by deliberate manipulative omission.



I found that bias or alarm was sparked more by “well-meaning” but shallow reporting, than by deliberate manipulative omission.

Chapter four gives recommendations on *avoiding* the errors and omissions. "reading" statistics, and questions to ask scientists.

Magazine features : *Sarie* (Published by Naspers/Media24) - Target: Afrikaans-speaking, family orientated women (Higher Lifestyle Measurement)

Health/Fitness magazines -- *Longevity* and *Shape* - Targets: Women mid twenties and up, Higher Lifestyle Measurement.

(The South African Advertising Research Foundation: All Media and Products Survey, (online) Retrieved from the worldwide web March 2003: [http:// www. Touchline.co.za](http://www.Touchline.co.za))

Newspaper reports from: *The Cape Argus*, *Die Burger*, *Weekly Mail and Guardian* and *The Daily Mail*.

News24 website - Health24 -- also part of the Media24 Group.

One television news report about the study was broadcast over the time: Both etv and SABC3 ran the same report by line agency Reuters as is, and did not solicit local opinion. CarteBlance, the MNet channel's investigative programme, informed that they never covered the HRT controversy.

## **2.2 Analysis**

### **Report 1**

#### **Time magazine July 2002**

##### **Headline - The truth about Hormones**

Comment: The headline implies that a lot of lies abound.

**Use of photos:** The cover photo shows a middle age-looking woman with an expression of what seems concern. Other photos are of another 40-plus, unsmiling woman. A third photo shows an older looking woman staring at herself in the mirror, looking concerned.

**By-lines** - Several reporters collaborated on the issue.

The article was the cover story, consisting of several pages of reporting with alarmist subtitles:

*A large federally-funded study provides definitive proof that oestrogen and progestin are not age-defying wonder drugs. What's a woman to do?*

**Comment: Oversimplification and dramatisation**

In *News and Numbers*, science writer Victor Cohn (Cohn, 1994: 59) points out that: "Virtually no single study proves anything. Two or 4 or 15 studies (only) add *credence*, especially if the diagnostic and outcome criteria and the people studied are similar."

But a single study rarely proves anything.

The phrase *What's a woman to do?* Conveys a sense of drama and frenzy.

The reports use anecdotal material, with quotes casting doctors as "bad guys" against unsuspecting women -- *Maybe I've been too trusting*.

It kicks off with a case study that says she is *confused and angry*.

The next paragraph again casts the doctor in the role of villain: *I did not have any symptoms, but he recommended it for general well-being, bones and heart*.

It stresses that women now don't know where to go or whom to listen to.

It interjects: *Whom indeed*.

That phrase editorialises. The reporters do not merely let the patients or the experts state the facts. It sets an ironic tone, and adds colour -- that of women left in the lurch.

The feminist debate surfaces in a quote by the International Organisation to Reclaim Menopause: *We need to accept menopause as a natural normal physiological process...the idea that our bodies fail us at menopause is ludicrous, extremely sexist and just plain wrong*. It then gives some background history about how hormone supplements were "pushed" about 40 years ago:



*Like latter-day Ponce de Leons, however, these women are watching their dream of eternal youth fade away. A large, federally funded clinical trial, part of a group of studies called the Women's Health Initiative (WHI), has definitively shown for the first time that the hormones in question-estrogen and progesterin-are not the age-defying wonder drugs everyone thought they were.*

Comment: **Generalisation and Incorrect reference to published study**

It's not sure what's meant by "age-defying". The end point of the study was to examine effects on health, not lifestyle - not whether it kept skin supple or give that "youthful glow". Medical Journals in the appendix clearly state that; "estrogen plus progesterin does not confer cardiac protection and may increase the risk of CHD among generally healthy postmenopausal women, especially during the first year after the initiation of hormone use. This treatment should not be prescribed for the prevention of cardiovascular disease."

They also state that HRT is still the best treatment for menopausal symptoms. The journals report positive findings from the WHI as well. HRT might play a role in preventing brittle bones (that causes what's known as a "dowager's hump") and it lowers the risk of cancer of the colon. Should these not be included under *age-defying*?

Whether it is or is not an age-defying wonder drug has been an open question for many years. So this is not *a finding*. The study's findings did not focus or comment on *youth* as such.

The paragraph can also be described as **selective : ignoring the good news while focusing on the bad news**. It does not even mention in passing that the study has also "definitely shown for the first time" that it prevents (or lowers the risk of) brittle bones and colon cancer.

*Definitely shown for the first time*

Comment: **Oversimplification**. A single study rarely proves anything so inconclusively. See discussion in Chapter 3.

*As if that weren't bad enough, the results, made public last week, proved that taking these hormones together for more than a few years actually increases a woman's risk of developing potentially deadly cardiovascular problems and invasive breast cancer, among other things.*

Comment: **Inaccuracy resulting from a need to dramatise.**

*As if that weren't bad enough*, is editorializing. Additionally; the results were going to be made public anyway. It sounds as if there was going to be an attempt to keep the findings a secret. The tone also accuses the makers of HRT of "breaking a promise" of supplying eternal youth. Again the phrase *the results proved* is used. Use of the adjectives *potentially deadly* and *invasive* is alarmist and unnecessary. What cardiovascular problems are not potentially deadly anyway?

The difference between invasive and non-invasive is not explained.

*Here at last is a rare moment of clarity. The debate over the long-term benefits and risks of HRT has lasted for decades. Now we have at least a few concrete answers. The findings are so striking that the study was stopped three years short of its scheduled completion. (The other WHI trials, which include a look at how estrogen alone affects women with hysterectomies, are still proceeding.) And the formal scientific report, which is being published in this week's Journal of the American Medical Association, was released a week early at a press conference in Washington.*

Comment: Starting the sentence with *Here at last is a rare moment of clarity* is **overdramatisation**. The WHI cast in the role of saviour of the female race. Many studies before have indicated similar results. One single study rarely provides conclusive clarity on anything.

The paragraph also contains an **incorrect reference to published study**.

The study was not stopped because the findings were so striking. Context was selectively omitted by the sentence.

Researchers set down a predetermined "safe" number of cases. If more cases of a disease than that predetermined number develop disease, it was agreed that on that



figure, it would be unethical to continue observing statistics. This is what's called the "predetermined hazard level". In other words, the safety bar was set very high.

The paragraph also does not present full context. This is **omission** that is misleading: The report was released a week early, not because of the staggering findings, but because it was leaked before an independent peer review (before the medical fraternity could advise on the findings).

Under the heading *Some questions still*.

The report does mention that one brand of medication was used in the HRT study group, Prempro, and that the WHI findings might not be applicable to other brands of medication. And that *so-called* natural oestrogens are not risk free.

The Times report is well-written from a statistical point of view.

However, it **selectively oversimplifies statistics**.

It gives the Relative Risk statistics for the "bad" news (heart attacks, blood clots, breast cancer) while giving the Absolute Risk figures, in brackets, for the "bad" news.

*Though the women on HRT suffered fewer hip fractures (1 woman per 1000 per year vs. 1 1/2 women per 1000 per year).*

### **Summary**

Anti HRT, presenting no "good news" contained in the medical journal reports, using adjectives not used in the medical reports.

It casts the medical fraternity in the role of villain.

It uses relative Risk (RR) figures mentioned in the medical journals only.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Mentioned that Prempro findings do not

	apply to other products
3.HT/HRT difference	Explains that the ET leg of the study continues
4. Period of use plays a big role	Mentions that HRT used over many years increases risk

If I was on HRT this report would have made me feel more nervous, distrustful of my doctor, and even guilty of vanity for using it.

## Report 2

### Longevity November 2004

**Title** -To be or not to be, on HRT

**Byline** - Prevashni Ramsamy

**Use of photo** - Positive image of 4 happy corporate looking women representing ages between 20 and 60.

**Introduction** -*Has the death knell sounded for hormone replacement therapy, as we know it?*

It also contains the phrase *pains of menopause*.

**Comment: Selective:** "Good" news emanating from the study put on the backburner. Although put in question form, the first line casts a feeling of doom over HRT use. The use of the phrase *death knell* in this context also creates bias. Menopause as a "pain" strengthens the image of women as choiceless victims at the mercy of pharmaceutical experts.

The tone setter or introduction starts with what is known in media jargon as a "Johnny"-  
- a case study.

*Felicity is an intelligent, respected 50something attorney.*



Although this sentence has no direct bearing on the reader's perception of HRT, it strengthens a stereotype. One detects prejudice - a tone of surprise that 50-something female attorneys are not intelligent and respected by default.

**Sensationalism/dramatisation:** Adjectives abound:

In the second paragraph the word *concern* about the *dreaded* disease is used three times.

The *medical fraternity's onslaught* portrays a negative image of the medical fraternity as villain and women as victims.

The reporter refers to the WHI study and the UK Million Women study as *Indicting* HRT as a central cause of increased breast cancer incidents, links to heart disease and deep vein thrombosis.

The word *indict* again creates the image of the medical fraternity as standing accused of pulling the wool over women's eyes.

*Wide-eyed women desperately seeking a simple solution to a difficult time in their lives*

More **sensationalism/dramatisation**. The sentence continues the use of adjectives conveying a sense of panic and stereotyped victimhood. Women are portrayed as victims of a plot to deprive them of a wholesome solution to their suffering.

*The WHI had planned to investigate the long-term effects of HRT over a period of eight years.*

Comment: **Selective and Incorrect reference to published study**. Reporter omits context and background. The aim of the WHI study was not merely to "investigate the long term effects of HRT over a period of eight years".

The study focused on whether or not HRT reduces the risk of coronary heart disease.

According to Dr Phillip Zinn, gynaecologist at Kingsbury Clinic in Cape Town (personal communication: October 2003), many studies before have investigated the long-term effects of HRT and it is not staggeringly new news that there is a slightly increased risk of contracting breast cancer.

*A study in the respected British Lancet medical journal compared the effects of treatment with HRT.*

Comment: Verbally clumsy. It was not a *study* in Lancet that compared the effects, but a *report on a study* in the Lancet that compared the effects.

It is also indeed true that figures indicate a 26 per cent *relative risk*. However, context is omitted.

The reporter refers to *noted allopathic experts* who called the issue *media frenzy and misrepresentation*. "Allopathic experts" is not commonly used. The reporter could have used the word "conventional medicine" instead.

It does present an opposing view by stating that the experts believe that hormones are still the treatment of choice for menopausal complaints.

The media in reporting on the WHI findings is portrayed as "on the side of" women.

It omits to say what the product or the dosage of progesterone/oestrogen treatment used in the WHI study was (Premorin and Provero), whether this product or similar is used in southern Africa, or what exactly a fairly high dose means.

The article then attempts to get the views of experts representing the two opposing view.

It quotes Professor Franco Guidozi, head of the department of Obstetrics and Gynaecology at Johannesburg Hospital. Saying he is doing *damage control* on the findings. He is quoted as accusing the media of *again creating an emotive wave of uncertainty*. This repeats the earlier image of a standoff -- doctors versus the media. He repeats the lower dose advice.

On the other side of the debate is Dr Arien van der Merwe. A holistic sounding quote is used when she talks about *science having finally caught up with the natural wisdom of centuries*. At the bottom of the page is a block containing the doctor's natural prescription.

It adds that her book on natural remedies is available through Tafelberg Publishers at bookshops.



Comment: In presenting two opposing voices on **two extreme** poles of the argument, balance is not provided. Simply providing a 50/50 view often does not help provide the bigger picture.

The main part of the article ends with a quote by the case study. The tone is reproachful - - somebody got a bad "deal", without her knowledge or consent:

*Her cancer, promoted by the HRT pill that was meant to prolong her life.*

It is also **generalisation**. All other possibilities but HRT that "promoted her cancer" (such as lifestyle) have not been exhausted. The article does not state any conclusive "smoking-gun" proof that HRT promoted her cancer.

To end, the article summarises the changing beliefs in the remedial qualities of HRT over the years.

It mentions a few positive effects of HRT "in passing". This is under the subheading "Benefits and risks of HRT *in context*", quoting Professor Guidozi.

Under the heading "until 2002":

*Studies indicate that HRT does prevent bone loss (osteoporosis) after four or five years.*

*Cognitive functioning, Alzheimer's, sleep disturbances, mood fluctuations and colon cancer are improved with HRT.*

Comment: **Selective:** When reporting on the positive effects, she omits to add credibility to the statement by specifying which study.

The reporter does add that bone loss is prevented after four or five years. However, when reporting on the risk (breast cancer, stroke and deep vein thrombosis) she omits to mention similar -- *after four or five years*.

The logical construction of *colon cancer improved with HRT* is confusing but probably meaningless error/negligible.

*The WHI study reflected a 26 per cent increase in breast cancer in women receiving HRT compared to those receiving the placebo is **Inaccurate**.* It should have read: the study reflected a 26 per cent **Relative Risk** increase, not an increase in cases.

Meanwhile, the "positive" outcomes (reduced colon cancer and bone fracture risk) are omitted in terms of Relative Risk.

(When comparing the medical journal report relative Risk figures, one sees that, the WHI study has likewise *proved* that:

Risk of hip fractures are down by 33 per cent for women on HRT, and colon cancer down by 37 per cent.)

Under the heading 2002-2003:

*HRT is associated with specific breast cancers - invasive breast cancers, and not with lesions that start growing and become cancers.*

Comment: Confusing terms.

(See discussion by Dr Zinn in Chapter 3)

She also touches upon the UK Million Women Study: *The study indicated that the risk of breast cancer (relative to placebo) is twice as high for those taking combined HRT.*

Again, **statistics oversimplified**. The difference between relative risk and absolute risk is not explained and only the relative risk figure is given. While the results have been called statistically meaningful in the medical journals, and should be reported in responsible media, the findings and statistics should be placed in context, so as not to spark public alarm.

The rest of the article states advantages of natural healthy therapies, with more quotes by Dr Arien van der Merwe:

The last point is an attempt at balanced objectivity, but in the light of the general tone of the article it is almost ironic: *Sensationalist statistics quoted in the media must be viewed with caution and in context if an informed decision is to be made.*



## Summary

Anti HRT. Even though an opinion is given by one independent expert that the findings are not applicable to all women, the general tone is that of the WHI report exposing all HRT as bad.

Only RR figures applied, good news played down, bad news prominent. Medical fraternity cast as villain. Sensational.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned that Prempro findings do not apply to other products
3.HT/HRT difference	Mentioned that oestrogen alone is different to combined HRT
4. Period of use plays a big role	Not explained

## Report 3

### Mail and Guardian October 3, 2002

Headline -**Does hormone replacement work?**

**Byline** - Sheree Russouw

The headline does not address the question exactly *for what* women want it to work.

**Picture:** Sinister picture association -- a woman with no hair (chemotherapy?) being scanned before or after a mastectomy.

The picture almost "answers" the question posed by the headline.

**Introduction** is subjective. It quotes an advertisement by drug maker Ayerst in the 1970s, referring to women's fear of losing their youth and their husbands.

The tone conveys the impression of drug makers luring women into using chemicals; then paying a dear price for their vanity and lust.

As quoted by Nelkin earlier in this paper, it is indeed true that in the 70s the medical establishment did promote HRT on a much bigger scale than now. But since the 90s, Feminist sensibilities and the fact that women are more informed, has changed the scene. Women are no longer the helpless stereotype.

Second paragraph: *Women have opted for HRT as an instant cure.*

Comment: It makes HRT sound like an "easy way out" or a "quick fix". A lot of stigma accompanies medical quick fixes, and such a phrase might sway any confused reader towards suspicion.

The next phrase reads: *The bad news does not stop here.*

This is editorialising for the sake of **drama**. The image of HRT is already blown; it's bad news all along

*While studies show that HRT can reduce osteoporosis and colon cancer and combat Alzheimers, the WHI study proved to be a medical tempest.*

Comment: **Selective**. The positive results found by the studies are mentioned almost as an afterthought.

The article then lists the negative findings of the WHI report.

The way it explains the difference between ET and HRT is also confusing.

The next sentence quotes Dr Theo Kopenhagen of Park Lane Clinic as saying "the incidence of risk". This is a confusing construction.

Note: It's Dr Kopenhager. The spellcheck probably changed it to Kopenhagen.

*Kopenhagen affirms that the majority of the 16 000 were not ideal candidates and that the hormone taken was not suitable.*



Comment: It's the only report surveyed that mentioned flaws in the study. She could have elaborated on the flaws: The women tested were all over 67 years of age (Much older than most women who enter menopause and go on HRT. Women that age usually have passed menopause or have had hysterectomies and would therefore not be on HRT.

Note: Two of the 3 points listed, as flaws in the study --that some of the women were obese and some were ex smokers -- are negligible. In a normal society, some people are indeed obese and ex smokers. The group was representative.

**Selective:** The word *affirms* is used. It seems that when a bad finding is mentioned, doctors *admit* but when any doubt is cast on whether the study might have flaws that might paint a brighter picture, the word *affirms* is used. It's also not clear what is meant by the hormone not being *suitable*.

*The WHI study used hormones found in pregnant mares, which is not normally used.*

Comment: Error. Plant-based hormones as well as mare urine hormones are both still widely used. 21<sup>st</sup> Century sensitivities will squirm at the fact that pregnant mares' urine is being taken orally. This might create revulsion and suspicion.

This links in with another vague quote ascribed to the doctor: *He believes that natural estrogens are the answer.* This is wrong - the only "natural" oestrogen is the oestrogen produced by the ovaries.

The reporter *does* mention the time period effect on risk:

*Various studies point out that if you take HRT for less than five years there is little or no increased risk of breast cancer.*

*Many women refuse to go on HRT.... the WHI study seems to buffer their belief.*

Comment: The word *refuse* induces the image of women force-fed against their will.

The WHI study *buffering* the belief creates the impression of the WHI and women *versus* the medical establishment. This is heightened by (in the 3<sup>rd</sup> last paragraph) saying Kopenhagen *concedes* the need for discussion - as if he stands accused of conspiring against women.

It reminds of the impression created by the word *indicted* in the previous report analysed.

This impression is strengthened by the reporter, without sourcing anybody; making the unsourced statement: *Some people believe that HRT is nothing more than the cunning product of menopause marketing that plays on women's fears.*

It seems as if the reporter can be counted among those *some people*.

The last sentence referring to *safe therapeutic options* is vague. One is left wondering what specific options.

### Summary

A slightly alarmist tone, added to the sinister picture, gives the report an anti-HRT tone.

RR figures used and AR figures omitted. Sensational adjectives. Doctors cast as villains.

1.Flaws (Study group age and health)	Mentions the age, smoking and obesity factor of study group
2.Prempro	Reference to mare urine is confusing
3.HT/HRT difference	Explains that the HRT leg was halted and that ET is used for women who have had hysterectomies only
4. Period of use plays a big role	Mentions that taking HRT for 10 years may increase risk.

### Report 4

**Health24 - November 7, 2003**

**Headline - Hormone Therapy: The latest**

**By-line - Mari Hudson**

*As little as five years ago doctors still hailed hormone therapy as the saviour of post-menopausal women. A year ago the bubble burst.*



Comment: Inaccuracy resulting from the media's need to **dramatise** findings .Use of the words *hailed* and *saviour* exaggerates reality. It's old news that there are certain risks involved in HRT; the *bubble has burst* many a time before. Doctors examine and instruct all women before prescribing HRT. HRT is not prescribed for smokers, women with weight problems, high blood pressure and a whole long list of medical symptoms.

The phrase *hailed as saviour* is not applicable.

It already does not seem as if this is *the latest*, as promised in the heading.

*Our primary objective is the best interest of women, not the pharmaceutical companies, nor any other interest group. If a natural product is better we will tell you. If you should worry about the risks of HT we will tell you. If this whole upheaval has blown the findings out of proportion, then we will tell you. Now read on.*

Comment: Heroic -- the media as saviour.

Paragraph 9 continues the tone of doctors as villains:

*They believed their GPs and gyneas. Many women...took hormones, either in pill form or as implants and later as patches. They took hormones, whether it was oestrogen alone or a combination of oestrogen and progestin. Most women did not bother to ask their gyneas whether it was one hormone or two, they took it.*

What goes for a small group is applied to a large group. It paints the alarming picture of women frantically grabbing hormones in a pill popping frenzy.

(There is not a sudden epidemic of death and disease as a result of HRT. There is a big scare).

Under the subheading *explaining the findings*, the reporter could have made a simpler distinction between ET and HRT. In a quest for **simplification**, the report loses me when elaborating under the heading *breast cancer risk*.

*\* A 50-year-old woman (regardless of combination HT or not) has a 2.8% chance of developing breast cancer by age 60.*

Does this mean between 50 and 60 a woman has 2,8% chance of cancer, regardless of whether she uses HRT or not? However then it says that after 5 years of HT by age 50 she has a chance of 3.5% -- which seems contradictory -- since that means it's *not* regardless of. And is that HT? or combination HT?

The article makes inconsistent reference to HRT as either *combined ET*, *ET therapy* or *combined oestrogen and progestin therapy*.

**Incorrect reference to published study** in an attempt to **simplify** statistics for the reader. Too many statistics.

The article presents balance by comparing the risk of HRT use with the risk of two drinks daily or obesity.

The *Bottomline* is lucid, apart from one inaccuracy. The reporter refers to *incidence* of cancer that might be a meaningless error. She should have said *risk* of cancer.

It is one of few articles that mentions the odd fact that, even though the *risk* is higher, actual breast cancer *mortality* for women on HRT is lower than for women not on HRT, because of better awareness.

It also mentions how big the natural health industry has become, but it does not elaborate to what extent there is market competition between the pharmaceutical industry and the natural remedy industry.

The explanation of the risks for heart disease, stroke and deep vein thrombosis is statistically correct and clear. The bottom line section is informative.

In fact this should have been the angle of all the reports on the WHI findings and an accurate reflection of the angle taken in the medical journal reports:

**"HRT is not the heart protector we thought it was".**

(Then again, *that* headline would not even have made Page 4, let alone tumble stock prices.)

The report talks about *More and more women are trying phyto-oestrogens*.



The Bottom line section explains clearly that natural remedies are not as effective in relieving symptoms of menopause.

The end summary is clear and objective, with two meaningless obscurities:

Under the fifth and sixth point she says: Women with a family history of breast cancer, heart disease, stroke or deep vein thrombosis *should be* instead of should *not* be considered for (combined oestrogen and progestin).

The word *statins* is not explained. These are a group of medications used in the treatment of high cholesterol. They have been suggested to have a beneficial side effect on bone density but this is not very promising with new information.

It's not clear what's meant by *low dose* is better.

### Summary

Neutral tone. Explanation of difference between RR and AR, as well as risk and mortality. Not over sensationalised. Tables of statistics confusing.

Media cast as saviour against unsympathetic medical fraternity.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Mentioned but confusing
4. Period of use plays a big role	Not noted

### Report 5

**Die Burger August 20, 2002**

**Title: Menopause: kuur of skete? (cure or ailments?)**

**Byline: Thalyta Swanepoel**

*Moet jy of moet jy nie? Dis die onsekerheid oor hormoonvervangings terapie wat vroue op hol het na skokbevindings oor die kuur wat help keer dat vroue droë ou koeie word.*

Comment: The phrase shocking findings is exaggeration. The findings were not described as shocking by the medical journal reports.

Otherwise, a well-balanced article that touches upon aspects neglected by other media.

The tone is re-assuring and conversational. It clearly states that the reasons why the WHI study that caused such a furore were stopped were because of the slightly increased risk of breast cancer.

The article quotes various experts and not just extreme opposing views.

It starts off with two spokespersons for pharmaceutical manufacturer Novo Nordisk SA.

It mentions that many women quit their medication, even though the WHI study used a different kind of medication -- that the WHI study used only one of an older HRT combination, and only one dosage.

The statements by the pharmaceutical interest group are backed up by an independent voice -- a woman gynaecologist from the University of Pretoria: *Daar was not altyd 'n hoë uitvalsyfer as dit by HVT kom, omdat vroue bang is vir borskanker.. Nou is almal bang HVT veroorsaak beroerte en hartaanvalle.*

### **Summary**

Neutral, not alarmist, lucid.

The article clearly explains without going into confusing detail:

- \* That results differ from patient to patient.
- \* It draws a clear distinction between the two legs of the study - the oestrogen only and the combination oestrogen progestin leg.
- \* That it was the first study that clearly indicated HRT may reduce colon cancer incidence.



\* The difference between *cases of* and actual *deaths of* breast cancer.

It also quotes independent experts calling for calm *Dit is nie nodig dat vroue so heftig reageer nie.*

It brings in a non-extreme opposing voice, from osteoporosis expert Dr Stanley Lipschitz.

He says that only 30 to 40% of women do get osteoporosis, meaning HRT is often not needed to prevent bone loss.

Once again the reporter does not present an extreme position in order to appear objective. She specifies and backs up with simple figures the areas in which the doctor has doubts about HRT.

The report quotes two women who tell of their experiences with and without HRT. The reporter refrains from adjectives and merely quotes them in full.

In general re-assuring and duly impartial, with no slant pro or against either HRT or the natural health industry.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Explained
4. Period of use plays a role	Noted

## Report 6

**Die Burger August 20, 2002**

**Title:** Gebruik van HVT raak al hoe meer omstrede

Not Bylined

The first two paragraphs are factually correct but long-winded. Whereas almost all other reports analysed in this paper can be accused of over-sensationalising, this one presents facts like an academic handbook. Sentences are long and one gets confused between the World Health Initiative study, the HERS study, the South African Association of Gynecologists, and the German Menopause Association.

When it states the percentages of risk as well as the percentages of reduced risk, it does not make a distinction between relative and absolute risk.

It later on translates the percentages in terms of Absolute Risk (cases per year), which makes it sound less ominous.

While the tone of the article is objective, it might run the risk of confusing/ losing readers.

### **Summary**

Neutral, uses RR as well as AR, slightly confusing.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Mentioned
3.HT/HRT difference	Not clear
4. Period of use plays a big role	Vague

### **Report 7**

**Die Burger, April 16, 2003-12-14**

**Title:** Ja en nee nie maklike antwoord

**Byline:** Petro Bosman

*Hokaai eers, sê Professor Stephen Hough, hoof van die departement interne geneeskunde....*



Comment: the first paragraph and starting off with "Hang on" is effective in dispelling panic. It clearly states that common sense must prevail and that what's applicable to a small group need not be applicable to the whole. The first paragraph lists the "good news" that HRT does protect against brittle bones, as well as that the "bad news" is actually "old news".

Toe is gedink dat vroue wat hormoonvervanging kry, is dalk slegter daaraan toe as wat eers gedink is *ten opsigte van hartbeskerming*.

Comment: It raises the issue that many other reports left for much later on: That the study merely proved that HRT is not as effective for heart protection as initially thought.

It uses Absolute Risk figures instead of using only Relative Risk figures: *Normaalweg sal 45 uit 1000 vroue wat geen medikasie gebruik nie, borskanker kry. Met hormoonvervanging skuif dit op na 47 uit 1000.*

Comment: By quoting the independent Professor, it clearly states the crux of the research -- It was found that of the women in the group on HRT, 47 women out of 1000 extra per year got breast cancer. While it was found in the group *not* on HRT, 45 women out of 1000 got breast cancer in a year.

It ends off, touching upon the issue of informed choice. Women are not stereotyped victims and doctors villains.

### Summary

Neutral, non-alarmist. States Absolute Risk figures, not Relative Risk figures. Doctors not portrayed as villains.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Not mentioned
4. Period of use	Not mentioned

**Report 8****Die Burger/Die Beeld/Die Burger Oos Kaap**

(web archives 11/7/03)

**Headline** - Navorsers wat mediese skade, was lank in SA (Oos Kaap)

And Hormoonbehandeling nadelig, bevind span in VSA (Beeld)

**Byline** -Pierre Steyn

Both headlines indicate partiality against HRT, the one by implying that a researcher has done a study that shook up the whole medical establishment with facts they never knew before; the other by simply stating that HRT is bad, according to a team in the USA.

The introduction might appeal to patriotic South African sentiment. A "home boy", Dr Jacques Rossouw, the head of the WHI study, has made waves.

It described how he emigrated to the United States after a *long and bitter fight* with the South African Medical Research Council, without stating *why* he fought with them. It's not clear why this fact had to be mentioned, other than that the WHI findings are Rossouw's "vindication".

*Rossouw en sy span navorsers het Dinsdag aangekondig dat hormoonvervangings behandeling wat tans deur meer as 6 miljoen Amerikaanse vroue gebruik word, meer skade as goed doen.*

Comment: **Dramatisation** leading to inaccuracy. It sounds as if Rossouw was the first to discover risks involved with HRT. This is inaccurate. It neglects to mention that there have long been cracks in the belief that HRT is 100% beneficial for all women and has no risks.

It mentions six million women in a way that creates context of Rossouw and his team fighting for the lives of millions of women against the nasty medical establishment.



*Hulle het bevind dat die middels, 'n kombinasie van estrogeen en progesteron, tot 'n klein toename in borskanker, hartaanvalle, beoertes en bloedklonte lei.*

Use of the phrase *klein toename* (small increase) in the next sentence seems almost an anticlimax -- since the first half of the article created anticipation of something earth shattering after the *years of intensive study that shook the medical establishment to its very foundation*.

*Tot onlangs het die mediese owerhede hier dokters aangeraai om elke vrou wat nog nie 'n histerektomie gehad het nie en menopause bereik, aan te moedig om die middels te gebruik.*

Comment: Unqualified statement, not attributed to any source. Gynecologists such as Dr Zinn keep stressing how they certainly would not recommend HRT for *every* woman, and only prescribe it under certain conditions.

**Selective:** The report ignores the good news and only reports on the bad news. It made no attempt to solicit any other opinion.

The reporter seems unaware of the history of HRT scares and seems out of his depth in the field. The report does not give context or background to the study.

### Summary

Anti-HRT, alarmist. No statistics mentioned

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Not mentioned
4. Period of use plays a big role	Not mentioned

### Report 9

**Sarie, February 2003**

**Headline -Jonger met hormone?****By-line - Lydia van der Merwe****Use of photo: Positive image of a smiling attractive middle-aged woman**

Introductory subheading: *Maar dit gaan om meer as net estrogeen en die menopause.*

The heading has a pro-hormone treatment tone - it asks the question whether hormones make women younger.

The focus of the article initially is on the WHI controversy. It can be deduced that the heading was a good teaser to lure readers interested in the ageing issue.

From the outset the article jumps from oestrogen replacement to combination replacement without specifying what exactly is meant by hormone replacement or by making a clear distinction.

Under the subheading *Die droom van ewige jeug (dream of eternal youth)*, there appears a slight confusing inconsistency when referring to HRT or ET.

*Niks gee skynbaar beter gestalte aan die droom van ewig jonk en vroulik wees as estrogeenervangingsterapie (EVT) nie.*

Two paragraphs later it refers to HRT - *HVT gee verligting van vroeë menopousale simptome.*

The article then lists the positive benefits from HRT. It quotes a Dr Willem Serfontein, a medical scientist, and tells the reader where to get hold of his book, by Tafelberg Publishers.

Later on the article refers to a book by Tafelberg Publishers, Dr Arien van der Merwe's *Kruie met Geneeskrag.*

It might cause a credibility issue when a book from a publisher that comes from the same group of companies as the magazine is promoted.



The reporter should also think twice before recommending a book by an author with the same name (van der Merwe), in order to avoid suspicions of nepotism.

Under the "fly in the ointment" the report says the risk of breast cancer is increased up to 35%.

Comment: **Incorrect reference to published study and oversimplification of statistics** (failure to explain the difference between absolute and relative risk.. She neglects to say if this refers to the WHI study she reports on later in the article. If so, this statistic is inaccurate, since the relative risk increases by 26%.

The article then describes the WHI study.

*Nie net was daar 'n klein toename in borskanker nie; die risiko vir hartaanvalle het met 41% verhoog. Aan die positiewe kant, afname van 37% in kolorektale kanker en aansienlike verlaging in heup-en werwelfraktur. (Die deel van die studie waar oestrogen gebruik is, word voortgesit).*

Comment: Tone is re-assuring and mentions positive findings with the same prominence as negative findings. One inaccuracy is that the relative risk of heart disease is up 29%, and not 41%. (See article and tables in appendix...)

Dr Theo Kopenhagen, the Johannesburg gynaecologist, is also quoted in this article. He says the media does not give the whole picture. This helps to give the reader a view from an independent expert.

It is one of few articles that specifies that only one HRT combination, Prempro, was used, and that outcomes with other combinations will be different.

It stresses sensible advice -- informed choice in consultation with doctors.

The rest of the article gets snared in medical and scientific terminology. It does not sufficiently explain terms such as *phyto-* or plant oestrogen and *hormonale voorlopers soos DHEA en pregnenoloon* and *topikale pro-gesteroon*.

The article is not clear why the subheading reads : it's about "more than just oestrogen and the menopause".

**Summary**

Neutral, but confusing. Only Relative Risk figures are mentioned for “bad” as well as “good” results.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Clearly explained
3.HT/HRT difference	Not clear
4. Period of use plays a big role	Clearly explained

**Report 10**

**Cape Argus, July 30,2003-12-14**

**Headline: Modern day Miracle or Killer Treatment?**

**Byline: Di Caelers**

**Use of picture: A graph listing benefits and risks equally.**

Introductory sentences set the stage that HRT helps against the symptoms of menopause, but that there is debate on its safety.

It then strikes a re-assuring note: fortunately, *there's plenty of good advice to be had.*

The article's focus is on the debate, not on whether HRT is good or bad -- which makes it duly impartial.

The reporter explains why some women need HRT by letting the expert list health problems that may arise during menopause She also stresses throughout that it is a woman's individual choice, in consultation with her doctor.

It mentions that the study was on *combined oestrogen and progestin use.*



But refers to *healthy post menopausal women* which is inaccurate since the 3 “flaw” factors (age, obesity, smoking) were not mentioned.

The article lists the "good news" (what HRT is good for) first, and the "bad news" (the risks of HRT) last.

After listing oestrogen's benefits (talking about oestrogen only), she refers to HRT again, which the reader might find confusing.

She then summarises the methodology of the WHI research.

The sentence that begins: *But in one part of the study a group of 17000 women with a uterus...* is an attempt to explain statistics, but the reader might get lost in too much detail.

She clearly states the objectives of the WHI study, which was not to test whether it's an “elixir of youth” as many other articles made it out to be.

*Researchers wanted to study the relationship between hormone therapy and its possible benefits for heart disease and hip fractures, and its possible risk for breast cancer, endometrial cancer and blood clots.*

It's one of few articles that state that the aim of the study was to examine the extent of benefits and risks, instead of making out as if this study was the *first* to prove that HRT is not a wonder cure.

The reporter quotes an independent expert, Dr Stephen Hough, as saying that the study has proved that protection against heart disease is not a reality. But *that it's still the best treatment available for the symptoms of menopause and osteoporosis.*

The reporter asks the question *so what does all this mean for the average woman on HRT?*

She lets the expert do the talking, explaining what the results meant.

The end message is that it's up to every individual woman to decide for what and for how long she wants to use HRT.

**Summary**

Balanced, neutral, not over sensationalised or alarmist.

This article accurately reflect medical journal reports on the published study:

\*That oestrogen plus progestin does not confer cardiac protection and may increase the risk of CHD among generally healthy postmenopausal women, especially during the first year after the initiation of hormone use.

\*That the treatment should not be prescribed for the prevention of cardiovascular disease.

In an attempt to "translate" or oversimplify, some confusion crept in.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Mentioned but confusing
4. Period of use plays a big role	Mentioned

**Report 11**

**Daily News** 25/4/04

**Headline** Dispelling the HRT myth

**By-line** Petra Lee

Headline: This line is normally only used when "debunking" the good myth about HRT. However, this report gives a fairly glowing account of HRT. So it's assumed the headline implies that it's dispelling the *nasty* myth about HRT.

The headline might also prove that the layout person or the editor finally responsible for the headline often does not grasp what the report is about.



*If you've heard that HRT will give you breast cancer, take heart. It won't happen.*

Comment: Unqualified generalisation. The study did not find that HRT does *not* give you cancer. Just as it did not find that it does *give* you cancer. The expert quoted later on did also not explicitly state that HRT would not give you cancer. This is bias towards the other extreme, which can also be dangerous for readers who change health patters according to media reports.

The reporter then quotes the *eminent* and *highly respected* Professor, as saying HRT promotes the growth of pre-cancer cells.

The adjectives describing the Professor convey a sense of a star struck and uncritical reporter. The reporter does mention the fact that he is a representative of a pharmaceutical company. However, the reporter does not see fit to bring in an independent source or opposing view.

As regards the discussion of epidemiology, and the question of whether HRT merely makes pre-existing cancer cells grow, it is uncertain whether the expert was quoted in context.

Independent experts like Dr Zinn (personal communication: January 5, 2004) explain:

"HRT may accelerate the growth of sensitive cancers -e.g. in the breast but may also give rise to cancers that would never have occurred. We all have genetic predispositions that make us susceptible to certain diseases but will not necessarily get these conditions unless the right conditions arise. In the case of oestrogen sensitive cancers this is the presence of oestrogen - normally not present in large quantities in the postmenopausal woman. Unfortunately we do not know which women are going to become susceptible except by inference from risk factors - family history smoking, alcohol intake, weight, number of children etc. My answer to the question would therefore be no. It is likely from current info that HRT can cause cancer that, otherwise, would not have occurred."

Confounding factors:

Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Not mentioned
4. Period of use plays a big role	Not mentioned

## Report 12

### Die Burger 18/9/02

Headline - Die waarheid oor HVT

Byline: Valda Jansen

An objective, informed and non-alarmist report. The headline is, however, the same headline as the Times article. The word *waarheid* "truth" implying that lies abound.

The phrase *facts or info on HRT* might have been more neutral.

The report makes a clear distinction between combination treatment and oestrogen-only treatment.

It mentions that the media had ignored the fact that only one brand of medication was used in the study, and that other combinations may not carry the same risks.

It does not over sensationalise or omit any of the "bad" findings, and mentions the "good" findings in the same sentence.

It also spells out that the only "new" finding was that HRT does not offer the high protection against cardiovascular disease as formerly thought and that it should not be prescribed for the prevention or treatment of cardiovascular disease.

### Summary

Neutral, not alarmist or confusing, No "sides" taken against medical experts, no stereotyping or editorialising.



**Confounding factors:**

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Mentioned
3.HT/HRT difference	Mentioned
4. Period of use plays a big role	Not mentioned

**Report 13****Shape Magazine May 2003**

Not bylined

Headline - HRT gets a double whammy

The headline is negative, saying that once again HRT has been slammed.

*Hot on the heels of the question mark about the safety of HRT are suggestions that the treatment may offer no real benefit for postmenopausal women.*

The sentence is an accurate reflection of a New England Journal of Medicine report about HRT and quality of life, even though the positive findings are not mentioned.

The report refers to the *oestrogen mystique*. This is confusing since it does not differentiate between HRT and ET.

It does quote an independent expert as saying oestrogen is still the most effective treatment.

The final message is one of common sense and caution.

It does not explain what phyto-oestrogens are. Some HRT medication is also plant based.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
--------------------------------------	---------------

2.Prempro	Not mentioned
3.HT/HRT difference	Not mentioned
4. Period of use plays a big role	Not mentioned

### Television - Report 14

To make reports understandable for a mass audience, television often has to personalise, or use a device called "The Johnny".

For television to retain maximum viewer's attention in around 2 minutes - scientific reports often exemplify people. (What's it going to do to *me*?) The device in TV jargon is called "The Johnny".

Nelkin (Nelkin, 1995: 57) believes that:

“The form and content of science information on television is conditioned by what producer Jeffrey Kirsch calls the marriage of the sales mentality to the electronic image. Producers have learned what formats, production, techniques, symbols, and personalities are most likely to succeed.”

Constraints of scientific complexity are very difficult for the television medium -- it's hard to give context to complex science issues.

etv news on 07/10/03 carried a Reuters news agency piece as is.

It contains almost the whole list of points to examine mentioned in the abstract, in less than a 2-minutes report--omission, sensationalism, oversimplification and lack of perspective.

**Visual material** – Not alarmist. Footage of women walking in the street and tablets.

However, the script, is one-sided.

1. The introduction ("attention grabber") simply says that doctors have issued a warning against the dangers of HRT .
2. It says a major US study was cancelled, without referring to what study.



3. It omits to mention that the oestrogen leg of the study carried on.
4. The introduction omits reference to proven benefits.
5. The item itself refers to 17 000 healthy women, omitting to say that there has been criticism of the selection of the group. (That at average age 63 they were not representative of the normal age of women starting HRT, that some were obese, and some ex smokers)
6. It says HRT *raises the number* of strokes by 41 per cent, heart attacks by 29 and breast cancer *cases* by 28 per cent. This is **inaccurate oversimplification**.  
(Medical journals clearly state that HRT increases the *Relative Risk of the incidents occurring* -- not the *number* of incidents)
7. One upsound by Dr Rossouw, the “leader” of the WHI study is used. It identifies him only as “doctor” The report does not solicit any re-assuring or opposing view.
8. It gives no advice or recommendations to women.
9. It gives low prominence that "HRT does lower" incidence of hip fractures and colon cancer.
10. The piece-to-camera is accusatory, implying that women have been hoodwinked.

Confounding factors:

1.Flaws (Study group age and health)	Not mentioned
2.Prempro	Not mentioned
3.HT/HRT difference	Not mentioned
4. Period of use plays a big role	Not mentioned

### Chapter three

#### Summary and analysis of error and bias

**Table 3.1 Coverage of the WHI HRT study in Southern African newspapers, magazines and television May 2002 until November 2003**

Report and number	Quote that forms	Neutral	Pro HRT	Anti HRT	Alarmist	Confusing
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	<b>“gist” of article</b>	<b>(“Use common sense”)</b>				
<b>1. Time</b>	<i>Dream fade away</i>			<b>1</b>	<b>1</b>	
<b>2. Longevity</b>	<i>Medical fraternity’s onslaught</i>			<b>1</b>	<b>1</b>	<b>1</b>
<b>3. WMG</b>	<i>Cunning product of menopause marketing</i>			<b>1</b>	<b>1</b>	<b>1</b>
<b>4. Health24</b>	<i>Grabbing hormones, clung to HT</i>	<b>1</b>			<b>1</b>	<b>1</b>
<b>5.DieBurger</b>	<i>Nee wat, kyk na die individuele risiko</i>	<b>1</b>				
<b>6.DieBurger</b>	<i>Klein risiko, maar ook positiewe uitslag</i>	<b>1</b>				
<b>7.DieBurger</b>	<i>Hokaai eers, kyk na individuele profiele</i>	<b>1</b>				
<b>8Die Burger</b>	<i>Meer skade as</i>			<b>1</b>	<b>1</b>	



	<i>goed</i>					
<b>9 Sarie.</b>	<i>Individuele profiel onder die loep neem</i>	<b>1</b>				<b>1</b>
		<b>Neutral</b>	<b>Pro-HRT</b>	<b>Anti-HRT</b>	<b>Alarmist</b>	<b>Confusing</b>
<b>10.Cape Argus</b>	<i>Make an informed decision</i>	<b>1</b>				<b>1</b>
<b>11.Daily News</b>	<i>Take heart – it won't happen</i>		<b>1</b>			<b>1</b>
<b>12.Die Burger</b>	<i>Individue verskil – Maak ingeligte besluit</i>	<b>1</b>				
<b>13. Shape</b>	<i>Not what it's cracked up to be</i>			<b>1</b>		<b>1</b>
<b>14. TV news</b>	<i>High increase. "Bad" disease, might be hurting you.</i>			<b>1</b>		<b>1</b>

### 3.1 Anti or Pro-HRT

**\*Seven out of the 14 reports (50%) show bias**

(Six out of 14 reports were anti HRT and one out of 14 was pro HRT).

*Time, Longevity, Weekly Mail & Guardian, Die Burger* (Report 8) *Shape*, and the television report were anti HRT, while the Daily News report was pro HRT).

**\*Three reports (Sarie, Health24, Cape Argus) were neutral but confusing**

**\* Four reports met the criteria of informative, re-assuring and neutral (*Die Burger* 5,6,7 and 12)**

Therefore, in total, 10 out of 14 were either biased or confusing.

Why the bias? This can be because the authors sincerely believe HRT is extremely dangerous and warrants a public outcry.

In *When MBAs rule the newsroom*, Doug Underwood (Underwood, 1995: 11) quotes a newspaper industry research expert as commenting on the fact that media marketing trends follow, instead of shape, public taste, in order to make more money. Therefore, bias, can be a conscious or unconscious pandering to reigning social beliefs.

Recent views about HRT taken from news sources such as the British or American National Women's health Networks do indeed show that the reigning social belief of our time is anti-HRT.

British Sociologist Kate Hunt (Wilkinson, Kitzinger, 1996: 152) refers to the *notorious* book by Robert A Wilson (*Feminine Forever*) She quotes feminist sources as stressing how modern feminist literature tends to be universally suspicious of HRT.

It might be true that both the medical and feminist presentations of the menopause exploit the fear of cancer to promote or demote medical control over menopause.

The media reflects this, instead of analysing the trend.

### **3.2 The villainous scientist, the helpless woman, and the heroic media**



Five out of 14 - Time, Longevity, Weekly Mail & Guardian, Die Burger (Report 8) and the television report gave a stereotyped impression -- that the WHI trial was "on the side" of helpless women *against* the villains in the medical fraternity.

Time - *Maybe I've been too trusting.*

Longevity - The choices *they confront me* with.

WMG - Dr Kopenhagen *concedes.*

Die Burger (Report 8)- (The tone is "I-told-you-so") *Tot onlangs het die mediese owerhede hier dokters aangeraai om elke vrou wat nog nie 'n histerektomie gehad het nie en wat menopause bereik het, aan te moedig om die middels te neem.*

The report actually mentions the word *misdadige* (criminal) when quoting the head of the WHI talking about local doctors prescribing HRT.

The Health24 report (Number 4), while not slanted against HRT, also gave the impression that the media is on the side of the women, against everybody else:

*Our primary objective is the best interest of women, not any other interest group .We will tell you (the truth), now read on.*

Johan Retief (Retief 2002: 393) writes that around 1992 a backlash occurred against feminist messages of the last two decades. First you had the 50s housewife, then the assertive independent feminist era and then -- "women who work and leave child rearing to others are flirting with disaster".

He's referring to the advertising industry but this is applicable to the popular press.

"Undoubtedly, the women's movement, with its harsh assessment of the advertising industry, has succeeded in diversifying the social roles of female characters. Nevertheless, images of women as pre-occupied with beauty, sex appeal and youth still abound in commercial messages directed at the mass audience."

### **3.3 HRT "versus" the natural health industry**

Three out of 12 reports showed distrust of conventional medicine and advises herbal or "natural" options.

Report 3 (WMG) -*safe therapeutic options*

Report 2 (Longevity) and Report 9 (Sarie) list herbal remedies and advise the reader about what books to buy

But no blatant propaganda for natural health products was detected.

Mentioning the names of the books might seem promotional of the natural health industry, but it might be excused on grounds that they are good books by credible and responsible experts and therefore in the public interest. Recommending extra reading materials is not completely unethical. One can also justify a newspaper or magazine wanting to promote a sister publication for commercial reasons. The link does not seem covert.

Dr Zinn (personal communication: October 2003) notes that Black Cohosh, mentioned in the magazine, has not shown great anti-menopausal symptom relief:

“There has been no evidence so far that it is better than a placebo. Soya is better but must be concentrated and from soya husks (i.e not dehusked soya). The main component is genistein which is the most effective of the phyto-oestrogens. They have only been shown to be effective in 60% of women with frequent hot flushes as opposed to 40% effectiveness of placebo.”

It has been noted that advertisements for natural or herbal medication for menopause were placed on or near the articles in three magazines - *Sarie*, *Shape* and *Longevity*.

### **3.4 Common errors and omissions that contribute to confusion or bias**

As seen in table 3.1, three reports, in attempting to simplify, became confusing.

Nelkin (1995: 118) says that:

“Studies assessing the extent and possible causes of error have produced mixed results. They suggest that 40 to 50 per cent of scientists complain about



inaccuracy. When pressed, however, they usually identify the problem as one of omission of relevant information and lack of qualifying statements rather than of error per se.”

### **3.4.1 Incorrect reference to the published study**

The reports in medical journals clearly state that HRT is still advised for treating adverse menopausal symptoms. It is simply not advised to help against **coronary problems, and might carry a slight increased breast cancer risk**. Translation of the scientific report in the popular press, being shorter and written in layperson's terms, generally omitted that angle.

Most reports neglected to point out that the breast cancer risk posed by HRT is old news, merely once again proven in a different study. All reports neglected to spell out clearly that one of the basic aims of the WHI study was to test whether HRT is beneficial for the heart (the WHI study tested whether HRT reduces the risk of coronary heart disease) The headline and angle of all the reports should simply have been "HRT has no proven benefits for the heart".

Only the longer feature articles gave background of research methods.

Even so, they included partial but inadequate information about the method. Some of the information about methods was erroneous or confusing.

Many discrepancies involve omissions or meaningless changes rather than blatant error.

Figures were generally correct but selectively quoted and out of context. No report clearly indicated the important difference between Relative Risk (big numbers) and Absolute Risk (small numbers).

### **3.4.2. Selectivity**

News reports written about lengthy research reports often ignore or downplay the "good news". Six out of 14 (43%) of the reports did not ignore the bad news.

*Time* magazine, *WMG*, *Longevity*, *Die Burger* (Report 8) *Shape*, and the television report focused on the heart disease and cancer angle while mentioning possible benefits in terms of colon cancer and osteoporosis much later and much less prominent.

Six reports, *Sarie*, *Health24*, and *Die Burger* (Reports 5, 6 and 12) tried to maintain a fair balance between good and bad findings.

Only the *Daily News* (Report 11) gave the good news and downplayed the bad news.

All the reports, when quoting statistics (except Report 6), informed readers of the benefits in terms of Absolute risk (small numbers) and the disadvantages in terms of Relative Risk (large numbers) .

### **3.4.3 Headlines and the use of photos**

Science writers complain that if they don't sensationalise the first line, they run the risk of having their story on a back page, or lower down in the bulletin.

Journalists constantly talk about "headline idiocies and the ignorance of editors," (Nelkin, 1995: 108). It is the editor who decides what is published, how each article is cut, and where it will appear in the paper:

“Journalists, unlike scientists, relinquish virtually all control over the final shape or presentation of their articles. This editorial control often means that stories are misrepresented in headlines.”

*Time* magazine and *Die Burger* (Report 8 - eastern Cape) rate highest in terms of an anti-HRT headline. The *Sarie* report (Report 9) headline can be described as positive even though it is in question form. The *Daily News* headline sounds negative, although it's probably meant *as dispelling the myth that HRT causes harm*. In general, most headlines were not biased, and in question or rhetorical question form.

When reporting on HRT, the favourite headline seems to contain the words "dispel" or "myth. Usually this means dispelling the myth that it's good, instead of dispelling the myth that it's bad.



It may also simply be a handy alliteration -- myth the first word that alliterates nicely when you need a quick menopause headline when deadline looms.

In order to help the reader "digest" pros and cons, they are often listed in tables or boxes with subheadings.

Such lists, albeit well meaning, may add to the confusion, as we have seen in the *Longevity* article (Report 2) and the *Health24* (Report 4) article.

### **Photos**

Apart from one picture used in Time magazine of an unhappy-looking ageing woman, and the alarming picture of a woman going in for chemotherapy in the WMG report, the articles used "neutral" or unalarming photographs.

Unlike the content of the script, the television report used neutral non-alarming images. Women were shown walking in the street and footage of tablets in bottles was shown. No sign of mastectomies and cancer wards.

#### **3.4.4 Statistics oversimplified**

**This table summarises the way the WHI statistics were presented in the 14 reports in terms of Relative Risk and Absolute Risk:**

	No stats but alarmist adjectives such as “high” and “shocking” numbers	Meaningless omission of stats	Only RR for bad <i>and</i> good news	Only AR	Only RR for bad news  But AR or no statistic for good news	Both RR and AR and clear	Both RR and AR but confusing
1. Time	1						
2. Longevity					1		
3. WMG	1						
4. Health24							1
5. Die Burger		1					
6. Die Burger						1	
7. Die Burger				1			
8. Die Burger	1						
9. Sarie			1				
10. Cape Argus		1					
11. Daily News		1					
12. Die Burger		1					
13. Shape	1						
14. Television					1		

Some reports deliberately used Relative Risk (impressive) while omitting Absolute Risk



(low) figures. This is either because of time and space constraints (meaningless) or manipulative. Sometimes the AR and RR figures are given but in an attempt at oversimplification, confusion sets in.

Two very important differentiations need to be made between:

#### **(a) Relative Risk and Absolute Risk**

**Relative risk** (Cohn, 1994: 55). compares two rates by dividing one by the other

“If for example the lung cancer mortality rate in non-smokers aged 55 to 69 was 19 per 100 000 per year, the risk in smokers was 188 per 100 000. Divides 188 by 19 equals almost 9.9. It therefore means that smokers are almost 10 times as likely to die from lung cancer.”

If eight more women per year out of 10 000 might get breast cancer compared to those not on HRT this means 26 per cent Relative Risk.

“26% Relative Risk increase” sounds far more impressive and understandable than “eight more out of 10 000”.

As seen in Table 3.4.4 -- In the reports analysed, Relative risk figures were not merely emphasised, but whenever statistics were quoted, only the Relative Risk figures were quoted in all the articles but one report.

In most cases the text simply read, "Risk for breast cancer was 26 per cent higher in the HRT group versus the non-HRT group." The difference between Relative and Absolute risk is never explained.

This is how Dr JC Stevenson, of the American Menopause Society, explains the difference:

“Relative risks give an indication of the magnitude of the increase in disease end-points but without reference to how commonly these events were occurring (absolute risk). Thus a small increase in relative risk for a disease event which occurs very frequently will result in a large increase in patients affected (large absolute risk), yet a larger increase in relative risk for a disease event which

occurs infrequently will have only a tiny impact in the number of patients affected (small absolute risk). The increases in the relative risk of coronary heart disease (29%), stroke (41%) and pulmonary emboli (lung blood clots) (213%) have been widely quoted in the media, yet the absolute risk increases, although significant, were fairly small. The true increased incidences are 0.09% for coronary heart disease, 0.02% for stroke, and 0.17% for pulmonary emboli. Thus, for 10,000 women taking HRT each year compared to those not taking HRT, there would be an additional 8 cases of invasive breast cancer, 7 heart attacks, 8 strokes and 8 pulmonary emboli. However, there would also be 6 fewer bowel cancers and 5 fewer hip fractures.”

(American Menopause Society letter 28/10/02)

**Absolute Risk** is a person's chance of developing a specific disease over a specified time period.

It's estimated by examining a large number of persons similar in some respect (such as age) and counting the number of individuals in this group who develop the disease over the specified time period. For example if we observe 100 000 women between 20 and 29 for one year, approximately 4 would develop breast cancer during this period. Therefore, the one-year absolute risk of breast cancer for a 20-to 29-year-old woman is 4 per 100 000 women, or 1 per 25 000 women.

Absolute risk of breast cancer for an individual woman - approximately 0.3 per cent per year. Prempro use added 0.1 percentage point risk per year.

A note on the importance of understanding statistics :

An example of the grave consequences of misunderstanding probability was given in the British *Financial Times* (Matthews:2004)

A mother who was found guilty of murder after two of her babies died.

At the centre was the figure of 73 million to one.



The figure came from Professor Sir Roy Meadow, an expert witness at the trial of solicitor Sally Clark, who insisted that two of her babies had died of deaths. Meadow told the jury that research suggested the chances of a single cot death taking place in a family such as Mrs Clark was one in 8 543. The chance of two cot deaths occurring was therefore the square of this figure -- or one in 73million.

The report describes how even judges fluffed the crucial point - that if an event occurs once, the chances of two such events are not always far lower still.

(The woman's conviction was quashed later by the Court of Appeal, which expressed concern that the jury had been misled by the huge odds.)

Crucially, DNA match probabilities are merely the odds of getting so good a match, given no involvement in the crime. That is not the same as the odds of the accused being innocent.

Matthews stresses that juries have to put match probability into context, using other sources as evidence. Only then can they estimate the probability of innocence -- which may be far higher than the match probability suggests.

The writer gives an example by science writer Gerd Gigerenzer to demonstrate the pitfalls of using common sense with probabilities:

Gigerenzer and his colleagues set a group of experienced medics the following problem, outlined in a recent paper in the British Medical Journal.

About 1 per cent of women have breast cancer and a cancer screening method can detect 80 per cent of genuine cancers but also has a false-alarm rate of 10 per cent. What is the probability that women producing a positive result really have breast cancer? Most doctors reckoned it was at least 70 per cent. The correct answer, found by only two doctors, is just 8 per cent.

Gigerenzer then repeated the test with another set of doctors, this time giving precisely the data as hard numbers: they were told that 10 in every 1 000 women have breast cancer and that, of these 10, eight will give a positive screening result; while of the 990 who do not have cancer, 99 will produce a false positive result.

Asked this time to estimate the probability that a woman with a positive result really does have cancer, most of the doctors could see that it was about 8 per cent.

The author uses this example to prove what science fiction writer H.G Wells meant by saying that statistical thinking would one day be as necessary for efficient citizenship as the ability to read and write.

**(b) Causation and association (Also see “confounding factors” section)**

Many women will develop breast cancer, whether or not on HRT.

Some women will die from it.

The fact that many women contract/die of breast cancer might not be such a “direct cause” of HRT use as media reports suggest. The HRT (Prempro) used in the study may also not be representative of all HRT .

The "worst offender" here is the television report that, instead of saying the Relative Risk of women on HRT to contract the following diseases goes up by the percentages mentioned, simply said" it *increases the number* of strokes, heart attacks and breast cancer *cases*.

Epidemiology cannot prove causation of a condition, it can only suggest association.

**(c) Risk and mortality**

Higher risk" does not mean higher mortality. According to Prof Davey, (personal communication: June 2003) the difference is often overlooked.

In reality, even though there might be a slightly increased *risk* or more *cases* of breast cancer for women on HRT, fewer women on HRT actually *die* of breast cancer than women *not* on HRT. This is because of indirect but related reasons.

This might be because they are more aware. Maybe concerned about the effects of HRT; they go for regular check-ups, join the gym and watch their fat intake.



### **3.4.5 Findings are over generalised and what goes for a small group taken to apply to a large group**

This is best described by Nelkin (Nelkin, 1995:166)

“Readability in the eyes of the journalist may be oversimplification to the scientist. Many accusations of inaccuracy are traceable to reporters' efforts to present complex material in a readable and appealing style.”

Overall the study's implications are more pessimistic than the findings warrant.

Cohn (Cohn: P. 59) points out that: "Virtually no *single study proves* anything".

Two or 4 or 15 studies (merely) add *credence*, especially if the diagnostic and outcome criteria and the people studied are similar.

But a single study rarely proves anything.

Media philosopher Herbert J. Altschull (Altschull, 1990: 1) also mentions the “facticity” of journalists – their tendency to provide graphic descriptions of a single tree when what readers need is a wider view of the forest.

### **3.4.6 Inaccuracies seem to result from the media's need to dramatise research findings**

“By their choice of words and metaphors, journalists convey certain beliefs about the nature of science and technology, investing them with social meaning and shaping public conceptions of limits and possibilities”(Nelkin, 1995: 11).

Hyperbole and sensational adjectives were found in 11 out of 14 reports analysed, with the exception of reports 5,6,7:

*Bad news, shocking, dreaded, potentially deadly, invasive, bubble burst, confused, angry. wide-eyed, desperate, onslaught, what's a woman to do? .*

### **3.4.7 In a quest for balance, journalists often represent extreme positions**

“Journalists' efforts to maintain objectivity, according to sociologist Gaye Tuchman, were only a "strategic ritual": subjective perceptions inevitably entered





<b>Prempro</b>	1	0	0	0	1	1	0	0	1	0	0	1	0	0
<b>HT/HRT difference</b>	1	1	1	0	1	0	0	0	0	0	0	1	0	0
<b>Period of use</b>	1	0	1	0	1	0	0	0	1	1	0	0	0	0

**This table adds up the results to calculate:**

**How effective was the media's communication of risk versus benefit in terms of the following?**

\*Did it explain adequately the difference between oestrogen only (ET) replacement and combined replacement (HRT)?

Five out of 14 -about 36%.

\*Did the media surveyed point out that only one brand of HRT, Prempro was used and that other combinations might not have the good or bad results?

Five out of 14 -reports 1,5, 6, 10 and 12 mentioned that the HRT (Prempro) study ended but the ET (Premarin) leg continued. Only two *explained* that different brands could have different risk factors.

\*Was a clear distinction made over safety of short-term versus long-term use?

Again, Five out 14 quoted health experts as saying HRT use should be used for short-term relief or discontinued after 5 years or stated the WHI findings over 5 years.

\* Regarding flaws in the way the study group was selected -- Only one report -- the *Weekly Mail and Guardian* (Report 3), mentioned that sixty per cent of the women were over 60, some were obese or ex smokers.

This is how the British Menopause Society (Newsletter: 2003) explains confounding factors:

“The small increase in breast cancer cases is in line with what previous population studies have suggested, as are the increases in blood clots, and the decreases in

fractures and in bowel cancer. But, knowing the effect of oestrogen on the function of blood vessels, the lack of benefit on heart attacks is more surprising. However, it must be remembered that these findings apply only to this particular HRT regimen, conjugated equine oestrogens 0.625 mg daily plus medroxyprogesterone acetate (MPA) 2.5 mg daily (similar to Premique in the UK). The findings may not be the same for other types of HRT, a point acknowledged by the study authors. It is quite likely that the effects of HRT regimens using different oestrogens and progestogens, and different routes of administration, would be similar in their effects on the breast, bowel and skeleton. But the metabolic effects of such different HRT regimens are clearly different, and this is most likely to impact on their cardiovascular effects. It is most unhelpful that this point was not appreciated by the recent recommendations of the Committee for Safety of Medicines/Medicines Control Agency, which were inappropriate with respect to cardiovascular disease. It is thus possible that this particular progestogen (MPA) had a harmful effect on breast cancer and on cardiovascular disease incidence. Particularly for the heart, the dose (and possibly type) of oestrogen and the type of progestogen may be crucial. It is therefore imperative that similar studies are carried out using different types of HRT than that used in WHI.”

## **Chapter 4**

### **Conclusion**

#### **4.1 Deliberate manipulation or inept omission?**

The media seems to have made up its mind whether the glass is half full or half empty, and it shows.

Instead of giving the facts, background context, and letting experts or victims speak for themselves. -- Facts and figures were selectively omitted to create context. Such methods of presenting risk information might sway the reader/viewer into changing health patterns.

However, examination has not unearthed blatant bias in favour of natural medicine.



The media seems aware of their ethical duty to the public good. Statistics in the WHI were significant and any responsible reporter should have mentioned these.

However, there are also risks involved in crying wolf, over sensationalising or pandering to reigning stereotypes.

In southern Africa none of the reporters interviewed mentioned being blatantly pressured by "either side" (pharmaceutical or natural) to pitch stories in specific ways. Reporters also claim that they are wary of propaganda. Magazines and newspapers mark articles from advertising agencies about health products under "advertorial". Although, this may not even be sufficient since many people in the region do not know what "advertorial" means.

It takes a lot of effort and skill to convey facts and statistics clearly. A lot of the omission is 'innocent'-- merely reporters trying to jazz up "cold facts" or get a space on the front page. Some of the sensation /inaccuracy might have crept in during final editing and layout.

But locally, even though anti HRT, the press does not seem in "cahoots" with the natural health industry.

#### **4.2 What editors say**

Apart from mentioning the need for specific training of health reporters, editors and journalists (personal communications: September 2003) pointed out the following:

\*Mari Hudson for *Health 24* said her editorial policy applies a "healthy pinch of salt". Health24 does receive press releases from pharmaceutical companies as well as natural health companies advertising their product. However, a verbatim report will rarely be published. The opinion of independent health experts is always solicited. She added that companies such as Wyeth might call media briefings about certain products. But the floor is open for questions afterwards, and once again backed up by "outside' medical opinion.

\*Robyn Von Guesau from *Shape* magazine made these points:

- Pharmaceutical companies and natural product companies are like any other; they want to sell their products. In doing so many of them actively market it to the media, often with presentations by people in the medical field.
- Any good journalist should be aware that these people are paid, in whatever manner, to say what they say and should, therefore, approach such presentations with a barrowful of scepticism.
- Journalists should take the material to a neutral source for their input.
- Unfortunately, there are journalists who seldom ask questions and simply soak up information only to regurgitate it onto health pages as fact – often this has more to do with lack of training than anything else.

\* Prevasni Ramsamy, *Longevity* magazine's features writer, says that pharmaceutical companies try to sneak in promotion of their products all the time.

“We only get to hear professional opinions via press conferences, workshops etc hosted by the huge pharmaceuticals. When the controversy arose over HRT, Wyeth, for example, immediately hosted the press conference and a medical specialist presented us with the “information” we required to write our stories. Even the natural health companies send through their products with “information” selling their product to us.

Obviously, going to these presentations requires an objective approach – use the information they present as just a segment of your research in a story and go in search of the opposing view to ensure you receive a balanced account of an issue.

Independent research is necessary because an obvious bias exists even among professionals who wish to secure their patient base, and reputations by declaring the questionable drugs they have been recommending for years as safe.”

\* Chris Nicklin, etv news editor, says it's easy to tar all media with the same brush, but he believes that local news organisations, with a few notable exceptions, fall woefully short when it comes to competent health/science reporting.

“This is due to a number of reasons, not least of all the widely held view that science writing is not mainstream reporting and that any specialism in this field does not need to be encouraged. As a consequence, important debates in the media around issues, like



the efficacy of ARVs for HIV treatments, have been obscured by superficial, uncritical reporting by inexperienced journalists.

Most journalists have a humanities background which often results in the misguided belief that if they haven't studied science, they cannot write about it. This is unfortunate, as I believe any good health/science reporter simply requires the same qualities as any other good reporter, namely

Curiosity, the ability to recognize a story, the desire to get it right, a determination to convey significance and the ability to write well.

But reporters showing an interest in health/science issues also need strong encouragement from editorial managers. The problem with medicine/science is not finding the stories, but in deciding which of the plethora generated by labs and journals are significant. Journalists with a strong interest are likely to be the only ones who take the time and trouble to find out, and who are prepared to go through the necessary hoops to establish whether a development is a genuine "breakthrough". It's all too easy to sensationalize health/science stories. What I think I'm arguing for is health/science reporting to be taken as seriously as other fields of journalistic specialism, such as political or financial reporting.

Health/science writing makes demands on our intellect and is not for the lazy. General reporters assigned a medical/science stories seldom apply the necessary checks to establish whether something is genuinely groundbreaking and will often recycle press releases, media handouts etc. at face value. In my view, any self respecting news organisation should have a dedicated health/science reporter, especially in this age of rapid technological advance.”

It's clear from the above that reporters are, if not objective, at least aware of a clash of interests between the pharmaceutical and the natural health industry. It also seems as if reporters are aware of their duty to aspire to objectivity for the sake of public interest.

However, there are reasonable constraints to be taken into account. Deadline pressure and competition between institutions should not be underestimated.

Medical experts such as Dr Zinn and Professor Davey agreed that, to be fair, the following should be taken into account:

The WHI was a meticulous study and the findings were significant. There were positive results (about HRT use) as well as negative results.

1. However, bad news sells and the media, in order to be commercially viable, has to focus the reader/viewer.
2. Well-intended but uninformed reporting, or personal bias will always play a role.
3. Attempts at simplifying, in the print as well as electronic media, add to inaccuracy or confusion.

It is indeed naïve to imagine there is such a thing as 50/50 impartiality.

"Make no mistake: objectivity is an indispensable journalistic ideal. The reality however, is that all people are subjective, partial and biased - and journalists are no exception," says Retief. (Retief, 2002:99)

It is evident that reporting is a process of "selection". Journalists decide which aspects are more important than other aspects. As Retief puts it, "It is immediately clear that nobody can be objective. Nobody can interpret objectively. In fact those words are contradictory to another." (Retief, 2002:100)

The BBC refers to the term "due impartiality" and acknowledges that it does not exist.

According to the BBC Producer's guidelines, the term "due impartiality" can be defined as "adequate or appropriate to the nature of the subject. It is better to realise your own subjectivity than foolishly to pretend otherwise. However, this does not exempt journalists from the responsibility to "report truthfully, comprehensively, intelligently"(Retief, 2002:102).

### **4.3 Summary**

"If I deal with the politics of an issue, I stop being a science writer" or "I want good science, not moralizing."



Nelkin (Nelkin, 1995: 98) uses this quote to illustrate how science writers try and separate science from politics. She talks about the language of "magic and wonder" that expresses their pleasure in describing science.

However, she warns that the assumption that politics is incompatible with science can in fact undermine norms of journalistic neutrality.

Nelkin writes how the younger generation of journalists is more cynical.

“Reflecting broader trends, they are more conscious of the social, ethical and economic costs of science and technology”.

Journalists in the 21<sup>st</sup> century are no longer merely retailing science rather than investigating it.

Wilson's book *Feminine Forever* is now “notorious”.

A backlash has set in. One can say that what Nelkin refers to as the language of magic and wonder has been replaced by horror and suspicion.

Over the years reporting has become more cautious. Reporters no longer pander to the social belief that women should feel guilty for using it as an "elixir of youth" out of vanity, and accept their lot or bear the "deserved consequence" of cancer.

Or, on the other hand, that women are under an obligation to stay young and fulfil their sexual obligations.

However, if health reporters maintain a reputation of being swayed by reigning social beliefs, instead of going after sober scientific facts, credibility will suffer.

This paper's aim was not to establish whether HRT is good or bad -- merely to reflect the media.

Journalists have a public responsibility to point out to women the risks of unnecessary or harmful medicine. They should keep up-to-date with latest developments and scientific concepts so as not to seem biased or cause alarm that changes health behaviour.

In order to make readers read useful information (instead of preaching to the converted) it is often necessary to write a dramatic headline or intro. Facts must be presented in a digestible format.

However, "jazzing up" "boring or difficult to understand material often feeds public fears, and might cause suffering.

Errors of omission were more frequent than blatant inaccurate statements.

In the process of reporting on HRT in a lively and understandable manner, most media reports introduce some errors of omission emphasis or fact. The errors are more often omissions and subjective emphasis rather than blatant incorrect facts.

Omissions -- of qualifying statements, details of methods and results, as well as shift in emphasis, less precise wordings and "translations" were widespread.

Fifty per cent of the reports seem to aspire to objectivity. It was oversimplification/misunderstanding of statistics that contributed to confusion and misrepresentation of facts.

Television and magazines are the most likely sources of information for most people.

They are crucial in shaping public perceptions of risk.

Scientific findings are often treated with more credit than warranted in the popular press.

Cause for concern is that this shallow reporting was found in widely read, established, credible media.

However, it might be too simplistic to portray journalists as ruthless and seeking sensation or meeting deadlines at *any* cost.

## **Chapter 5**

### **Recommendations**



Know the jargon and statistics. In this paper the most important distinction journalists missed out on was the one between Relative and Absolute Risk, malignant and non-malignant, invasive and non-invasive, cases and mortality.

- It might have been useful to ask more questions about the background and design of the study.

Cohn (1994: 58-62) has a handy list:

\* What specific questions and hypotheses did you set out to test or answer?

\*Do you have reason to believe that your subjects were representative of the general population?

\*Does the investigator frankly document or discuss the possible biases and flaws in the study?

\*Is there any basis in these findings for any patient to ask his doctor for a change in treatment?

\*How much weight should your work be given?

\*Has there been peer review of the material?

- Reporters should get a wider "pool" of independent experts. The material surveyed often quoted Dr Theo Kopenhagen. He might be a credible and respected medical expert, but is linked to the pharmaceutical company NovoNordisk's opinion group according to a newspaper report (La Femme: *The Herald* 11/9/02).

The article elaborates how the Prempro used in the HRT leg of the WHI study is made by pharmaceutical company Wyeth, which markets Prempro in South Africa under the name Premelle. Wyeth and its competitor NovoNordisk each have nearly a third of the extremely lucrative HRT market here.

More than one article used Dr Arien van der Merwe as natural health expert and at the same time recommended buying her book.

- It is crucial to know how to communicate risk and the difference between Absolute and Relative Risk figures, or whether the risk can be compared to anything else – For instance: compare taking HRT for 5 years to driving in your car for 5 years or drinking two units of alcohol a day for the same time.
- Sub editors should take care that the headline, photo and caption are fair reflections of the report.
- Follow-up research that negate today's headline reports should be published with the same prominence. For example, the oestrogen leg of the WHI study has produced very positive “good news” health results.

The fact that by the time this paper is published more than a third of the women who quit HRT are back on it since they cannot bear the symptoms of menopause, and advances in HRT (e.g a device inserted in the uterus called the “mirena” combined with low-dose estradiol patches) will make for another 15 000 words.

Cause for comfort is that half the reports attempted to remain critically objective, and that editors interviewed aspire to ethical objectivity.

In reporting health, the best reporter is the one who ignores the politics and knows the jargon -- who reflects all angles and interpretations of “truth”.



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Professor Dennis Davey, Dept Obstetrics & Gynaecology, Groote Schuur Hospital, Cape Town

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## **APPENDIX**

**\* Reports 1-14**





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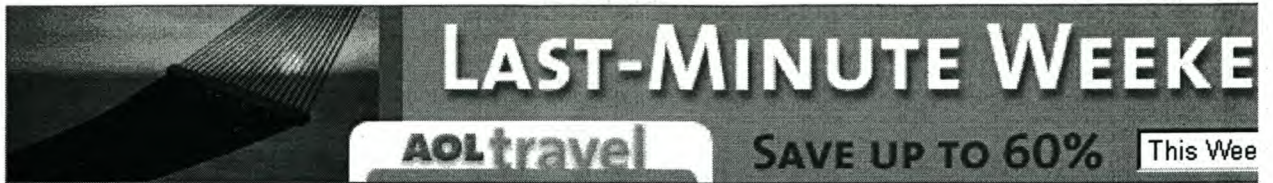
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**Tropic of Cancer**   
 The news on breast-cancer research that could save lives  
 2/18/2002



**Estrogen**   
 It may be an elixir of youth, but is



GAIL ALBERT HALABAN/CORBIS SABA FOR TIME

**STAYING ON:** Four months ago, Christine Fulbright, 53, was in menopausal agony. HRT was "like a miracle." She is not about to give it up.

**■ MEDICINE**

## The Truth About Hormones

**A large, federally funded study provides definitive proof that estrogen and progestin are not age-defying wonder drugs. What's a woman to do?**

By CHRISTINE GORMAN and ALICE PARK



Posted Sunday, July 14, 2002; 12:31 p.m. EST

Susan Pierres, a Miami photojournalist who just turned 60, is confused and angry. Ten years ago, when she was approaching menopause, her doctor started her on hormone-replacement therapy, or HRT. "I didn't have any symptoms," she recalls, "but he recommended it for general well-being, bones and heart." Many years and pills later, her gynecologist suggested that perhaps it was time to stop. After all, there had been reports that HRT might increase a woman's risk of breast cancer, a disease that had afflicted Pierres' mother and aunt. She turned to several other physicians for advice. They couldn't seem to agree. Now comes word from a really big study that taking HRT for years at a stretch isn't such a great idea after all.

Should Pierres believe these latest results or go back to her doctor for an explanation? Which doctor? It's not as though she's all that eager to get off hormones: "You feel it is your last vestige of youth. What if my skin turns scaly and my hair falls out?" she worries. "These are complicated matters. People like me don't know where to go or whom to listen to."

Whom indeed. For decades, millions of women like Pierres have been told that HRT is a veritable fountain of youth. It kept the skin supple, held back heart disease, boosted old and brittle bones and might even have staved off senile dementia. More than 40% of all women in the U.S. start some form of HRT in their menopause years. Many of them continue well into their 70s and 80s, convinced that the little pills give





there a risk of cancer?

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them a youthful glow.

**"These are complicated matters. People like me don't know where to go or whom to listen to."**

— Susan Pierres

Like latter-day Ponce de Leons, however, these women are watching their dream of eternal youth fade away. A large, federally funded clinical trial, part of a group of studies called the Women's Health Initiative (WHI), has definitively shown for the first time that the hormones in question—estrogen and progestin—are not the age-defying wonder drugs everyone thought they were. As if that weren't bad enough, the results, made public last week, proved that taking these hormones together for more than a few years actually increases a woman's risk of developing potentially deadly cardiovascular problems and invasive breast cancer, among other things.

As with any major medical announcements, there are caveats and complications. The WHI wasn't designed to look at short-term use during menopause, for instance. But the principal message is this: taking estrogen and progestin for years in the hope of preventing a heart attack or stroke can no longer be considered a valid medical strategy.

Here at last is a rare moment of clarity. The debate over the long-term benefits and risks of HRT has lasted for decades. Now we have at least a few concrete answers.

The findings are so striking that the study was stopped three years short of its scheduled completion. (The other WHI trials, which include a look at how estrogen alone affects women with hysterectomies, are still proceeding.) And the formal scientific report, which is being published in this week's *Journal of the American Medical Association*, was released a week early at a press conference in Washington.

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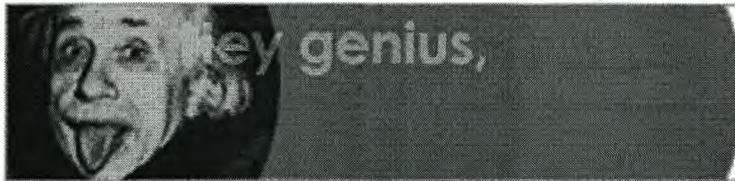
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Tropic of Cancer **P**  
The news on breast-cancer research that could save lives  
2/18/2002



Estrogen **P**  
It may be an elixir of youth, but is there a risk of cancer?

### MEDICINE

The phones haven't stopped ringing since. Women across the U.S. immediately started calling their doctors, their mothers, their daughters, their friends. Are you still taking your pills? Do you think plant-based hormones are any better? Would lowering the dosage make it any safer?

"Maybe I've been too trusting. I still don't feel like I have all the facts and details," says Jodi Simma, 55, a homemaker who engaged nine friends in a spirited discussion over salads and lemon dessert in New Richmond, Wis., last week.

"We're all concerned," says Muriel Smith, membership coordinator at the Dave and Mary Alper Jewish Community Center, south of Miami, which is organizing a panel discussion on the topic. "Everyone wants to know what to do."

Some, like Ellen Robinson, 58, a commercial litigator who works in Chicago, have already made up their minds. Robinson decided last week to stop taking her hormones cold turkey. "I haven't had breast cancer, a stroke or a heart attack," she explains, "but now I'm nervous. Everyone has been in the dark about the risks."

Others who were skeptical of hormones all along feel vindicated. "I'm not antiestrogen, but we need to accept menopause as a natural, normal, physiological process," insists Vicki Meyer, founder of a cybercommunity called the International Organization to Reclaim Menopause. The idea that our bodies fail us at menopause, she says, is "ludicrous, extremely sexist and just plain wrong."

Physicians are scrambling to keep up. A gynecologist in Dallas has written a script to help her office staff deal with the deluge of calls. The American College of Obstetrics and Gynecology has created a task force to rethink its guidelines on HRT. "The bubble has burst," says Dr. Isaac Schiff of the Massachusetts General Hospital in Boston, who is chairing the task force. Schiff admits that in the aftermath of last week's news, doctors need as much guidance as their patients. "Some physicians say they are not going to change things in their practice at all and will be as proactive for HRT as they've ever been," he says. "Others say this will change their thinking dramatically."

#### The Estrogen Express

To understand how we got to this point, it helps to know a little medical history. About 40 years ago, attention was focused on just one female hormone, estrogen. Its greatest popularizer was a gynecologist named Robert Wilson, who thought the hormone could serve as an all-purpose rejuvenator for women of a certain age. There was, it must be admitted, more than a little sexism, not to mention ageism, in his point of view. In his hugely successful book, *Feminine Forever*, published in 1966, Wilson wrote of menopause as a "living decay" in which women descended into a "vapid cow-like" state. Supplemental estrogen, Wilson insisted, would almost magically transform the dull cow into a supple, younger-looking wife and mother. She would not only feel better but also make those around her feel better—especially, it was implied, her partner in bed.

Those were different times, of course. But the idea that a single pill might turn back the clock quickly caught the popular imagination. It didn't hurt that the hormone's No. 1 manufacturer, Wyeth



Intriguingly, the part of the WHI study that focuses on the long-term benefits of estrogen alone among women who have undergone hysterectomies is ongoing. So far, the safety board has not detected any excess risk of breast cancer in this group. Apparently, estrogen plus progestin has a negative cumulative effect on the breast that estrogen by itself seems not to have.

### Some Questions Still

So much for the major conclusions. Now for the caveats and complications. The WHI study looked at the most popular brand of estrogen and progestin, which is called Prempro and is made by Wyeth. Technically speaking, the WHI findings do not apply to other products. Some doctors have speculated that lower-dose hormones or estrogen-progestin patches and creams might somehow avoid some of the risks associated with Prempro. That has yet to be proved. Even so-called natural hormones (those derived from plants) aren't necessarily risk free. For one thing, they haven't been as carefully tested as Prempro. There is preliminary laboratory evidence, says Dr. Wulf Utian, who heads the North American Menopause Society, that natural hormones may promote tissue growth in the breasts and thereby contribute to a cancer risk.

There is also a chance that certain estrogen-like compounds may be developed that will capture all the hormone's benefits without any of its risks. One such drug, raloxifene, has been shown to prevent fractures, so far without increasing a woman's risk of breast cancer. But a number of women suffer hot flashes and even blood clots while on raloxifene, making it an unlikely candidate to replace estrogen completely.

Though last week's news raises big questions for anyone on hormone-replacement therapy, women taking birth-control pills shouldn't panic. True, these pills also contain estrogen and progestin, but most women take them before menopause, when their bodies are making more of their own hormones. So it's quite possible that their bodies are better able to handle the excess. In any case, it's impossible to extrapolate from the WHI study.

Nor should women panic if they are using HRT for short-term relief of menopausal miseries. For in a strange sort of way, the study brings HRT back to the basics, doing what it always did best—alleviating intense hot flashes, night sweats and mood swings during the limited period in which they occur. "Estrogens," says Dr. Howard Judd of UCLA, one of the WHI principal investigators, "are still the best, and in many ways the only, way of treating menopause."

Is it worth a very slight, short-term risk of blood clots to battle hot flashes? You bet, says Christine Fulbright, 53, who runs her own hair salon in Venice, Calif. Fulbright's menopausal symptoms, which started a year ago, were so bad she thought she was dying. "I was aching all over and crying all the time," she recalls. "At one point I was cutting a man's hair when, out of the blue, I had to fight back tears." Fulbright tried alternative remedies, like yam creams, but relief came only when she tried Prempro four months ago. "It was like a miracle," Fulbright says. "I was back to my normal self."

The tricky part is going to be figuring out just how long women like Fulbright need to stay on HRT, how best to wean them off the treatment and then how to protect them from osteoporosis and other ravages of age without resorting to old-fashioned hormones. "The world of menopause management," says Utian of the North American Menopause Society, "has just become a lot more complex."

And part of that complexity is dealing with the emotional attachment that some women have to their HRT regimen. Many like the way they look and feel on the stuff. Change is scary.

And that, perhaps, is why Susan Pierres, the angry and frustrated Miami photojournalist, has yet to make her move in the wake of last week's news. Along with so many other women, she continues to fret over whether she really has to part with her pills.

—With reporting by Amanda Bower/New York, Wendy Cole/Chicago, Jeanne DeQuine/Miami and Jeanne McDowell/Los Angeles





6/26/1995

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## ■ CNN

▶ HRT Study Halted

## ■ LETTERS

E-mail your letter to the editor

Stellenbosch University <http://scholar.sun.ac.za>

Pharmaceuticals, launched an aggressive marketing campaign. Thank goodness today's spots have been updated to feature the dulcet tones of singer Patti LaBelle and have abandoned patronizing messages like the one in a 1975 ad—"Almost any tranquilizer might calm her down ... but at her age, estrogen may be what she really needs."

Over the years the medical arguments for prescribing estrogen were also updated. "The vapid cowl-like state was gone, and there was very scientific language about bone density and heart disease," explains Cynthia Pearson, executive director of the National Women's Health Network, a longtime skeptic of HRT.

It all seemed so logical and convincing. Women are much less likely than men to suffer heart attacks and strokes in their 30s and 40s. But when natural estrogens stop flowing after menopause, women's risk quickly catches up to men's. Clearly estrogen has some kind of positive influence. And sure enough, a number of studies in the 1980s showed that women who took the hormone at menopause had lower levels of LDL cholesterol, the so-called bad cholesterol, and higher levels of HDL, the so-called good cholesterol, than those who didn't. The benefits of supplemental estrogen couldn't be more obvious.

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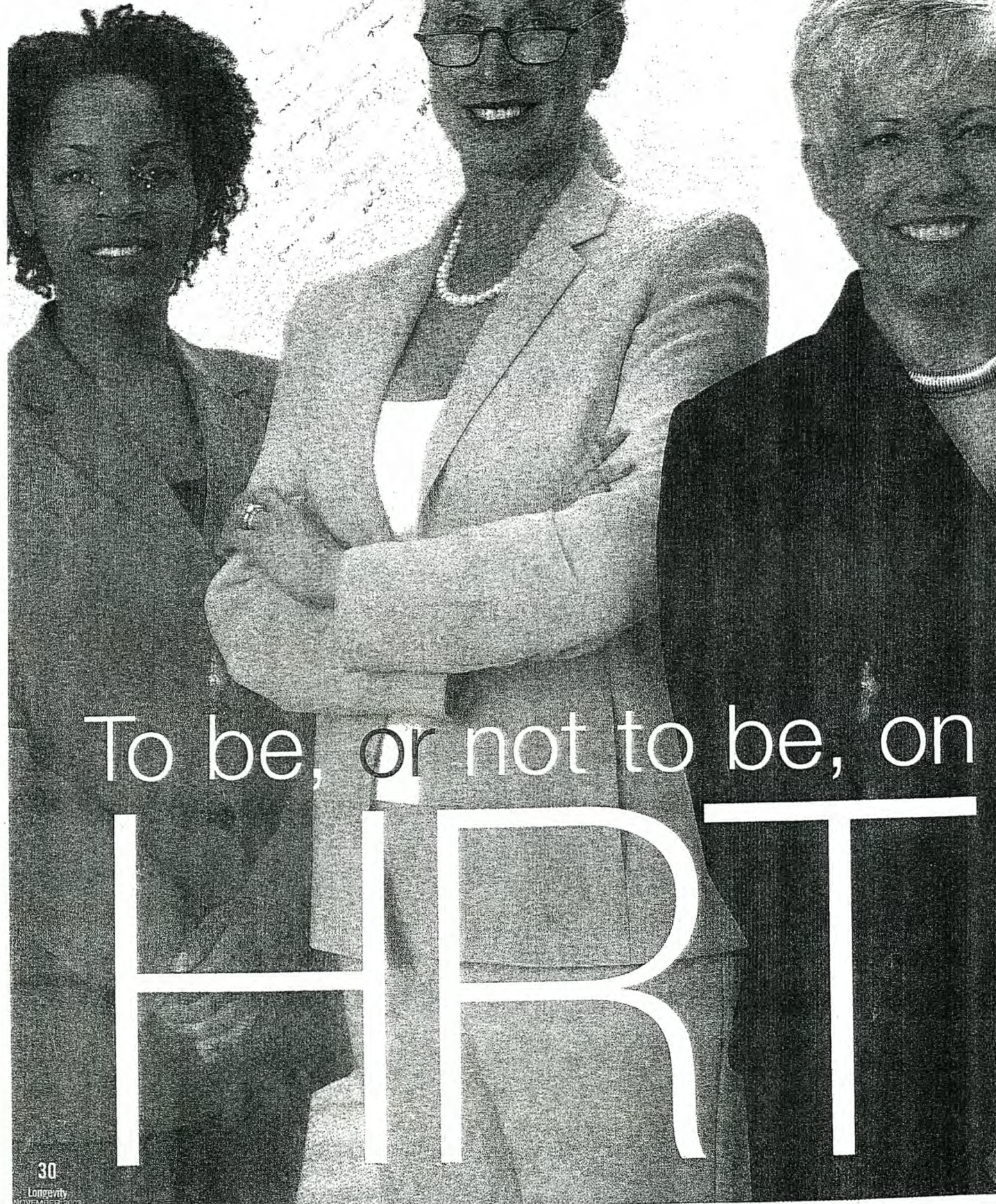
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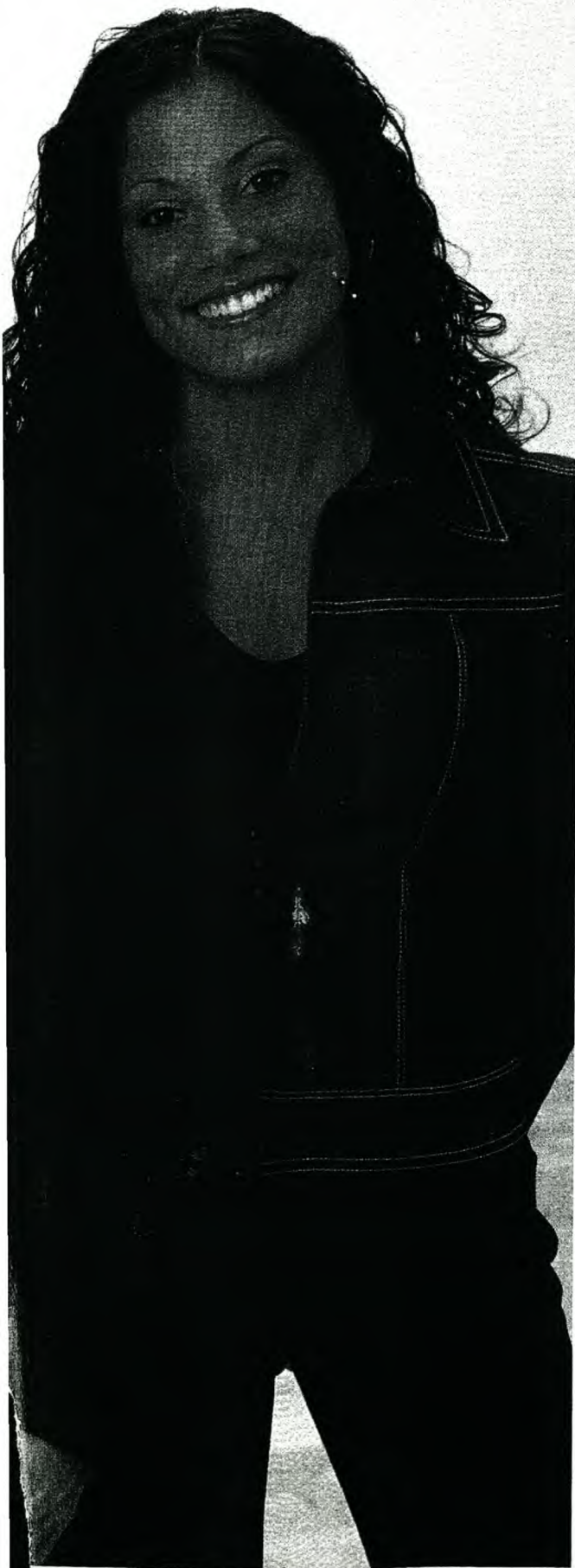


To be, or not to be, on

# HERT

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Has the death knell sounded for hormone replacement therapy as we know it? Should we be looking to newer approaches to ease the pains of menopause? The medical fraternity still seems divided on this issue, but stay tuned, more's to come. By Prevasbni Ramsamy

Felicity is an intelligent, respected 50something attorney. She keeps abreast of issues relating to her health and that of her family. In the past year, like many women of similar age, she has familiarised herself with the latest developments in the ever-continuing hormone replacement therapy (HRT) controversy.

But in recent months, Felicity's concerns have increased dramatically. Unlike her female counterparts, whose fears of contracting breast cancer from HRT usage form only a distant but nagging concern, Felicity has already contracted the dreaded disease. This means that the continually challenging reports from respected medical journals are a very real concern for this mother of four.

Homeopathic alternatives to conventional HRT do exist in the form of natural remedies. But these too have experienced their share of controversy and, as Felicity has learned, being presented with alternatives is not always the easiest route. "I wanted to devour every bit of information about every available treatment to make up my mind about which form of therapy would be best for me," she says now. "But the choices they confronted me with only increased my uncertainty".

The 'they' Felicity refers to is the medical fraternity's onslaught of information on menopausal women since the release, in the past year, of not one but two studies indicting HRT as a central cause of increased breast cancer incidents, links to heart disease and deep vein thrombosis.

Medical circles are steeply divided over these reports and their furiously raging debate demands the attention of wide-eyed women desperately seeking a simple solution to a difficult time in their lives.

The study that first sparked the current furore was The US Women's Health Initiative (WHI) study. Initiated in 1998, the WHI had planned to investigate the long-term effects of HRT over a period of eight years. Over 160 000 post-menopausal women, on average 67 years old, were enrolled into the study. The women were divided into five major groups and every aspect of lifestyle, from diet to exercise to hormonal levels, was examined.

Last year, three years from completion, a study in the respected British *Lancet* medical journal compared the effects of treatment with combined HRT in the WHI study to placebo (or dummy) treatment in two groups of women. It was found that the numbers of breast cancers in the HRT group had reached a

PICTURE: GREATSTOCK



predetermined 'hazard' level. Figures indicated a 26 percent relative risk increase in breast cancer incidents in women receiving the combined HRT compared to those on placebo.

Further, it was decided that risk exceeded benefits. Another group of the study, comparing synthetic oestrogen only to placebo, continues; results of this study are not yet known.

The second study, called The One Million Women study, was initiated by the UK Cancer Research Epidemiology Unit in Oxford, England. In August this year, findings in the *Lancet* confirmed previous findings that "current and recent use of HRT increases the risk of breast cancer". The study indicated that the risk of breast cancer (relative to placebo) is twice as high for those taking combined HRT.

Needless to say, the combined impact of both studies has resulted in pretty explosive debate surrounding the safety and efficacy of conventional HRT. To quell the "media frenzy and misrepresentation", 25 noted allopathic experts from around the world met in Madeira in February this year to discuss clinical relevance to HRT today. This forum concluded that hormones are still the treatment of choice for menopausal complaints.

According to their recommendation, HRT should be initiated early when symptoms occur and at the lowest effective dose. They also concurred that not all hormone replacement therapies are the same and that treatment should be individualised for each woman.

Professor Franco Guidozi, head of department of Obstetrics and Gynaecology at Johannesburg Hospital and a University of the Witwatersrand Medical School academic, was a South African representative at the Madeira convention

and is one of the first to perform damage control on the studies' findings. "The media has again created an emotive wave of uncertainty for patients and doctors," he said at a recent *Longevity* workshop on the topic, referring to the release of the One Million Women study.

"Once again, data has been presented out of context and without reference to subject profiles. Personally, I feel that from the late 90s to the present time, no new real data supports the overwhelming emotive concerns. There is no reason to believe that there should presently be any radical changes."

Regarding the findings of both studies, Guidozi does admit: "What has emanated from recent studies is that there is potential to consider lower-dose forms of HRT, which are effective and may minimise the likelihood of adverse events".

US professor of obstetrics and gynaecology at the New York Center in Manhattan, Dr Steven Goldstein, advises a similar approach to women questioning their dose of HRT: "If a patient tapers her dose on HRT over a few months and she feels okay, I would recommend going off it. If, on the other hand, she doesn't like the way she feels, she can have her HRT back."

But to another group of medical practitioners, the recent findings place an entirely new spin on HRT. Medical doctor and natural medicine expert Dr Arien van der Merwe even argues that the hormone debate may mean good news for women, allowing for a totally new approach to menopause treatment.

"Science has finally caught up with the natural wisdom of centuries. HRT comprises of potent hormones given to women at a time in their lives when nature dictates that hormone levels should decline because reproductive years are over."

#### DR ARIEN VAN DER MERWE'S NATURAL PRESCRIPTION

- Take isoflavone phytoestrogens. They are found abundantly in soy foods and soy protein-extracted supplements (also in chickpeas, red clover, linseed, most nuts and seeds). Try to eat at least one portion per day.
- Eat 1tbsp crushed linseed every day. Flaxseeds contain lignans, another group of phytoestrogens that balance oestrogen and progesterone levels and reduce symptoms of menopause while protecting breast tissue from cancer.
- Take a teaspoon of sesame and sunflower seeds daily with your breakfast as well as a handful of various nuts to nibble on (fibre, essential fatty acids, plant oestrogens and many more).

- Dong quai (*Angelica sinensis*) balances the female hormones. This herb stands midway between the very weak plant oestrogens and the progesterones.
- Sage reduces hot flushes (make a tea using fresh or dried sage leaves).
- Black cohosh has also been shown to reduce hot flushes and prevent osteoporosis and vaginal dryness.

#### Dietary and lifestyle advice:

- Eat foods low in refined sugar, in saturated fat and in salt
- Avoid stimulants such as spicy food, too-hot drinks and alcohol
- Increase daily intake of fresh or lightly cooked vegetables and fruit

- Reduce intake of red meat to a portion the size and thickness of your palm once or twice a week.
- Increase intake of cold-water fish like salmon, sardines and trout, also poultry – at least two to three times a week.
- Include 600ml low fat or fat free dairy products or alternate with soy milk.
- Drink at least eight glasses of water a day.
- Don't smoke; it accelerates bone loss and ageing.

\* Refer to Van Der Merwe's book called *Herbal Remedies, Health and Happiness (Tafelberg Publishers)*, available at bookshops



A new approach would mean that the 470 million women worldwide aged 50 and above can target menopausal symptoms in other ways, either through lifestyle changes or different drugs. "People are not satisfied by being told what to do any longer. They don't want to experience the side-effects of drugs or take the risks associated with them. They want to take responsibility for their own health by exploring other options," asserts van der Merwe.

These options include the many alternative treatments available. But they, too, are in their own maelstrom as constant challengers question the lack of research conducted into the safety and efficacy of these products. Van der Merwe says: "Actually, there has been substantial research done on some of the HRT alternatives – like soy, black cohosh and antioxidants.

"Black cohosh is one of the most widely studied herbal remedies for menopausal symptoms. Germany has a specially assigned commission that has investigated and approved extracts of the root stock of black cohosh for the treatment of menopausal symptoms. Similar intensive studies are being carried out on other therapies as well."

Dr Barbara Lewis, another campaigner for natural menopausal relief, recommends dietary as well as exercise intervention. "A healthful diet of large amounts of fresh fruit and veggies, soy products and natural grains and cereals should aid a smooth menstrual transition. Regular weight-bearing exercise is necessary for bone and cardiovascular health."

For Lewis, it all comes down to each individual choosing the best solution to her menopausal angst. "A responsible position is to use the lowest possible dosage available that gives a woman symptom relief at menopause, and use this in the most natural form possible in line with the basic premise that menopause is a natural body transition, not a disease process."

For Felicity, the challenge of fighting her cancer (potentially promoted by the HRT pill meant to "prolong her life", as was claimed) remains the only concern. "I've read that chances of survival are greater because the disease is hormonally linked. But what kind of life would it be if I have no breasts? And if that life is lived fearing a relapse in my condition?"

## BENEFITS AND RISKS OF HRT IN CONTEXT

Guidozzi's summary of events

Until 2002:

- HRT is the most effective treatment for early menopausal symptoms. It improves quality of life in symptomatic women
- Early cardiovascular disease studies showed that oestrogen did have a protective effect against cardiovascular disease in postmenopausal women. Later studies, like WHI, indicate a 29 percent increase in risk of cardiovascular events in women taking combined HRT compared to those on placebo drugs, i.e. there is a 29 percent increase over what

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is expected if the patient was not taking HRT. There was, however, no increase in death due to cardiovascular events in the HRT group compared to the placebo group.

- Studies indicate that postmenopausal HRT does prevent bone loss and osteoporosis after four to five years of treatment.
- Cognitive functioning, Alzheimer's, sleep disturbances, mood fluctuations and colon cancer are improved with HRT.
- In the WHI study, a two- to 2.5-fold increase of blood-clotting events. This equates to an absolute risk of one in 5 000 users of HRT per year extra than what was expected in non-HRT users.
- Medical studies do not show consistent results for the effect of HRT in stroke. In the WHI study, there was a 41 percent increase in stroke risk compared to placebo users.
- The WHI study reflected a 26 percent increase in breast cancer in women receiving combined HRT compared to those receiving the placebo, an increase that is similarly seen in women who are obese and who use alcohol. The One Million Women study also found a breast cancer risk increase.

#### 2002-2003:

- Oestrogen alone does not apparently increase the risk of breast cancer. Combined HRT appears to increase risk of breast cancer. It may be progestogens and not oestrogens that increase the risk of breast cancer.
- The risk of cancer only appears to be increased after five years of HRT use. This risk disappears after five years or

more after discontinuing HRT use.

- HRT is associated with specific breast cancers – invasive breast cancers, and not with lesions that start growing and become cancers. So HRT is thought to promote existing breast cancers – not causing new breast cancers.
- Women who get breast cancer while on HRT tend to have a lower mortality rate than women who get breast cancer without being on HRT.

#### What Guidozi advises

- Oestrogen replacement is the best treatment for menopausal complaints.
- Length of treatment with HRT, should be individualised.
- The lowest effective dose of HRT should be used.
- All women should have an annual mammogram and an annual examination by their gynaecologist. Each separate exam must be at six-monthly intervals: in other words, see your doctor and six months later, have a mammogram.
- All women should be taught to perform a clinical self-examination of their breasts and this should be done regularly.
- Healthy lifestyle modification is important – stop smoking, limit alcohol intake and maintain a healthy body weight.
- All women offered HRT must be informed of HRT's risks and benefits so they can decide about their quality of life. A baseline mammogram must precede commencement of HRT.
- Sensationalist statistics quoted in the media must be viewed with caution and in context if an informed decision is to be made.

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HealthCare

BAD TOO Continue BUT  
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# Does hormone replacement work?

REPR(3)

de Russouw

When a woman develops hot flashes, sweats, and wrinkles on her face, she is quite concerned that she is losing her youth — that she may be losing her husband."

For menopausal women hearing the verdict, aired in a film commissioned by the United States drug giant Ayerst in the 1970s, would probably rushed out for a prescription for Hormone Replacement Therapy (HRT).

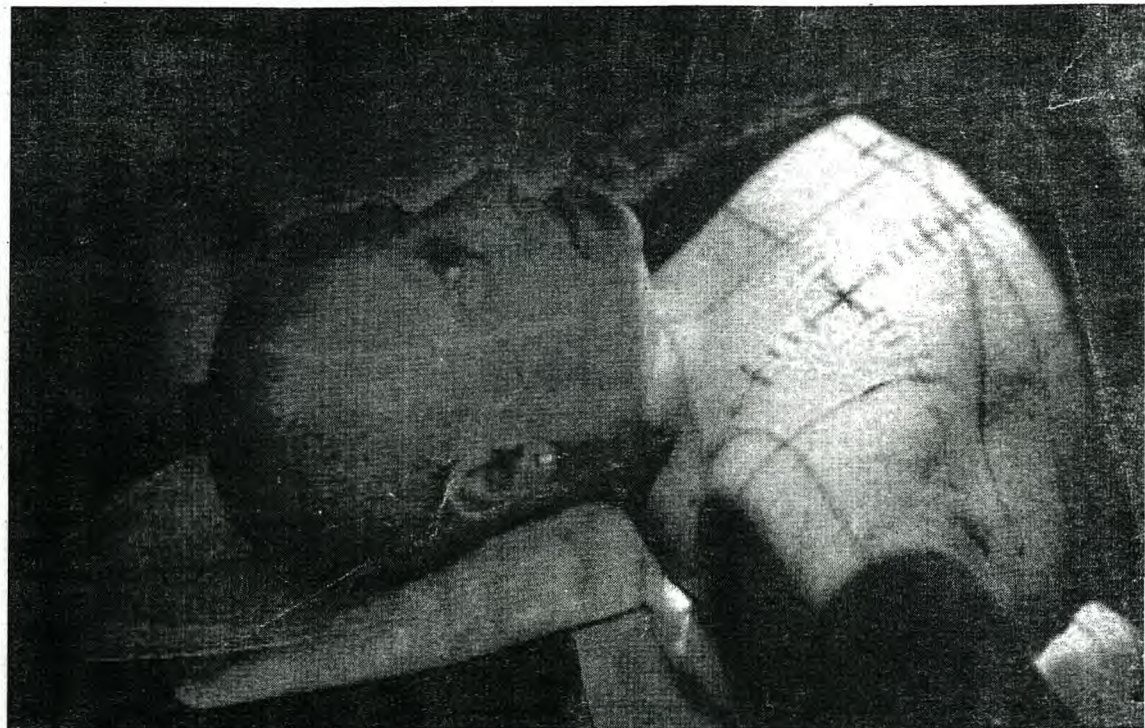
Today, menopausal women worldwide have opted for HRT as an instant cure for hot flashes, poor memory, memory loss and skin ageing. HRT replaces the female hormones that decrease as women age. It is believed that every woman spends 30% to 40% of her life in menopause, during which she will be increasingly vulnerable to osteoporosis, coronary heart disease, strokes and colon cancer.

The bad news does not stop there. Recent studies on HRT show that it can reduce osteoporosis and colon cancer and can combat debilitating diseases such as Alzheimer's, a study by the Women's Health Initiative (WHI) in the US proved to be of medical tempest.

The study, which focused on the long-term use of hormones, came to an end in July because participants were taking a combination of oestrogen and progestin hormones and an increased risk of breast cancer, heart disease and stroke.

Oestrogen is mainly used for women who have had hysterectomies, and is typically referred to by critics of HRT as the "youth pill", while progestin, once combined with oestrogen, is HRT. Coronary heart disease is the leading cause of death among women.

Dr Theo Kopenhagen, a gynaecologist at Park Lane Clinic, says the incidence of risk of



Many women refuse to go on hormone replacement therapy as they associate breast cancer with it

heart disease is small, especially with low-dose HRT. He affirms that the majority of the 16 000 participants in the study were not ideal candidates, and that the hormone taken was not suitable.

"The WHI study used hormones found in pregnant mares, which is not normally used. Sixty percent of the women were over the age of 60, 50% were current or past smokers and a large number of them were obese. The study completely ignored the quality of life aspect — those symptoms associated with menopause such as hot flashes, skin ageing, atrophy of the vulva and memory loss."

Kopenhagen believes that natural estrogens, or low-dose HRT, are the answer as they have the ability to reduce the risks of cancer and counter the side-effects of normal dose HRTs — side-effects such as

weight gain, headaches, vaginal bleeding and swelling of the breasts.

Many women refuse to go on HRT as they associate breast cancer with it, and the WHI study seems to buffer this belief. However, Kopenhagen affirms that the risk of breast cancer increases in all women as they age, regardless of whether they take HRT or not.

"The risk of breast cancer after the age of 65 is 12 times less than the risk of heart disease. After 50, deaths from breast cancer decrease, while deaths from cardiovascular disease increase." He believes that the risk of breast cancer is small in comparison to the benefits, but that the period in which you take HRTs may play a role.

Various studies point out that if you take HRTs for less than five years, there is little or no increased risk of breast cancer, but taking

HRTs for more than 10 years may increase your risk. Kopenhagen says some women have taken HRTs for more than 20 years, but he concedes that there is a need to discuss the issues in an annual assessment risk if a patient has been on HRT for more than five years.

Still, some people believe that HRT is nothing more than the cunning product of menopause marketing that plays on women's fears. However, Kopenhagen says women who take HRTs are new women. "They feel great. It makes women feel so much better. But not every postmenopausal woman needs HRT. I think that the most important thing is that women watch their diets, exercise and just take care of themselves. If you do, there is convincing data that points to safe therapeutic options," he said.





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## Hormone Therapy: The latest

As little as five years ago doctors still hailed hormone therapy (HT) as the saviour of post-menopausal women. A year ago the bubble burst when a huge study, known as the Women's Health Initiative (WHI), was prematurely halted in the USA due to concern about the risks of long-term use of combined progestin and oestrogen.

The publicising of the findings has had a ripple effect. New studies in the USA and New Zealand have shown that more than half of women on HT stopped their therapy immediately. In general, menopausal and post-menopausal women are left with a sense of unease and confusion concerning HT.

Health24 investigated. After attending a lecture by Dr Alan Alperstein from the Department of Obstetrics and Gynaecology, University of Cape Town, and private practitioner at the Kingsbury Hospital in Cape Town, an interview with Dr Jacques Rosseau from the WHI and National Institutes of Health (NIH) in the USA, and scanning medical journals for the latest articles and reports on HT, we bring you the latest findings. Dr Alperstein reported back from the very recent North American Menopause Association's (NAMA) congress.

Our primary objective is the best interest of all women, not the pharmaceutical companies, nor any other interest group. If a natural product is better, we will tell you. If you should worry about the risks of HT, we will tell you. If this whole upheaval has blown the findings out of proportion, then we will tell you. Now, read on.

### The initial euphoria of a "fountain of youth" *(No 30)*

Five, ten years ago doctors presented the option of HT almost as a "fountain of eternal youth" to their post-menopausal patients.

Many women face menopause and the post-menopausal time of their lives with dread. Not because menopause is a deadly disease - in fact, it is a natural phase in the ageing woman's life. And that is just it: ageing is very natural, but not quite on everybody's wish list. Neither are the symptoms of post-menopause. Does any woman in her right mind like to deal with hot flushes, mood swings and vaginal dryness when she still wants to feel attractive, sexy and wanted?

With oestrogen production dropping due to declining ovarian function (they are no longer needed for reproduction, translated to: sorry, you are now really too old for another baby), the protective effect of the woman's own oestrogen against heart disease, osteoporosis and Alzheimer's disease gradually disappears and the risk of these diseases and breast cancer will increase with age in the post-menopausal woman.



It made sense and sounded logical that replenishment of lost oestrogen will keep all the symptoms of menopause at bay, keep the risks for diseases of old age low, will keep the distraught, red-faced women happier and more even-keeled and their partners sane.

The logic went further: if a little bit of a good thing is good for a year or two, why not stick to hormones till you are 65 or maybe eighty? Why shrivel up, get Alzheimer's and osteoporosis, and lose your protection against heart disease?

Who can blame women that they clung to HT as their elixir of youth and protector against diseases of old age? They believed their GPs and gynaes. Many post-menopausal women - especially after a hysterectomy (uterus surgically removed) or ovariectomy (ovaries surgically removed) - took hormones, either in pill form or as implants and later as patches. They took hormones, whether it was oestrogen alone or a combination of oestrogen and progestin. Most women did not bother to ask their gynaes whether it was one hormone or two, they took it.

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**The new studies**

Between 2001 and 2002 the results from the WHI and other similar studies were published, showing an increased risk for breast cancer and cardiovascular disease for women on combination therapy. Women got scared and more than half stopped taking their hormones.

However, one out of four couldn't tolerate their symptoms of hot flushes and mood swings and grabbed their hormones again.

Right now women are confused. Should one take hormones at all, and for how long? What about the risk for breast cancer? What about long-term use, what about plant hormones?

Grammar

With female life expectancy on the increase and with the incidence of post-menopausal women, it is important to establish the status quo.

**Explaining the findings**

The first important aspect of the findings is that there is a difference between the risk due to the use of double HT (a combination of oestrogen and progestin) and the use of oestrogen alone.

Women should note that the findings are based on the use of oestrogen and progestin simultaneously. The preliminary findings of the trial in which women are receiving oestrogen alone (without progestin), have shown no increase in health risks. This arm of the trial is still continuing.

**Breast cancer risk:**

- A 50-year-old woman (regardless of combination HT or not) has a 2.8% chance of developing breast cancer by age 60.
- No increase in the risk for breast cancer was seen in the first four years of oestrogen and progestin treatment, according to the WHI study.
- The WHI study reflected an absolute chance of breast cancer by age 50 after five years of HT of 3.5%. After five years on HT therapy, a woman's chance will be 0.7 % higher to develop breast cancer by age 60. Dr Rossouw of the WHI described the increased risk as small.
- If a 1000 women have two drinks daily, or have their first child at age 30 or older, or are obese, but are not taking any HT after age 50, 35 of them are likely to develop breast cancer at age 60.
- Using another calculation called the "estimated cumulative incidence of breast cancer", 45 out of 1000 women between 50 and 70 years and not using HT will develop breast cancer. After five years of HT use 47 out of 1000 women will develop breast cancer (two extra per

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losing me



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... 17 out of 1000 women will develop breast cancer (six extra per 1000). After 10 years of HT use, 51 out of 1000 women will develop breast cancer (six extra). After 15 years on HT, 57 out of 1000 women will develop breast cancer (12 extra).

*Should've been a table rather*

**Bottomline:** There is an increased risk for breast cancer, especially after four years of HT use. Despite the increase in breast cancer incidence, the mortality is unchanged. It seems that breast cancer is detected earlier in women on double HT because of increased awareness and annual mammography.

*Is it detected earlier*

**Risk for heart disease, stroke and deep vein thrombosis:**

- About 37 out of 10 000 women older than 50 and who are taking HT are likely to develop heart disease, instead of 30 out of 10 000. Therefore, for every 10 000 women on HT, seven more are likely to develop heart disease.
- About 29 out of 10 000 women older than 50 and taking HT are likely to suffer from a stroke instead of 21 out of 10000. This is an increase of eight per 10 000 women.
- About 34 out of 10 000 women older than 50 and taking HT are likely to suffer from deep vein thrombosis instead of 16 per 10 000. This signifies an increase of 18 per 10 000.
- The risk for stroke and pulmonary embolism appeared to increase within the first two years of use in the WHI study. This increase may be followed by a decreased risk. According to Dr Alperstein the decreased risk after two years does not sound enticing enough for women to put their health and life on the line in the first two years.

*This should've been the ANGLE*

**Bottom line:** This so-called protective benefit against heart disease and stroke is now recognised as an increased risk. There should be no combined therapy for women with a family or personal history of heart disease, stroke, hypertension, elevated cholesterol or lipid levels. No combined therapy with the objective to reduce the risk for heart disease. Delete this idea. The American College of Obstetricians and Gynaecologists (ACOG) states: Combined oestrogen and progestin is not recommended for the prevention of heart disease in post-menopausal women.

**Risk for colorectal cancer, hip fractures and Alzheimer's:**

- The use of HT decreases the risk for cancer of the colon and endometrium.
- The risk for colorectal cancer may drop from 16 per 10 000 women to 10 per 10 000 women using HT.
- The risk for hip fractures, an indicator of osteoporosis, may decrease from 15 per 10 000 to 10 per 10 000. HT can be regarded as a bone protector.
- HT can be regarded as a protector against Alzheimer's disease.

**Bottom line:** Protection against cancer of the colon and endometrium, and against bone loss (osteoporosis) is real.

**What about alternatives?**

According to Dr Alan Alperstein women are desperately looking for alternatives to HT because of the "scare" stories, and because of some side effects of HT (including headache, nausea, breast tenderness and weight gain).

In the USA, the trend towards natural remedies is so huge that the public's expenditure on alternative therapies is approximately four times its contribution towards all pharmaceuticals.

More and more women are trying phyto-oestrogens derived from plants. Studies on phyto-oestrogen from the Black Cohosh specie *Cimicifuga racemosa* has shown relief of menopause symptoms. according to

**Ask an expert**

		CyberDoc
		GynaDoc
		CyberShrink
		Sexologist
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	<b>SANP</b> Natural Expe
	Skin Doc
	Plastic surge
	Teen health expert
	Physiotherap
	<i>PathCare</i> Pathologist
	GENE CARE Geneticist
	Optometrist

naturopath Dr Chase Webber. Phyto-oestrogens do not act in the same way as HT. It may relieve some of the menopause symptoms, with no additional health benefits.

Studies have also shown that high amounts of soya in the diet is effective to treat some menopause symptoms, but that phyto-oestrogen extracts from soya supplements are not. Other herbals that may be effective in providing some relief from menopause symptoms are Dong Quai (*Aelica sinensis*), licorice root (*glycyrrhiza glabra*) and chaste berry (*vitex agnus castus*).

**The bottom line:** Some natural remedies do relieve some symptoms. They do not act like HT and are not as effective in relieving symptoms of menopause as HT.

**The ultimate bottom line for all post menopausal women**  
Menopause is not an illness, but a discomfort.

The following applies to the use of combined oestrogen and progestin therapy (not to the oestrogen therapy alone – that seems to be fine and without the health risks involved in combined HT.)

- HT (oestrogen plus progestin or oestrogen alone) should be prescribed primarily for the treatment of menopause symptoms such as hot flushes, mood swings and vaginal dryness, and not primarily to protect against heart disease as was previously the case. Rather treat women with heart disease with statins.
- Combined oestrogen and progestin treatment can be prescribed with relative safety for four to five years to women without a personal or family history of breast cancer and heart disease. If prescribed for longer than five years, re-assessment of the benefits and risks is recommended, because the risk of breast cancer seems to increase after four years.
- The short-term use (up to five years) of combined oestrogen and progestin to manage menopause symptoms is regarded as appropriate treatment. Added benefits will include protection against osteoporosis, Alzheimer's disease and colorectal and uterine cancer.
- If a woman still suffers from menopause symptoms after five years, and she needs the protection against bone loss, Alzheimer's or colorectal cancer, the doctor should discuss the benefits and risks again before continuing with the long term use of HT. She may need annual mammography.
- A woman with a family history of breast cancer or a personal history of breast lumps should be considered for combined oestrogen and progestin therapy.
- A woman with a family or personal history of or increased risk for heart disease, stroke or deep vein thrombosis, or who has hypertension, should be considered for oestrogen plus progestin therapy. These women should be treated with statins. Studies show that women are under-treated in this regard.
- It is important to use the most effective dose of the purest hormones for the shortest duration. In older women using HT for more than five years, it may be best to change to low dose oral or transdermal preparations (skin patches).
- The oestrogen alone trial should bring even more insights.

– (Mari Hudson, [www.health24.co.za](http://www.health24.co.za))

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typo expert*

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# Menopouse: kuur of skete?

**Thalyta Swanepoel**

Moet jy of moet jy nie. Dis dié onsekerheid oor hormoonvervangingsterapie (HVT) wat vroue wêreldwyd op hol het ná skokbevindings oor dié kuur wat help keer dat ouer vroue "droë ou koeie" word. Thalyta Swanepoel berig. HVT doen dit vir jou vrouwees as die menopouse-wolf by die deur staan. Daarsonder gaan jy gebuk onder baie skete, sukkel jy met gloede, val jou hare uit, kry jy hare op die gesig selfs 'n snorretjie, sê vroue wat weet. Jy kwel jou ook meer oor siektes soos osteoporose, blaasbeheer, kanker. En jy verouder. Vinnig.

Sowat 40 jaar gelede het die ginekoloog Robert Wilson die wêreld se aandag op 'n veeldoelige "verjongingskuur" vir vroue van 'n sekere ouderdom gevestig: die hormoon estrogeen.

In sy boek *Feminine forever* skryf hy in 1966 dat die menopouse 'n tydperk is waarin vroue met 'n droë ou koei vergelyk kan word, luidens 'n berig in *Time* van 22 Julie. En dat estrogeen haar weer 'n jeugdiger en wulpser vrou en ma sou maak.

Minder estrogeen maak vroue vatbaar vir osteoporose, laat die risiko vir hartsiektes styg, veroorsaak gemoedsversteurings en warm gloede, maak seks ongemaklik omdat die wande van die vagina uitdroog en verdun, en vat aan jou blaasbeheer.

Maar menopouse is 'n natuurlike proses en baie vroue verkies om die natuur sy gang te laat gaan. Die gloede en gemoedsversteurings bedaar tog met verdrag. Tog maak HVT die lewe net makliker en teerheid van die borste en ander nuwe-effekte is 'n klein prys om daárvoor te betaal.

Talle voordele is toegeskryf aan HVT estrogeen vir vroue ná 'n histerektomie en 'n kombinasie van estrogeen en progesteron vir dié met 'n baarmoeder: dit verhinder én behandel osteoporose, dit doen jou hart goed, stuit die verlammeende simptome van die menopouse, en as jy gereeld 'n mammogram ondergaan, hoef jy jou nie te veel te steur aan die effens hoër risiko vir borskanker nie.

Toe, einde Mei vanjaar, het navorsers 'n kat in die duiwehok kom gooi deur die Amerikaners se Women's Health Initiative-studie (WHI) voortydig op te skort. Die redes? Dat HVT op die duur die risiko van borskanker verhoog en dalk nie soveel doen om hartsiektes te voorkom as wat voorheen gemeen is nie.

Dit het vroue wêreldwyd nóg meer verward gelaat. Me. Cynthia Stoltz, bestuurder van vroue-gesondheidsorg by die farmaseutiese vervaardiger Novo Nordisk SA, sê die maatskappy se telefone gons behoorlik. "Vroue weet nie wat hulle moet doen nie. Hulle is nie net verward nie, hulle is bang. Talle staak selfs hul behandeling, al is dit ander middels as wat in die studie gebruik is, sonder om 'n dokter te spreek."

NEE wat, sê dr. Timmy Kedijang, mediese direkteur van Novo Nordisk SA. Mense jaag nou spoke op. "Die WHI-studie het net een van die ouer HVT-kombinasies wat in Suid-Afrika beskikbaar is en ook net een dosis ondersoek.

"Boonop is net een vertakking van die studie, met 'n spesifieke kombinasie van estrogeen en progesteron, gestaak."

Dr. Greta Dreyer, ginekologiese onkoloog aan die Universiteit van Pretoria, stem saam. "Daar was nog altyd 'n hoë uitvalsyfer as dit by HVT kom, omdat vroue bang is vir borskanker, simptome soos veral borsteerheid en die koste van die behandeling. Nou is almal bang HVT veroorsaak beroerte en hartaanvalle."

Sy raai vroue aan om HVT te gebruik net vir spesifieke indikasies soos die verligting van die



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simptome van die menopouse en die voorkoming van spesifieke siektes. "Die voor-en-nadeelverhouding is vir elke pasiënt anders. 'n Mens moet kyk na die individuele siekterisiko. Vroue moet liefers hul dokter spreek voordat hulle die behandeling staak."

Dreyer sê verder nie 'n enkele probleem wat deur die WHI-studie bespeur is, is van toepassing op vroue wat nie 'n baarmoeder het nie en wat net estrogeen gebruik nie. "En as jy enige ander progesteron en estrogeen gebruik as die middels wat in die studie gebruik word, is dit ook nie noodwendig op jou van toepassing nie."

Sy meen daar is heelwat positiewe bevindings in die studie wat nou oorskadu word. "Dit is die eerste studie wat duidelik wys hoe doeltreffend hormone is in die voorkoming van osteoporose. HVT is ook die kostedoeltreffendste behandelingsmetode. Dit is dus 'n wesentlike punt. En die vroue in die studie is nie eens vir hierdie risiko gekies nie; anders sou die uitslag nog beduidender gewees het.

"Dis ook die eerste studie wat duidelik toon dat HVT die voorkoms van dikdermkanker verlaag. En daar sterf nie meer vroue aan borskanker nie, daar is net meer gevalle. Dit is nie nodig dat vroue so heftig reageer nie."

K ENNERS is dit verder eens dat HVT nie 'n lewenslange "vonnis" is nie, na gelang van waarvoor jy dit gebruik. As dit is om simptome te verlig, is dit gewoonlik korter as vyf jaar en as dit kom by beskerming teen siektes, is dit langer as sewe jaar, sê Dreyer. Baie vroue kan ook voortgaan met 'n laer dosis heelwat aandag word tans aan hierdie denkrigting geskenk."

Dr. Stanley Lipschitz, osteoporosekenner van Johannesburg, sê egter hy behou uitspraak voor oor HVT. "Daar is bewys dat HVT teen die menopouse beenverlies in 70% tot 80% van alle vroue verhinder. Maar as jy kyk na 100% van die vroue, sal net 30% tot 40% wel osteoporose kry. Dit beteken talle word onnodig behandel. As jy 'n uiters veilige middel gebruik, maak dit nie saak nie, maar as daar probleme is soos die WHI-studie nou uitgewys het, moet jy weer dink. En daar is ander selfs beter middels op die mark."

Mev. Bessie Louw (62) van Bela-Bela (Warmbad) in Limpopo (Noordelike Provinsie) is een van talle vroue wat met die "ander kant" van HVT kennis gemaak het. Sy het byna 20 jaar lank HVT ontvang voordat borskanker 7 jaar gelede by haar gediagnoseer is. Was dit HVT se skuld? "Die dokters was versigtig om hulle te verbind, maar het gesê dit kon daartoe bygedra het."

Louw het op 28 'n histerektomie gehad, haar eierstokke is verwyder weens herhaalde sistis toe sy iets in die veertig was. Ná die eerste mastektomie in 1996 is die HVT onmiddellik gestaak. "Toe was dit weer die warm gloede, die hoofpyn, die depressie, die droë vel. En ek het onmiddellik begin verouder. Maar wat maak ek? Met borskanker is hormone vir jou taboe."

Sy is bekommerd oor chroniese siektes, veral osteoporose, omdat haar ma daaraan gely het. Louw het 'n ruk lank een van die sogenaamde bifosfonate gebruik, maar dit later gestaak.

"Dit is geweldig duur. Ek gaan nou elke jaar vir 'n beendigheidstoets as deel van die kankertoets en drink maar natuurlike goed soos ekstra kalsium. Osteoporose is 'n verskriklike siekte. Dit is die moeite werd om HVT net daarvoor te gebruik."

Het sy 'n keuse gehad, sou sy by HVT gehou het. "Met HVT voel jy baie lekker, en jy is langer jeugdig."

Haar HVT laat staan? Nooit, sê mev. Martie Pieterse (44) van Roodepoort selfs al bewys watter studie wat. Haar baarmoeder en eierstokke is einde verlede jaar verwyder.

"Binne 'n week het ek begin gloede kry en begin sweet. As ek my pille net 'n dag of twee oorslaan, begin dit weer. Ek sien eenvoudig nie daarvoor kans nie."

Vroue kan Novo Nordisk tussen 9 vm. en 4 nm. tolvry by 0800 116 941 met vrae oor dié kwessie



# Gebruik van HVT raak al hoe meer omstrede

DIE Women's Health Initiative-studie (WHI) het hoofsaaklik ondersoek of die meeste vroue met 'n baarmoeder in die dekades ná die menopouse hormoonvervangingsterapie (HVT) moet oorweeg om chroniese siektes soos hartsiektes, bors- en kolonkanker en beenfrakture te voorkom.

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Die Amerikaanse National Institute of Health (NHI) het met dié studie begin nadat die sogenaamde HERS-studie getoon het ná gebruik van sowat vier jaar beskerm HVT nie teen hartsiektes nie, volgens 'n beleidsdokument van die Suid-Afrikaanse Vereniging van Verloskundiges en Ginekoloë (SAVVG). WHI moes dus kyk na die uitwerking van die behandeling op die duur.

Werwing vir die studie is al in 1993 begin, volgens die Duitse Menopousevereniging (DMV). Dit sou tot 2005 (dus 8,5 jaar) duur. Altesame 8 506 vroue het 'n spesifieke kombinasie van estrogeen en progesteron ontvang en 8 102 'n plasebo.

Die WHI-studie is einde Mei vanjaar beëindig weens 'n verhoogde risiko vir borskanker, veral ná sowat vier jaar van behandeling. Dié rede het wenkbroue wêreldwyd laat lig, omdat dit alom bekend is dat meer gevalle van borskanker voorkom met langtermyn-hormoonvervangingsterapie (HVT). Boonop lyk dit of gewasse wat tydens HVT ontwikkel, minder kwaadaardig is en minder geneig is om te versprei.

Die groot probleem is egter dat dit lyk of HVT nie net min beskerming teen hartsiektes bied nie, maar ook of dit die risiko vir dié siektes kan verhoog. Dié gebrek aan beskerming is die belangrikste bevinding van die WHI-studie, volgens die SAVVG.

Volgens 'n artikel in die uitgawe van 17 Julie van die Journal of the American Medical Association was die risiko vir 'n hartaanval 29% hoër onder die groep vroue wat die kombinasie terapie ontvang het. Beroerte het ook met 41% onder dié vroue toegeneem.

check

Wat kolorektale kanker betref, het die studie egter 'n afname van 37% getoon. Die voorkoms van kanker in die algemeen, van die endometrium en longkanker is glad nie geraak nie.

check

Nóg 'n positiewe uitslag van die studie is dat langtermyn-HVT die voorkoms van heup- en werwelfrakture beduidend verlaag het. Die kombinasie beskerm dus teen osteoporose.

Die studie het getoon die risiko's is klein: onder 10 000 vroue wat die kombinasie middel 'n jaar lank neem, sal daar sewe meer hartaanvalle wees, agt meer gevalle van borskanker en agt meer gevalle van beroerte en bloedklonte. Daar sal egter ook ses minder gevalle van kolorektale kanker en vyf minder heupfrakture wees, volgens die DMV.

✓

Nadat al die probleme egter bymekaar getel is, was daar 'n negatiewe uitwerking onder een uit elke honderd vroue klein, maar dit dui daarop dat die probleme meer word hoe langer HVT voortduur.

Wat die skrywers wel benadruk, is dat die uitslag van die studie nie noodwendig van toepassing is op laer dosisse of ander kombinasies van estrogeen en progesteron nie. Die SAVVG stem hiermee saam.

✓

Die bestudering van 'n derde groep vroue van 10 739 wat 'n histerektomie gehad het en net met estrogeen behandel word, gaan steeds voort.

✓

Dieselfde probleme is nie in dié groep bespeur nie.

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## REPORT 7

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*Hormoonvervangings terapie (HVT) was die afgelope tyd dikwels 'n besprekingspunt in mediese kringe. Ná sekere studies is skielik "wolf-wolf" geroep toe daar krakies in die mondering van dié menopousale aanvulling bespeur is. PETRO BOSMAN doen verslag.*

## Ja en nee nie maklike antwoord

HOKAAI egter eers, sê prof. Stephen Hough, hoof van die departement interne geneeskunde van die fakulteit gesondheidswetenskappe op die Tygerbergkampus van die Universiteit Stellenbosch. Daar is nie 'n eenvoudige "ja" of nee" vir hormoonaanvulling nie. Dit gaan immers oor elke vrou se persoonlike profiel. Vroue met gewone menopousale probleme reageer goed op HVT. Dit is ook algemeen bekend dat die toediening van estrogeen wel die skelet beskerm, sê prof. Hough, maar die eerste krakies oor hormoonvervangings terapie het in 1998 met die Hers-studie na vore getree.

Toe is gedink vroue wat hormoonvervangings kry, is dalk slegter daaraan toe as wat eers gedink is ten opsigte van hartbeskerming.

Navorsingresultate wat onlangs gepubliseer is, het betrekking op 'n kombinasie van estrogeen en progesteron. "Normaalweg sal 45 uit 1 000 vroue wat geen medikasie gebruik nie, borskanker kry. Met hormoonvervangings skuif dit op na 47 uit 1 000. Studies met estrogeen alleen gaan nog voort."

Elke vrou se voordeleprofiel teenoor haar nadeleprofiel moet egter opgeweeg word teen mekaar, sê Hough. As hartsiektes of borskanker bv. in 'n familie voorkom, verhoog die pasiënt se risiko dalk met die toediening van hormone. Maar elke geval is uniek en moet so gehanteer word. Liggaamsbou en risikofaktore vir osteoporose sal ook 'n rol speel.

"Die klem het geskuif na waar dokters in die verlede basies net besluit het 'n vrou sal 'n hormoonaanvulling op 'n sekere ouderdom neem na waar bemaagtigde vroue vandag saam met hul dokter 'n ingeligte besluit kan neem oor die gebruik van hormoonvervangings terapie," sê Hough.

Hough, wat ook die president van die nasionale osteoporose-stigting is, sê daar word egter nog teen die moderne vrou gediskrimineer wat die beskikbaarheid van sommige medisyne betref.

"Vrouegesondheid geniet nie altyd die aandag wat dit verdien nie. Sommige siekefondse en provinsiale hospitale wil van hul verantwoordelikheid wegstroom om sekere middels aan vroue te verskaf. Vroue kry nie altyd hul regmatige deel met byvoorbeeld osteoporosemedikasie nie.

"Provinsiale hospitale in die Wes-Kaap het die laaste tyd nie spesifieke middels gehad om osteoporose te behandel nie. Onderhandeling is egter aan die gang om die onaanvaarbare situasie die hoof te bied en ons hoop ons sal met nuwe gesprekke met provinsiale owerhede wel tot 'n skikking kan kom."

Verdere navrae hieroor kan gerig word aan [nofsa@iafrica.com](mailto:nofsa@iafrica.com).



REPORTS

# Navorser wat medici skud, was lank in SA

**Pierre Steyn**

Washington. 'n Voormalige navorser van die Suid-Afrikaanse Mediese Navorsingsraad (MNR) het hier aan die spits gestaan van 'n studie oor hormoonvervangings wat die wêreld se mediese establishment tot in sy fondament geruk het.

Dr. Jacques Rossouw, wat in 1989 na die VSA geëmigreer het ná 'n lang en bitter geveg met die destydse leierskap van die MNR, is nou waarnemende direkteur van die vroue-gesondheidsinisiatief van die VSA se nasionale gesondheidsinstituut (NIH).

Hy en sy span navorsers het vandeeweek aangekondig dat die hormoonvervangingsbehandeling wat tans deur meer as 6 miljoen Amerikaanse vroue ontvang word, meer skade as goed doen.

Ná jare se intensiewe navorsing het hulle bevind dat die middels, 'n kombinasie van estrogeen en progesteron, tot 'n klein toename in borskanker, hartaanvalle, beroertes en bloedklonte lei.

"Die resultate is van geweldige belang vir vroue. Een van die belangrikste gesondheidsbesluite wat 'n vrou moet neem, is of sy hormoonbehandeling ná haar menopouse moet kry," het Rossouw gesê.

Tot onlangs toe het die mediese owerhede hier dokters aangeraai om elke vrou wat nog nie 'n histerektomie gehad het nie en wat menopouse bereik het, aan te moedig om die middels te neem.

Rossouw het gister aan Beeld gesê hy het nog voordat die studie begin het, die voordele van hormoonvervangings betwyfel.

Hy het byvoorbeeld in 1998 op besoek aan Kaapstad gesê die feit dat vroue al 50 jaar aan estrogeenbehandeling blootgestel word sonder dat die uitwerking daarvan op die hele liggaam behoorlik nagevors is, "grens aan misdadige en eenogige mediese praktyk".

Hormoonvervangings was egter in die vorige dekade 'n "reuse-groeibedryf". Die NIH is aanvanklik gekritiseer toe hy in 1998 bekend gemaak het dat hy die saak gaan ondersoek, het Rossouw gesê.

Sedertdien, namate meer studies twyfel uitgespreek het oor die voordele van hormoonvervangings, het al hoe meer wetenskaplikes begin waarsku dat vroue mooi moet dink voordat hulle die behandeling begin.

Rossouw, wat as een van die wêreld se voorste kenners oor vroue-gesondheid gereken word, is in Luderitz in Namibië gebore, maar het die grootste deel van sy lewe in Kaapstad deurgebring. Twee van sy drie seuns woon en werk steeds in Kaapstad.

Rossouw het gesê hy het aanvanklik beplan om net twee jaar in die VSA deur te bring, maar die navorsingsgeleentheid by die NIH kan nie met enige ander plek ter wêreld vergelyk word nie.



REPORT 8

# Hormoonbehandeling nadelig, bevind span in VSA

PIERRE STEYN

WASHINGTON. 'n Voormalige navorser van die Suid-Afrikaanse Mediese Navorsingsraad het hier aan die spits van 'n studie oor hormoonvervanging wat die wêreld se mediese establishment tot in sy wese geruk het.

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"Die resultate is van geweldige belang vir vroue. Een van die belangrikste gesondheidsbesluite wat 'n vrou moet neem is of sy post-menopousale hormoonbehandeling moet neem," het Rossouw gesê.

Tot onlangs het die mediese owerhede hier dokters aangeraai om elke vrou wat nog nie 'n histerektomie gehad het nie en wat menopause bereik, aan te moedig om die middels te gebruik.

Rossouw het gister aan Die Burger gesê hy het nog voor die studie begin het, die voordele van hormoonvervanging betwyfel.

Die Women's Health Initiative is 'n reeks kliniese toetse en waarnemingstudies waarby meer as 165 000 post-menopousale vroue betrek is.

Die navorsing oor hormoonvervanging was net een deel van die betrokke studie.



REPORT 9



Die debat oor hormoonvervangingsterapie (HVT) woed voort, terwyl die gebruik daarvan aansienlik toeneem. Dit gaan om meer as net die gebruik van estrogeen en die menopousale

# JONGEF MET HORMONE?

deur LYDIA VAN DER MER

**Wie ouer as 40** wil nie tien jaar jonger lyk en voel nie?

Daarom is die versoeking om hormoonaanvullings te neem deesdae groot. Daar is beloftes dat dit jou jonger kan laat voel, lyk en optree. Dit kan die ergste ouderdomsverwante siektes, soos osteoporose en hart-siektes, glo afweer; ook die plooi op jou gesig versag, jou seksdrang opkikker, jou spiere ferman maak en jou geheue opskerp.

Tradisioneel verwys die term hormoonvervangingsterapie (HVT) na hormoonpreparate wat vroue in en ná die menopouse gebruik (estrogeen en/of progesteron en soms ook testosteron).

Volgens dr. Christiaan, skrywer van *Gesond vir 'n Leeftyd* (Tafelberg-Uitgewers, 2000), strek HVT wyer.

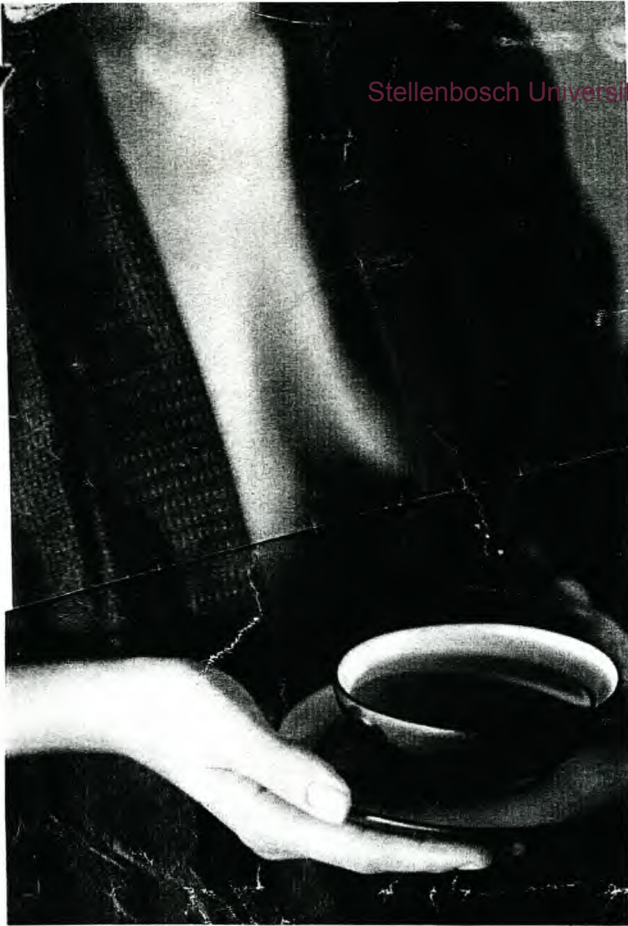
Want die produksie van 'n hele aantal hormone neem af namate ons ouer word – by vroue én mans. Dit lei feitlik altyd tot die veroudering van die liggaamsfunksies.

Deesdae is daar hormoonvervangingpreparate beskikbaar vir onder meer estrogeen, progesteron, testosteron, skildklierhormoon, dehidro-epiandrosteron (DHEA), pregnenolon, melatonien en groeihormoon (GH).

Die fontein van ewige jeug blyk dus binne jou bereik te wees – dikwels op die rak van jou naaste gesondheidswinkel.

Maar daar word nog gedebatteer of HVT so 'n goeie ding is. Een van die vrese is dat die langtermyn-gevolge daarvan nog onbekend is. Mens neem dit eenvoudig nog nie lank ge-





noeg sodat met sekerheid gesê kan word dis veilig nie.

## DIE DROOM VAN EWIGE JEUG (SONDER DIE GLOEDE!)

Niks gee skynbaar beter gestalte aan die droom van ewig jonk en

**DIE FONTEIN VAN EWIGE JEUG BLYK DUS BINNE JOU BEREIK TE WEES - DIKWELS OP DIE RAK VAN JOU NAASTE GESONDHEIDSWINKEL**

vroulik wees as estrogeenvervangings terapie (EVT) nie. Maar dis omstrede: dis langer as veertig jaar beskikbaar en steeds wil mense mekaar daarvoor takel.

Die afname in die produksie van estrogeen en progesteron in 'n vrou se veertiger- en vyftigerjare is die oorsaak van die ongemaklike simptome van die menopouse. In die vroeë menopouse sluit dit simptome in soos warm gloede, gewrigspyne en slaapprobleme. Op die lang termyn

word lae estrogeenvlakke met gesondheidsrisiko's verbind.

HVT gee verligting van vroeë menopousale simptome. Dit verminder die risiko van kolonkanker, verminder die effekte van Alzheimersiekte, en verbeter lewenskwaliteit (onder meer seksuele funksie en slaapprobleme). Veleroudering geskied ook stadiger.

Volgens dr. Willem Serfontein, 'n mediese wetenskaplike van Pretoria en skrywer van *Geneesende Voeding* (Tafelberg-Uitgewers, 2001), het dit 'n beskermende effek teen osteoporose, maar net vir sewe tot tien jaar. Daar is eers geglo dit beskerm jou teen ovariale kanker, maar dis verkeerd bewys.

Die vlieg in die salff? Dit verhoog die risiko vir endometriale kanker (kanker van die baarmoederbinnewand) en ook van bloedklonte (veral in die eerste jaar en as jy rook). Die risiko vir borskanker styg met tot 35% by vroue wat dit langer as tien jaar gebruik. Dit kan onder meer migraine en ander hoofpyne vererger, en gewigstoename, waterretensie, galstene en borsteerheid veroorsaak. Geen wonder nie dat sowat 50% van vroue HVT ná 'n jaar los weens nuwe-effekte of die vrees vir kanker op die lang termyn.

Die debat oor EVT het onlangs nuwe momentum gekry. Die Amerikaanse Women's Health Inisiatief Study (WHI) moes die mate van beskerming ontleed wat kombinasie-HVT (estrogeen en progesteron, of sintetiese progesteron) op die lang termyn bied. Die studie is ná vyf jaar gestaak. Nie net was daar 'n klein toename in die risiko van borskanker nie; die risiko vir hartaanvalle het met 41% verhoog. Aan die positiewe kant was daar 'n afname van 37% in kolorektale kanker en 'n aansienlike verlaging in heup- en werwelrakture. (Die deel van die studie waar net estrogeen gebruik is, word voortgesit.)

Dr. Theo Kopenhager, 'n

ginekoloog van Johannesburg, sê die mediaberigte bied nie die volle prentjie nie. Die WHI-studie verwys na 'n spesifieke middel, Prempro, wat jare reeds die standaardvorm van HVT in Amerika is. Plaaslik word dit onder die naam Prempak bemark. Dit is sintetiese estrogeen van perde-urien, gekombineer met progesteron, 'n veranderde vorm van progesteron.

Daar is egter ander HVT-produkte in verskillende kombinasies – die uitkoms is dus anders. Die nuwe neiging is lae dosisse HVT-produkte wat as "natuurlike" of bio-identiese estrogeen geklassifiseer word.

"Elke vrou moet haar unieke situasie saam met haar dokter onder die loep neem. Nie alle postmenopousale vroue het HVT nodig nie. Vir dié wat dit wel moet neem, is daar veilige terapeutiese keuses. Ná vyf jaar moet die risiko's en voordele jaarliks teen mekaar opgeweeg word," sê hy.

Maar dr. Serfontein sê kanker is kanker. Dit het min met individuele pasiënte te doen.

Volgens hom is daar maniere om die voordele van estrogeen-terapie te behou, terwyl die nadele uitgeskakel word. Dit sluit in die gebruik van fito- of plant-estrogeen, soos soja-ekstrak en swart slangwortel (*black cohosh*), die neem van hormonale voorlopers soos DHEA en pregnenoloon, die gebruik van estriol ('n natuurlike estrogeen), en ook 'n topikale pro-gesteron- room om progesteron te vervang.

Dr. Christiaan waarsku dat jy nie tegelykertyd 'n estrogeen- en isoflavoon-preparaat moet neem nie. Baie vroue kla dan van warm gloede.

\*Meer inligting oor die natuurlike benadering tot menopouse: *Kruie met Geneeskrag* deur dr. Arien van der Merwe (Tafelberg-Uitgewers, 2002).

## MENEER, MAAK NIKS JOU MEER OPGEWONDE NIE?

Meneer, is jy so om en by aftreeouderdom – swaarmoedig, met 'n



## HVT GEE VERLIGTING VAN VROEE MENOPOUSALE SIMPTOME ... DIT VERMINDER DIE RISIKO VAN KOLONKANKER, VERMINDER DIE EFFEKTE VAN ALZHEIMER-SIEKTE, EN VERBETER LEWENSKWALIT

an niks maak jou meer  
kroegewonde nie?

Prof. Riana Bornman van die afdeling andrologie, Departement Urologie aan die Universiteit van Pretoria, sê mans se testosteroon-vlakke begin ná 30 geleidelik daal. Simptome kom al meer ná 45 voor, soos buierigheid, 'n verlies aan dryfkrag, depressie en 'n gevoel van "moenie met my karring nie". Seksuele vermoëns neem af en dis gewoonlik die dryfveer wat mans hulp laat soek.

Testosteroon speel ook 'n belangrike rol om spiermassa en beendigheid te behou – dit kan verband hou met osteoporose by ouer mans.

Daar is lank geglo testosteroon-aanvullings kan jou risiko vir prostaatkanker en kardiovaskulêre siektes verhoog. Die jongste navorsing toon dat testosteroon dalk juis kardiovaskulêre funksies beskerm. Daar is ook geen bewyse dat dit prostaatkanker by gesonde mans kan veroorsaak nie.

Mans wat prostaatkanker het, moet dit egter vermy. Prostaatkankerselle verskil van die normale selle waaruit dit ontwikkel en groei makliker in die teenwoordigheid van testosteroon. Voor jy testosteroon-aanvullings neem, moet jy eers 'n bloedtoets (PSA) en rektale ondersoek ondergaan om te bepaal of daar nie kankeragtige selle is nie. Dit moet bo die ouderdom van 40 jaarliks herhaal word.

Daar is 'n ander kinkel in die kabel. Volgens dr. Serfontein word testosteroon by mans bo 40 in estrogeen omgesit (deur 'n spesifieke ensiem). Daar is weten-

skaplikes wat glo dis in werklikheid stygende estrogeenvlakke wat prostaatkanker veroorsaak. Tensy die risië onderdruk word help testosteroon-aanvullings net vir 'n kort tydperk.

Testosteroon-aanvullings is op voorskrif beskikbaar in die vorm van inspuitings en pille, maar ander oorsake van onder meer lae libido en moegheid moet eers uitgeskakel word. Die behandeling is duur en siekefondse betaal gewoonlik nie daarvoor nie. Jy moet dit die res van jou lewe neem en ook gereeld jou testosteroon-vlakke laat toets.

By vroue val die produksie van testosteroon ná die menopouse, hoewel nie so vinnig soos estrogeen nie. 'n Simptoom is 'n verlaging in libido. Testosteroon-aanvullings kan oormatige harigheid en aknee veroorsaak. Maar dr. Christiaan sê as dit omsigtig gedoen en 'n lae dosis geneem word, kan dit wondere vir jou lewensenergie en libido beteken. Gesels met jou ginekoloog of huisdokter daarvoor.

### DHEA – GOED VIR DIE LIBIDO

Dis 'n steroïedhormoon wat deur die biniere vervaardig word, is 'n

tiewe effek hê op jou energievlakke, libido, geheue, immuunstelsel, stresvlakke, fyn plooitjies en rumatiekpyn. Dit kan hartsiektes voorkom, liggaamsveer verminder en jou teen sekere kankers beskerm.

Diere-eksperimente wil dit laat lyk of dit jou ook langer kan laat lewe. In een studie het DHEA-aanvullings rotte se lewensverwagting met tot 50% vermeerder.

Neuwe-effekte van oordosering kan insluit haarverlies, geïrriteerdheid, aggressiwiteit, aknee en menstruele veranderinge. Daar is ook kommer dat hoë dosisse lewerskade by sommige pasiënte kan veroorsaak.

Volgens dr. Serfontein is daar gevrees dat dit die risiko vir prostaatkanker kan laat toeneem, maar die meeste studies-toon dis nie die geval nie. Daar is selfs aanduidings dat dit jou daarteen kan beskerm. Mans met prostaatkanker het dikwels 'n geskiedenis van baie lae DHEA-vlakke in hul jong dae.

Die veiligheid van DHEA in estrogeen-afhanklike borskanker is nog nie duidelik nie.

Hy sê die maksimum dosis wissel van mens tot mens – van 15-75 mg p/d in drie verskillende

## BY VROUE VAL DIE PRODUKSIE VAN TESTOSTEROON NÁ DIE MENOPOUSE, HOEWEL NIE SO VINNIG SOOS ESTROGEEN NIE

voorloper vir hormone soos estrogeen, testosteroon en progesteron, en het 'n uitwerking op die meeste liggaamsorgane.

Dr. Serfontein sê DHEA-vlakke daal skerp met die ouderdom. Op 90 het die gemiddelde mens net 10% van 'n twintigjarige s'n. Die dalende vlakke is nou gekoppel aan die agteruitgang van die immuunstelsel en die verouderingsproses in die algemeen.

DHEA-aanvullings kan 'n posi-

dosisse. Laat toets jou DHEA-vlakke voor jy aanvullings begin neem en herhaal die toets elke drie maande.

### KLOP VLUGVOOS- HEID EN SLAAP- PROBLEME

Die hormoon melatonien, wat deur die pineaalklier in die brein afgeskei word, reguleer onder meer die immuunstelsel, vrugbaarheid en slaappatrone. >



Aanvullings word o.m. gebruik vir vlugvoosheid en slaapversteurings.

Dr. Christiaan sê slaap speel 'n belangrike rol by lewenslewendheid; dit kan bv. hormoonproduksie verbeter. (Sy boek oor slaap, *Smart, Rollerbird-uitgewers*, verskyn in Maart.)

Volgens dr. Serfontein is daar sterk bewyse dat melatonien-aanvullings teenverouderingsterapie met 'n wye omvang is en baie gesondheidsvoordele het. Dis ook voordelig in die behandeling van sekere kankers, in kombinasie met konvensionele behandelingsmetodes soos chemo- en radiote-rapie.

Dit het nie nuwe-effekte nie. Mense wat dit moet vermy, sluit in pasiënte met leukemie, limfoom- en ander kankers van die immuunstelsel, outo-immuunsiektes soos lupus en rumatoïede artritis, eierstokkanker, swanger vroue, vroue wat swanger wil raak (hoë dosisse kan dalk 'n voorbehoedmiddel wees), en mense jonger as dertig.

Dr. Christiaan sê die algemeen-

ste dosering is 3 mg so twee uur voor slaaptid. Moenie dit meer as vyf keer per week neem nie, omdat dit die funksie van die pineaalklier kan onderdruk. Daar is nie 'n toets in Suid-Afrika beskikbaar wat jou melatonien-vlakke kan meet nie.

## JONGER – MET WOEM

Volgens dr. Serfontein is die dele van menslike groeihormoon-aanvullings (mGH) goed nagevors. Dit het 'n positiewe effek op feitlik elke orgaan en sel in die liggaam. Dis 'n verjongingskuur vir die vel en bene, gee nuwe woema aan die hart, lewer, longe en niere en vernuwe ander liggaamsfunksies. Dit bou spierweefsel, verbeter die immuunstelsel, beheer stresskade en verminder liggaamsvet. Die tempo van herstel hang af van hoe laag die GH-vlakke in die eerste plek was.

Daar kan wel nuwe-effekte wees. Volgens 'n studie wat onlangs in die *Journal of the American Medical Association* gepubliseer is, het bejaarde proefpersone wat GH geneem het komplikasies soos karpaletonnelsindroom, gewrigspyn, geswelde ledemate, diabetes en ander bloedsuikerversteurings getoon. Die nuwe-effekte het verdwyn toe die behandeling gestaak is. Volgens dr. Christiaan is die simptome deur té hoë dosisse veroorsaak.

Dis ook onprakties om te gebruik. Dr. Christiaan sê GH moet gereeld ingespuut word en dis duur. Ná 'n jaar of wat begin die liggaam daaraan gewoon raak en moet die dosis vermeerder word. Gereelde bloedtoetse is nodig om die GH-vlakke in jou liggaam te bepaal.

Volgens dr. Serfontein kan sulke inspuitings die produksie van jou natuurlike GH onderdruk, veral as dit oor 'n lang tydperk gebruik word. Dis beter om die produksie daarvan op 'n natuurlike manier te stimuleer. Jy kan dit met een-

voudige dieetgewoontes doen: verlaag bv. jou insulienvlakke deur suikeragtige kosse (soos vrugte en verfynde koolhidrate) 2-3 uur voor slaaptid te vermy. Vermy die oormatige inname van kalsium. Neem aanvullings soos die aminosure l-triptofaan (5-10 g p/d), en l-arginien (sowat 1-5 g p/d) op 'n leë maag.

## BETER GEHEUE

hormonoloon is die voorloper van teroon en soos DHEA, testosgetoon dit vermeer. Studies het kognitiewe funksies. 'n geheue en

Die dosis is 30 mg sogg.

Nie almal is opgewonde oor die gewildheid van hormone as teenverouderingsmiddels nie. Die Amerikaanse Nasionale Instituut vir Veroudering sê in 'n verklaring daar is nie genoeg wetenskaplike navorsing wat toon dat HVT enige voordele inhou nie. Natuurlike hormoonproduksie verskil boonop van mens tot mens. Dis onmoontlik om 'n enkele veilige dosis van 'n bepaalde hormoon vir 'n hele bevolking te bepaal.

Dr. Christiaan sê die ideaal is dat 'n profiel van die hormoonstelsel saamgestel en lae dosisse van 'n verskeidenheid van hormone dan toegedien word. Betrelike goedkoop speekseltoetse kan oorsee gedoen word, maar is nie plaaslik beskikbaar nie.

Voordat jy hormoonaanvullings neem, besoek jou dokter vir 'n volledige mediese ondersoek en bloedtoetse om te bepaal of jy tekorte het. Weeg die risiko's en die voordele daarvan teen mekaar op.

En gebruik dit onder dokters-toesig.

Dr. Serfontein beklemtoon dat jy nie net op "jeug-eliksers" kan staatmaak vir lewenskwaliteit op jou oudag nie. Dit verg 'n holistiese benadering, insluitende 'n gebalanseerde dieet, oefening, vermindering van stresvlakke en 'n doel om te lewe.

## NIE ALMAL IS OPGEWONDE OOR DIE GEWILDHEID VAN HORMONE AS TEENVEROUERINGSMIDDELS NIE



Foto: Ian Reeves



All headings hysterical Sensationalist

# Modern day miracle or killer treatment?

## Hormone Replacement Therapy relieves the nasty symptoms of menopause, but is it safe?

comp LONGER 14 AUGUST 03

DI CAELERS  
Health Writer



**T**HERE's nothing to get the hormones in a knot quite like the debate around hormone replacement therapy (HRT).

But if you're the woman facing the question of whether or not to take the drugs, the final decision is unfortunately going to have to be yours.

Fortunately there's plenty of good advice to be had, so women today – and their doctors – should examine the options and not see HRT as the simple answer to being happier, living longer or getting fewer heart attacks.

Specific indications and good judgment regarding the risks and benefits of HRT are essential, says Professor Stephen Hough, head of the department of internal medicine at the University of Stellenbosch.

Interviewed in the latest edition of *Tygerland*, the publication of the faculty of health sciences, Hough pointed to the turnabout that had taken place since the Women's Health Initiative long-term study, sponsored by the United States National Institute of Health.

The study, on combined oestrogen and progesterone use in healthy, post-menopausal women, was halted last year, citing small but significant increased risks of breast cancer and coronary heart disease.

These developments resulted in worldwide anxiety and confusion among women, many of whom firmly believed that HRT was a panacea for menopausal miseries, heart disease, osteoporosis, mental deterioration, colon cancer and ageing skin.

HRT, touted as "the closest thing in modern medicine to an elixir of youth", had revealed a dark side.

Hough, cutting through the debate, says it's clear there is no answer to fit all women, and that a prescription

menopausal women, including:

● **Heart disease:** several suggested that post-menopausal women on oestrogen have about half the incidence of heart disease compared with those not taking hormones.

● **Mental deterioration, including Alzheimer's Disease:** several small, short-term trials suggest that oestrogen improves the memory of post-menopausal women. One study in the early 1990s reported that HRT enhanced the mental function of women with mild to moderate symptoms of Alzheimer's Disease.

● **Colon cancer:** a large study reported that oestrogen users had a 29% lower risk of dying from colon cancer than non-users. For those on oestrogen for 10 years and longer, the risk was reduced by 55%.

● **Ageing skin:** Claims were made generally that HRT helped preserve skin elasticity by maintaining

an anti-oestrogen. These are very promising drugs that can prevent vertebral fractures, but have not yet been shown to prevent hip fractures," he says.

The Women's Health Initiative study, by former South African researcher Jacques Rossouw, threw the cat among the pigeons.

The entire study took in 27 000 healthy, post-menopausal women, half of whom were randomly assigned to HRT and the other half to a placebo. But in one part of the study a group of 17 000 women with a uterus were divided into half, who took a combined hormone (oestrogen and progesterone), and the other half a placebo. The researchers wanted to study the relationship between hormone therapy and its possible benefits for heart disease and hip fractures, and its possible risk for breast cancer, endometrial cancer and blood clots.

In July last year the NIH halted the trial after only five years, concluding that the risks for the study group on combined therapy outweighed the benefits.

"The risks included a very small, but statistically significant increased risk of breast cancer, coronary heart disease, stroke and blood clots," Hough explains.

A separate part of the trial, on the use of oestrogen alone in women who have had a hysterectomy, is continuing because researchers have apparently not seen similar risks in these women.

So what does all this mean for the average woman on HRT?

Where heart disease is concerned, Hough says, the study has proved beyond doubt that protection against heart disease is not a reality when women use combination therapy (oestrogen and progesterone), as was previously believed.

So if a woman is using HRT only to protect against heart disease, she needs to examine other options.



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# Modern day or killer ment?

Therapy relieves the nasty  
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*comp. Longevity August 2003*

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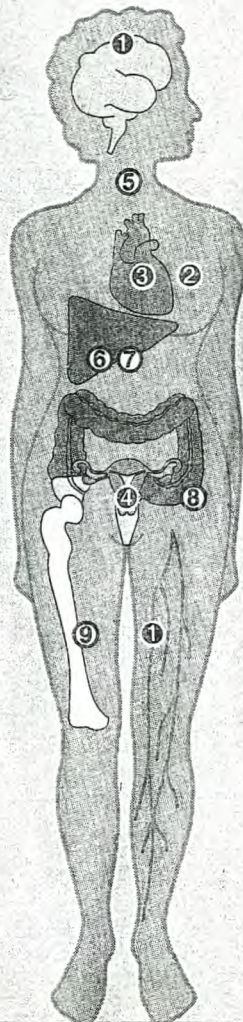
## Oestrogen effects associated with hormone replacement therapy during menopause

### THE RISKS

- ① Increases risk of stroke and blood clots
- ② Increases breast cancer risk
- ③ Increases risk of heart disease
- ④ Increases uterine cancer risk

### THE BENEFITS

- ⑤ Reduces menopausal symptoms (eg: hot flushes)
- ⑥ Lowers LDL\* (bad) cholesterol
- ⑦ Raises HDL\*\* (good) cholesterol
- ⑧ Reduces colon cancer risk
- ⑨ Strengthens bones

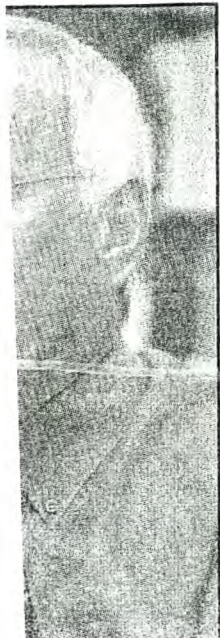


\*Low-density lipoprotein

\*\*High-density lipoprotein

GRAPHIC: BOB GRIERSON

*Care again No mention of flaws in the study.*



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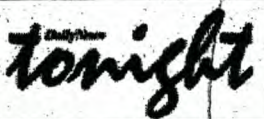
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## COMMENT AND FEATURES

### Dispelling the HRT myth

April 25, 2003

By Petra Lee

A visiting professor has added a voice of reassurance to the debate on HRT. He spoke to Peta Lee.

If you're pre-menopausal, or actually going through menopause and have heard that Hormone Replacement Therapy will give you breast cancer, take heart. It won't happen.

Not that you might not be diagnosed with breast cancer while you're on HRT- you might - but HRT itself will not cause the cancer.

Confused?

So was I, until it was all spelled out to me by the eminent and highly-respected Professor David Archer, an obstetrician and gynaecologist from Eastern Virginia Medical School, in Norfolk, Virginia, America.

Archer has been involved in the issue of menopause for 15 years, and is also past president of the North American Menopause Society. As editor of the quarterly publication Menopausal Medicine, he's also well qualified to discuss, in layman terms for people like myself, every aspect of hormones, oestrogen, menopause and all things related.

Brought out to SA by pharmaceutical company Novo Nordisk to speak at the 4th SA Menopause Society Congress in Durban, he tackled the thorny and contentious issue of HRT and the link with breast cancer with extraordinary clarity.

It boils down to epidemiology, he said. Epidemiology is when experts look at the association of things relating to a disease. In other words, HRT does not cause breast cancer, although it may be linked to it.

Archer's theory, which is one held by a lofty percentage of his peers, is that HRT promotes the growth of pre-existing cancer cells.

Every single cell in the body is programmed to die. But cancer cells never die. Although we don't have cancer cells just lying around dormant in our bodies, according to Archer, one theory is that cells may be frequently altered, but that the body normally destroys them.

In some instances, the cells are not destroyed and, if the chromosome in that cell is damaged, it could become cancerous. If this happens to a hormone responsive cell then the hormones being taken by the woman could stimulate its growth.

By the way, did you know that 80% of women who develop breast cancer have never taken hormones?

The media, says Archer, is partly to blame for giving the impression that HRT causes breast cancer.

"In reality, it's all a numbers game. You're more likely to be involved in a car accident than to develop cancer of the breast."

Interestingly, he added, those who do develop breast cancer while on hormone therapy have a better chance of survival - 90% after five years - than those who aren't on therapy (their survival chances are only 70%).

"From the time that cancerous lump starts growing, it takes 10 years before it's big enough to be medically detected. If you've been on HRT for five years, the hormones will promote and stimulate its growth so that yes, you suddenly believe the HRT."

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# Die waarheid oor HVT

VALDA JANSEN

DIE media het onlangs wêreldwyd op loop gegaan oor die voortydige afstel en "skokkende resultate" van 'n studie oor die risiko's en voordele van hormoonvervangings terapie (HVT) by post-menopousale vroue.

Onlangse uitslae van 'n Women's Health Initiative (WHI)-studie beweer dat HVT die risiko van borskanker en hartsiektes kan verhoog. Ook die gesaghebbende tydskrif Time het die uitslae uitgebasuin.

Vroue die wêreld oor wat reeds die terapie ontvang, sowel as vroue wat die behandeling oorweeg, het bekommerd geraak.

Die WHI-studie het veral gekonsentreer op die risiko van kardiovaskulêre siektes, bors- en kolonkanker en beenfrakture by post-menopousale vroue wat HVT oor 'n lang tydperk gebruik.

Hierdie studie, wat deur die Nasionale Gesondheidsinstituut in die VSA begin is, is vyf jaar gelede van stapel gestuur en sou agt jaar duur. In Mei vanjaar is een deel van die studie voortydig gestop, ná bewyse gevind is dat die risiko's meer as die voordele is. Daar is bevind dat sommige vroue wat HVT in 'n kombinasie van estrogeen en progestien (vir vroue wat nie 'n histerektomie gehad het nie) gekry het, 'n groter kans het om borskanker te ontwikkel.

Die media het ook die volgende feite oor die studie geïgnoreer: die WHI-studie het nie betrekking op lae dosisse van kombinasie-medisynie nie en neem ook nie ander formules vir mondelikse estrogeen en progestien in ag nie.

In 1993 is die medisyne wat deur die WHI gekies is, wêreldwyd gebruik. 'n Onlangse benadering is om eerder lae dosisse HVT-produkte te gebruik, wat as natuurlike estrogeen geklassifiseer word. Verskillende mediese instansies het tot hul redding gekom deur dié vrese te besweer.

In Suid-Afrika het die SA Menopause-vereniging onlangs op sy kongres in Durban die uitslae van die WHI-studie in die regte konteks geplaas met wat reeds oor HVT en vroue se gesondheid bekend is.

Simptome van die menopouse is die gevolg van die afname in estrogeen-produksie op die ouderdom van 50 tot 60 jaar. Vroeë simptome, soos warm gloede, hartkloppings en slapeloosheid verdwyn geleidelik. Lae estrogeenvlakke lei tot 'n groter risiko van hartaanvalle, beroerte en osteoporose wat tot beenfrakture kan lei.

Hoewel sommige van die vroeë simptome later verdwyn, word die kans op kardiovaskulêre siektes en osteoporose verhoog.

Die vervanging van estrogeen deur HVT is die doeltreffendste behandeling vir die vroeë simptome van die menopouse en kan ook beenvermindering en die kans op osteoporose voorkom. Daar bestaan genoeg bewyse dat HVT die lewensgehalte van vroue ná die menopouse verbeter.

Maar ander langtermyn-uitwerkings van HVT is nie so duidelik nie. Terwyl daar genoeg rede is om te glo dat HVT help om kardiovaskulêre kwale te voorkom, was die resultate van verskillende navorsingstudies nie konsekwent nie.

Toe die uitslae van hierdie groep ontleed is, is soortgelyke toenames in risiko vasgestel vir kardiovaskulêre siektes. Maar aan die ander kant is vasgestel dat die kans op kolonkanker en beenfrakture as gevolg van osteoporose met HVT-gebruik afneem.



'n Ander groep vroue in die studie wat slegs estrogeen sonder die progestien ontvang het, het geen toename in enige gesondheidsrisiko's getoon nie en hierdie deel van die studie gaan dus voort. Die gesondheidsvoordele vir hierdie groep vroue sal oor drie jaar bekend wees.

Die media het grootliks gekonsentreer op persentasies vir die toename in gesondheidsrisiko vir vroue wat die kombinasie-HVT ontvang het. Hierdie getalle is misleidend omdat dit nie die ware risiko-toename weerspieël nie. Eintlik is die bykomende risiko vir borskanker en hartsiektes by vroue wat kombinasie-HVT ontvang, baie klein.

Dit is belangrik om in gedagte te hou dat die risiko van borskanker vir alle vroue in elk geval met die ouderdom toeneem, ongeag of hulle HVT gebruik of nie. Prof. Alistair MacLennan, hoofredakteur van Climacteric, die amptelike tydskrif van die Internasionale Menopousevereniging, verduidelik dat die klein toename in risiko wat die WHI-studie met HVT-behandeling getoon het, gelykstaande is aan een ekstra kanker geval per 200 vroue oor tien jaar. Om twee standaard-alkoholiese drankies per dag te drink, of die eerste swangerskap van 20 na 30 jaar oud uit te stel, hou dieselfde risiko in om borskanker te kry.

Die waarneming dat HVT nie daartoe bydra om hartsiektes te voorkom nie, was 'n verrassende uitslag. Omdat die vroue wat aan die WHI-studie (gemiddeld 63 jaar) deelgeneem het, ouer was as dié aan wie HVT normaalweg voorgeskryf sal word, is dit logies dat die risiko van hartaanvalle en beroerte groter was.

In Suid-Afrika word HVT nie voorgeskryf vir die voorkoming of behandeling van kardiovaskulêre siektes nie. Hierdie siektes moet eerder beheer word deur toepaslike leefstyl-aanpassings (byvoorbeeld deur op te hou rook) en medisyne.

Die voordele van HVT met betrekking tot verligting van simptome en verbeterde lewensgehalte is reeds aangeteken.

Ná die bekendmaking van die WHI-uitslae beveel die SA Menopousevereniging die volgende aan:

Vir die meeste vroue wat deur die menopouse gaan, is die korttermynvoordele van HVT meer as die risiko's. Die gebruik van HVT oor langer tydperke behoort deur elke vrou individueel oorweeg te word. Dit is egter belangrik dat alle vroue ingelig word oor die resultate van die WHI en ander gepubliseerde studies sodat hulle 'n ingeligte besluit oor hul toekomstige gesondheid kan neem wanneer hormoonvervangingsterapie oorweeg word.

Vroue wat reeds HVT ontvang, moet dit nie summier stopsit nie, maar dit eers met hul dokter bespreek.

"Vroue moenie paniekbevange raak nie," het dr. Theo Kopenhagen gesê. Kopenhagen is 'n eredosent en eksaminator aan die departement ginekologie by Wits se mediese skool. Vir die meeste vroue hou HVT meer voordele as risiko's in. Geen ander terapie is so doeltreffend om menopousale simptome te beheer nie (waaronder warm gloede, moegheid en hoofpyne). HVT voorkom en behandel beenverlies en osteoporose en help ook om die volgende te voorkom: kolonkanker, oog-degenerasie, kognitiewe afname en Alzheimer se siekte.



SHAPE YOUR LIFE

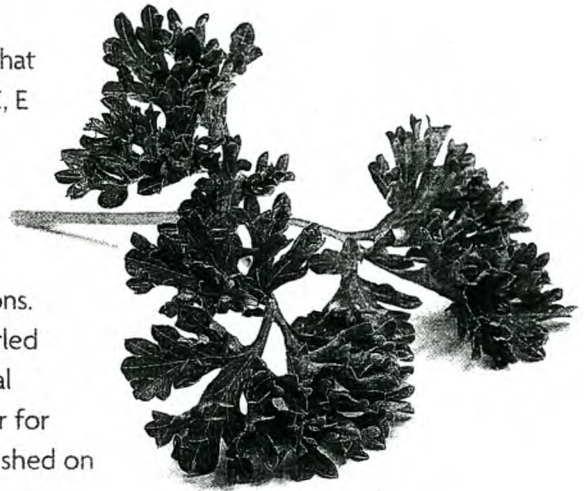
## Herb of the month: Italian parsley

(*Petroselinum crispum* Italian)

It's time to start boosting your immune system for winter, which is what makes parsley such a good idea right now. We're talking vitamins A, C, E and iron, as well as antioxidant properties. Try getting two table-spoons of chopped, fresh parsley each day – sprinkle on salads, add it to meat, pasta or cheese sauces at the end of cooking, or juice it up in a blender with apple or tomato juice. A cup of parsley tea is also very refreshing, and helps treat kidney and bladder infections.

The flat-leaf Italian parsley is even easier to grow than the moss curled variety, and it has a more distinctive taste. It needs full sun or partial shade, and does best in rich soil that is kept moist. Plant as a border for roses and it will keep pests away while enjoying the water that's lavished on the roses. More information: 012-8081044 or [www.herb.co.za](http://www.herb.co.za)

PHOTOGRAPHY RONI RAMOS



### Shake your booty

Biodanza and Nia are two of the stars dancing in *Shape's* eyes. We've featured both dance-based disciplines in the past, and both are gaining fans every week.

- Catch up with Carolina Churba (left), the Biodanza queen of SA, on Wednesday evenings at the Parktown North Methodist Church Hall (64 7th Avenue, Parktown North) from 6.30 to 8.30pm. Cost: R80; inquiries: Carolina on 011-8846403 or [biodanza@netactive.co.za](mailto:biodanza@netactive.co.za)
  - Kathy Wolstenholme, who brought the smash-hit Nia to South Africa, is opening her own studio at the River Club in Observatory, Cape Town, on May 4. There'll be classes every day, with up to 50 being able to be accommodated in the wonderful, newly renovated space. For details, call Kathy on 021-6743747 or e-mail: [kwolstenholme@zanet.co.uk](mailto:kwolstenholme@zanet.co.uk)
- Johannesburg's going to get Nia soon, too, with a series of classes at Planet Fitness gyms in July. For details contact: [charmaine.lifestyle@planetfitness.co.za](mailto:charmaine.lifestyle@planetfitness.co.za)

### HRT gets a double whammy

Hot on the heels of the question mark about the safety of hormone replacement therapy are suggestions that the treatment may offer no real benefit to postmenopausal women. The *New England Journal of Medicine* reports that further research shows virtually no improvement in their quality of life: women taking the drug were no less depressed, more energetic or had more sexual satisfaction or restful sleep than a placebo group. Until last year, before the first report appeared about significant health risks associated with HRT, it was the most widely prescribed drugs regime. Sales dropped by 50% when studies revealed that the treatment could mean increased risks. "This is additional information showing that the

oestrogen mystique is not what it was cracked up to be," said Dr Deborah Grady in an accompanying editorial. Dr Andrew Newham, a member of *Shape's* advisory board said: "Hormones must be taken for the right reason and oestrogen for severe menopausal symptoms is still the most effective treatment – one must just be very selective who one gives it to. In the correctly chosen women it could give a dramatic improvement. However, there are a lot of vague symptoms associated with that time in a women's life, and hormones are too often prescribed unnecessarily for non-hormone related issues. "There has been a big growth in plant-based oestrogens (phyto-oestrogens), which are showing promising results especially for treatment of menopausal symptoms," he says.



## Rene Lotter

Stellenbosch University <http://scholar.sun.ac.za>

**From:** Vicky Zigras  
**Sent:** Wednesday, October 29, 2003 11:14 AM  
**To:** Rene Lotter  
**Subject:** HRT Therapy stories

Dear Rene

I could only find 1 story on e-news. It's a Reuters or CNN piece done on 2002/07/10. You're welcome to come and view it upstairs:

Doctors have issued a new warning against the dangers of **hormone** replacement therapy for women.

Earlier this week, a US major study of its effects was cancelled.

Results showed an increased risk of heart disease, breast cancer and other chronic illnesses.

(PAUSE)

SUPERNew York/USA

The study examined the effects of combined **hormone** replacement therapy on nearly 17 thousand healthy women.

But the risks were so high that the US government called an abrupt halt to the trial.

They also issued a warning to doctors and patients.

SUPERJacques Rossouw/ Doctor

UPSOUND: The therapy increases the risk for heart attack or stroke. Additionally it increases the risk for breast cancer and blood clots.

The study found that HRT does lower the incidence of hip fractures and colon cancer.

But it raised the number of strokes by 41 percent, heart attacks by 29 percent, and breast cancer cases by 26 percent.

This presents a second blow to HRT.

Last week, doctors confirmed that estrogen and progestin combined does not protect menopausal women from heart disease.

For years, estrogen was touted as a healthy replacement for **hormones** that were lost at menopause.

Drug companies promoted HRT for the prevention of osteoporosis

And said it could keep women young, healthy and attractive.

But the latest findings have forced millions of women to rethink their treatment options.

SUPER  
Patricia Whitsett

UPSOUND: It does kind of take you aback when you think something is helping you that it also might be hurting you.

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Appendix B

Research results published in medical journals

In September 2002, the South African Medical Journal reports as follows on The Women's Health Initiative findings.

The principal results from the Women's health initiative (WHI) randomised controlled trial (RTC) published on 17 July 2002 have evoked a widespread response in the medical and laypress. For instance, time magazine of 22 July 2002 carried a 7-page article entitled 'The truth about hormones' with the subtitle "A large federally-funded study provides definitive proof that oestrogen and progestin are not age-defying wonder drugs. What's a woman to do?"

As expected patients are alarmed and their doctors face a dilemma. Clearly the study in question needs to be put in perspective. This editorial addresses the pertinent findings and suggests management guidelines. The overall goals of the WHI are to test methods of reducing the risk for cardiovascular disease, breast cancer, colorectal cancer and osteoporotic fractures in women. Many other health outcomes are being monitored as well. It is the largest and most expensive research study even funded by the National Institute of Health (NIH) with a budget of \$628 000 000 over the 15-year period 1992-1997. It includes a randomised trial of about 64 000 women and an observational study of about 100 000 women in the age range 50-79 years, of diverse race/ethnicity and socio economic status. The three branches of the randomised trial are designed to test hypotheses concerning the effects of disease incidence of (i) dietary modification (ii) hormone replacement and (iii) calcium/vitamin D. Women may participate in one, two or three branches of the trial.

Almost all observational epidemiological studies find that oestrogen replacement therapy (ERT) reduces the risk of coronary heart disease (CHD). However, there is concern that a tendency for healthier women to use HRT may make it appear that the beneficial effect is greater than it really is. Moreover, the effects of progestin and oestrogen replacement together are less certain, because this combination of hormone has not been used for as long a period of time as oestrogen on its own.

The principal results of the WHI paper concerning the risks and benefits of oestrogen plus progestin in healthy post-menopausal women are summarised below. The trial included 16 608 postmenopausal women who were randomised to receive either one daily tablet containing conjugated equine oestrogen (CEE) 0.625 mg and medroxyprogesterone acetate (MPA) 2.5 mg (treatment group - N=8 506) or a matching placebo (control group - N=8 102). This primary prevention study was due to run for 8.5 years but was halted at an average follow-up of 5.2 years because the number of cases of breast cancer had reached a pre-specified safety limit. Moreover, the global index that summated important aspects of health benefits versus risks, consisting of the earliest occurrence of CHD, invasive breast cancer, stroke, pulmonary embolism (PE), endometrial cancer, colorectal cancer, hip fracture, or death due to other causes, revealed a hazard ratio of 1.15.

As absolute risks statistics are easier to apply to clinical practice, these are outlined below. For 10 000 women taking such HRT for a year, compared with those not taking it, there would be an additional 8 cases of invasive breast cancer (38 vs 30), 7 heart attacks (37 vs 30), 8 strokes (29 vs 21) and 8 pulmonary embolisms (15 vs 7). However there would also be 6 fewer bowel cancers (10 vs. 16) and 5 fewer hip fractures (10 vs 15). Overall mortality was not increased with therapy.

The small increase in the number of patients with breast cancer did not appear in the first 4 years of use and accords with previous population studies. After 5 years of this combined HRT the increased risk of breast cancer was less than 1 in 1000. Parenthetically, studies to date show no increase in deaths from breast cancer in association with HRT.

In view of the generally favourable biological effects of oestrogen on the cardiovascular system, the lack of benefit on coronary heart disease is surprising. The Kaplan Meier estimates of cumulative hazards for CHD indicate that the difference between treatment groups began to develop soon after randomisation. Although the WHI trial was a primary prevention study



in predominantly healthy women, aged 50 to 79 years, 7.7% had prior cardiovascular disease. Moreover, there were some factors that may have increased the harmful effects of HRT. The women included in the study had a mean age of 63 years, with two-thirds being over 60. On average, the women were overweight, and one third were obese. Fifty per cent were previous or current cigarette smokers when they entered the study. One third had received treatment for high blood pressure, and over 10% had raised cholesterol levels requiring medication.

The WHI is the first trial with definitive data supporting the ability of postmenopausal hormones to prevent fractures at the hip vertebrae and other sites.

It needs to be emphasised that the WHI trial arm consisting of conjugated equine oestrogen only, for women with hysterectomies, has not been stopped as the balance of risks and benefits in the unopposed oestrogen component, at interim analyses, remains uncertain. The planned end of the latter trial is March 2005, by which time the average follow-up will be about 8.5 years. It is also important to note that the paper reporting the first WHI results did not consider the proven benefits for menopausal symptom control e.g. hot flushes and also did not report the effects of HRT on urinary and vaginal health.

Overall quality of life measures were not reported. In particular it has not yet reported on the effect of HRT on brain function and dementia. It therefore does not allow assessment of the overall balance of all risks and benefits of long-term HRT. Nevertheless it does indicate that the particular combination utilised should not be used for long-term disease prevention in postmenopausal women because the benefits are not sufficient to justify the risks of such use. Although this conclusion could potentially apply to all oestrogen/progestin combination hormone products, there are currently no large randomised clinical trials (RCTs) that definitely prove a better long-term effect associated with utilisation of other formulations or routes. This must become a research priority, especially as the metabolic effects of different regimes are different which may have an effect on their cardiovascular and possibly other effects.

The relevance of the WHO findings to the use of the particular HRT regimen in short-term treatment to the use of the particular HRT regimen in short-term treatment of symptoms in women at the time of menopause is less certain.

However, treatment should not be initiated for the sole purpose of prevention of cardiovascular disease. For those already on such treatment, it is mandatory that they are informed of the WHI findings, and those who elect to continue on it should probably limit utilisation to 4 years. Those who choose to discontinue HRT or to convert to other preparations or routes should probably be weaned off gradually. Above all, individualisation and patient information are paramount.

Professor AH MacLennan (personal communication, 24 July 2002) makes the following helpful points. Most women initiate HRT for symptom control. For the first 4 years the serious risks may be few. After 4-5 years, if there are no other indications to continue HRT, it may be reasonable to wean the patient off HRT and try without it. Up to 40% of women previously on HRT may experience a recurrence of sufficient symptoms to warrant further years of treatment.

A decision to continue HRT after 4-5 years is currently understandably difficult when it brings potential risks as well as potential benefits. It is to be hoped that more information to help in making these decisions will come from other ongoing WHI trials and another long-term trial abbreviated as WISDOM (Women's International Study of Long Duration oestrogen after menopause) the latter, begun in 1999, is being run in the UK, Australia and New Zealand, and will eventually recruit a total of 22 000 women aged 50-69 years.

February 13, 2003 NEJM

In May 2002, the Women's Health Initiative (WHI) trial of daily combined therapy with estrogen and progestin was terminated early. The reason for stopping was an increased risk of breast cancer (and evidence of greater overall risk than benefit) in the hormone-therapy group. Far more surprising, however, was the associated increase in the risk of myocardial infarction. An expectation of coronary benefit had been a major reason for many women's decisions to use postmenopausal hormone therapy.

Earlier reports had failed to show improvement in cardiovascular outcomes in



postmenopausal women with known cardiovascular disease who were treated with conjugated equine estrogen either alone or in combination with medroxyprogesterone. But it was still considered plausible that healthy women would benefit. Several observational studies involving women without coronary disease had shown roughly a halving of the risk of myocardial infarction among hormone users. These findings might have been explained at least in part by the tendency of healthier women to use this therapy. However, physiological data - such as improvement in lipid profiles and measures of endothelial function with estrogen therapy - suggested mechanisms for potential benefit.

The results of the WHI left many women with more questions than answers. How great are the risks of such therapy? Should women who are currently taking estrogen and progestin stop immediately? What about hormonal formulations other than that studied in the WHI (0.625 mg of conjugated equine estrogen and 2.5 mg of medroxyprogesterone [Prempro, Wyeth-Ayerst])?

In reality, the absolute risks associated with daily combined estrogen-progestin therapy are small (see Table <<http://content.nejm.org/cgi/content/full/348/7/579>>). For example, the 29 percent increase in the risk of coronary heart disease and the 26 percent increase in the risk of invasive breast cancer associated with hormone therapy in the WHI translate to 4 additional coronary events and 4 additional breast cancers for every 1000 women followed for an average of 5.2 years. Thus, the argument against using postmenopausal hormone therapy for the prevention of chronic diseases is not that the likelihood of harm is high, but rather that the potential harm outweighs the potential benefit.

This does not mean that postmenopausal hormone therapy should never be used. Postmenopausal symptoms - such as hot flashes and vaginal dryness or discomfort - remain a valid indication in the absence of contraindications such as a history of venous thromboembolism or coronary disease. For symptoms of genital atrophy alone, local estrogen or nonhormonal lubricants may be sufficient and should be considered. Although there are other possible treatments for vasomotor symptoms - for example, selective serotonin-reuptake inhibitors - hormone therapy is very effective and still reasonable as first-line treatment. Because vasomotor symptoms are generally transient, short-term use (for no more than two to three years) is all that is generally needed, and such use carries few risks. Using the minimal dose of estrogen that controls symptoms (e.g., 0.3 mg rather than 0.625 mg of conjugated estrogen) makes sense, although there are no long-term data indicating that a lower dose reduces risk.

What about women who are using postmenopausal estrogen-progestin therapy for reasons other than control of symptoms? On the basis of available data, these women should be advised to stop. Long-term use cannot routinely be encouraged for the protection of bone, given the availability of alternative therapies, and there are no data from large clinical trials to support the belief that long-term therapy will help women preserve cognitive function or maintain a youthful appearance.

That said, there is no urgency to stop hormone therapy abruptly. In women whose symptoms recur after stopping, therapy can be gradually tapered (by reducing the frequency of administration, the dose, or both) over a period of weeks to months. For a small number of women - those with persistent symptoms and reduced quality of life - continued treatment may be justified, as long as they understand the potential risks and the alternatives.

The findings of the WHI and other trials do not rule out the possibility that some postmenopausal women might derive cardiovascular benefit from hormone therapy. In this issue of the Journal (pages 645-650), Grodstein et al. hypothesize that benefit might be more likely in younger women who are treated from the time of menopause; however, as the authors acknowledge, this hypothesis is unproved and unlikely to be tested. Post hoc analyses of clinical-trial data suggest that certain polymorphisms - for example, in the gene for prothrombin or that for estrogen receptor - might predispose women to cardiovascular harm or benefit from hormone therapy. Nonetheless, our current ability to identify "good candidates" for hormone therapy is too rudimentary to support differential prescribing. Thus, the prudent approach is to avoid hormone therapy for the purpose of long-term prevention of disease.

The WHI findings have led some younger women who use oral contraceptives or who use hormone therapy after premature menopause to wonder whether they should stop. Studies of hormone therapy in women 50 years of age or older, however, cannot be generalized to these groups.

In response to the WHI, other hormonal regimens or preparations have been



touted as alternatives to conjugated estrogen with medroxyprogesterone. Estrogen therapy alone (without a progestin) is not recommended unless a woman has had a hysterectomy, because it is associated with increased risks of endometrial hyperplasia and cancer. More information about the long-term effects of estrogen alone after hysterectomy should be forthcoming from an ongoing part of the WHI study. Different formulations (including "natural" estrogens or progesterone) or transdermal administration has also been suggested. However, their long-term effects have simply not been studied. On the basis of available data, the Food and Drug Administration recently recommended that labeling for all postmenopausal estrogen and estrogen-progestin products include a boxed warning emphasizing the associated risks of coronary disease, stroke, and breast cancer. What should postmenopausal women do now? Women older than 65 years of age or younger women with other risk factors for osteoporosis should have their bone mineral density measured. Women should routinely be advised to consume adequate calcium and vitamin D and to engage in weight-bearing exercise. For women who have osteoporosis, the bisphosphonates alendronate and risedronate substantially reduce the risk of both hip and vertebral fractures. The selective estrogen-receptor modulator raloxifene (discussed in this issue of the Journal [pages 618-629]) also reduces the risk of vertebral fracture, although it has not been shown to reduce the risk of hip fracture. In contrast to estrogen, it appears to reduce the risk of invasive breast cancer but does not improve (and may cause) menopausal symptoms. Raloxifene also increases the risk of venous thromboembolism, although its effects on cardiovascular disease remain uncertain. To reduce cardiovascular risk, coronary risk factors should be assessed, including reevaluation of the lipid profile, which may worsen after the cessation of hormone therapy. A healthful diet, exercise, and smoking cessation should be encouraged; medications including statins and antihypertensive agents should be used in appropriate patients. The combination of these approaches is much more likely than estrogen-progestin therapy to optimize health and longevity in postmenopausal women.

#### Source Information

From the Department of Medicine, Brigham and Women's Hospital, Boston (R.G.D.).

#### Bibliography

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## **APPENDIX**

**\*Table of WHI results and Medical Journal Reports**



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The principal results of the WHI paper concerning the risks and benefits of oestrogen plus progestin in healthy post-menopausal women are summarised below. The trial included 16 608 postmenopausal women who were randomised to receive either one daily tablet containing conjugated equine oestrogen (CEE) 0.625 mg and medroxyprogesterone acetate (MPA) 2.5 mg (treatment group - N=8 506) or a matching placebo (control group - N=8 102). This primary prevention study was due to run for 8.5 years but was halted at an average follow-up of 5.2 years because the number of cases of breast cancer had reached a pre-specified safety limit. Moreover, the global index that summated important aspects of health benefits versus risks, consisting of the earliest occurrence of CHD, invasive breast cancer, stroke, pulmonary embolism (PE), endometrial cancer, colorectal cancer, hip fracture, or death due to other causes, revealed a hazard ratio of 1.15.

As absolute risks statistics are easier to apply to clinical practice, these are outlined below. For 10 000 women taking such HRT for a year, compared with those not taking it, there would be an additional 8 cases of invasive breast cancer (38 vs 30), 7 heart attacks (37 vs 30), 8 strokes (29 vs 21) and 8 pulmonary embolisms (15 vs 7). However there would also be 6 fewer bowel cancers (10 vs. 16) and 5 fewer hip fractures (10 vs 15). Overall mortality was not increased with therapy.

The small increase in the number of patients with breast cancer did not appear in the first 4 years of use and accords with previous population studies. After 5 years of this combined HRT the increased risk of breast cancer was less than 1 in 1000. Parenthetically, studies to date show no increase in deaths from breast cancer in association with HRT.

In view of the generally favourable biological effects of oestrogen on the cardiovascular system, the lack of benefit on coronary heart disease is surprising. The Kaplan Meier estimates of cumulative hazards for CHD indicate that the difference between treatment groups began to develop soon after randomisation. Although the WHI trial was a primary prevention study



in predominantly healthy women, aged 50 to 79 years, 7,7% had prior cardiovascular disease. Moreover, there were some factors that may have increased the harmful effects caused by HRT. The women enrolled in the study had a mean age of 63 years, with two-thirds being over 60. On average, the women were overweight, and one third were obese. Fifty per cent were previous or current cigarette smokers when they entered the study. One third had received treatment for high blood pressure, and over 10% had raised cholesterol levels requiring medication.

The WHI is the first trial with definitive data supporting the ability of postmenopausal hormones to prevent fractures at the hip vertebrae and other sites.

It needs to be emphasised that the WHI trial arm consisting of conjugated equine oestrogen only, for women with hysterectomies, has not been stopped as the balance of risks and benefits in the unopposed oestrogen component, at interim analyses, remains uncertain. The planned end of the latter trial is March 2005, by which time the average follow-up will be about 8.5 years. It is also important to note that the paper reporting the first WHI results did not consider the proven benefits for menopausal symptom control e.g hot flushes and also did not report the effects of HRT on urinary and vaginal health.

Overall quality of life measures were not reported. In particular it has not yet reported on the effect of HRT on brain function and dementia. It therefore does not allow assessment of the overall balance of all risks and benefits of long-term HRT. Nevertheless it does indicate that the particular combination utilised should not be used for long-term disease prevention in postmenopausal women because the benefits are not sufficient to justify the risks of such use. Although this conclusion could potentially apply to all oestrogen/progestin combination hormone products, there are currently no large randomised clinical trials (RCTs) that definitely prove a better long-term effect associated with utilisation of other formulations or routes. This must become a research priority, especially as the metabolic effects of different regimes are different which may have an effect on their cardiovascular and possibly other effects. The relevance of the WHO findings to the use of the particular HRT regimen in short-term treatment to the use of the particular HRT regimen in short-term treatment of symptoms in women at the time of menopause is less certain.

However, treatment should not be initiated for the sole purpose of prevention of cardiovascular disease. For those already on such treatment, it is mandatory that they are informed of the WHI findings, and those who elect to continue on it should probably limit utilisation to 4 years. Those who choose to discontinue HRT or to convert to other preparations or routes should probably be weaned off gradually. Above all, individualisation and patient information are paramount.

Professor AH MacLennan (personal communication, 24 July 2002) makes the following helpful points. Most women initiate HRT for symptom control. For the first 4 years the serious risks may be few. After 4-5 years, if there are no other indications to continue HRT, it may be reasonable to wean the patient off HRT and try without it. Up to 40% of women previously on HRT may experience a recurrence of sufficient symptoms to warrant further years of treatment.

A decision to continue HRT after 4-5 years is currently understandably difficult when it brings potential risks as well as potential benefits. It is to be hoped that more information to help in making these decisions will come from other ongoing WHI trials and another long-term trial abbreviated as WISDOM (Women's International Study of Long Duration oestrogen after menopause) the latter, begun in 1999, is being run in the UK, Australia and New Zealand, and will eventually recruit a total of 22 000 women aged 50-69 years.

February 13, 2003 NEJM

In May 2002, the Women's Health Initiative (WHI) trial of daily combined therapy with estrogen and progestin was terminated early. The reason for stopping was an increased risk of breast cancer (and evidence of greater overall risk than benefit) in the hormone-therapy group. Far more surprising, however, was the associated increase in the risk of myocardial infarction. An expectation of coronary benefit had been a major reason for many women's decisions to use postmenopausal hormone therapy.

Earlier reports had failed to show improvement in cardiovascular outcomes in



postmenopausal women with known cardiovascular disease who were treated with conjugated equine estrogen either alone or in combination with medroxyprogesterone. But [Stellenbosch University http://scholar.sun.ac.za](http://scholar.sun.ac.za) what healthy women would benefit. Several observational studies involving women without coronary disease had shown roughly a halving of the risk of myocardial infarction among hormone users. These findings might have been explained at least in part by the tendency of healthier women to use this therapy. However, physiological data - such as improvement in lipid profiles and measures of endothelial function with estrogen therapy - suggested mechanisms for potential benefit.

The results of the WHI left many women with more questions than answers. How great are the risks of such therapy? Should women who are currently taking estrogen and progestin stop immediately? What about hormonal formulations other than that studied in the WHI (0.625 mg of conjugated equine estrogen and 2.5 mg of medroxyprogesterone [Prempro, Wyeth-Ayerst])?

In reality, the absolute risks associated with daily combined estrogen-progestin therapy are small (see Table <http://content.nejm.org/cgi/content/full/348/7/579>). For example, the 29 percent increase in the risk of coronary heart disease and the 26 percent increase in the risk of invasive breast cancer associated with hormone therapy in the WHI translate to 4 additional coronary events and 4 additional breast cancers for every 1000 women followed for an average of 5.2 years. Thus, the argument against using postmenopausal hormone therapy for the prevention of chronic diseases is not that the likelihood of harm is high, but rather that the potential harm outweighs the potential benefit.

This does not mean that postmenopausal hormone therapy should never be used. Postmenopausal symptoms - such as hot flashes and vaginal dryness or discomfort - remain a valid indication in the absence of contraindications such as a history of venous thromboembolism or coronary disease. For symptoms of genital atrophy alone, local estrogen or nonhormonal lubricants may be sufficient and should be considered. Although there are other possible treatments for vasomotor symptoms - for example, selective serotonin-reuptake inhibitors - hormone therapy is very effective and still reasonable as first-line treatment. Because vasomotor symptoms are generally transient, short-term use (for no more than two to three years) is all that is generally needed, and such use carries few risks. Using the minimal dose of estrogen that controls symptoms (e.g., 0.3 mg rather than 0.625 mg of conjugated estrogen) makes sense, although there are no long-term data indicating that a lower dose reduces risk.

What about women who are using postmenopausal estrogen-progestin therapy for reasons other than control of symptoms? On the basis of available data, these women should be advised to stop. Long-term use cannot routinely be encouraged for the protection of bone, given the availability of alternative therapies, and there are no data from large clinical trials to support the belief that long-term therapy will help women preserve cognitive function or maintain a youthful appearance.

That said, there is no urgency to stop hormone therapy abruptly. In women whose symptoms recur after stopping, therapy can be gradually tapered (by reducing the frequency of administration, the dose, or both) over a period of weeks to months. For a small number of women - those with persistent symptoms and reduced quality of life - continued treatment may be justified, as long as they understand the potential risks and the alternatives.

The findings of the WHI and other trials do not rule out the possibility that some postmenopausal women might derive cardiovascular benefit from hormone therapy. In this issue of the Journal (pages 645-650), Grodstein et al. hypothesize that benefit might be more likely in younger women who are treated from the time of menopause; however, as the authors acknowledge, this hypothesis is unproved and unlikely to be tested. Post hoc analyses of clinical-trial data suggest that certain polymorphisms - for example, in the gene for prothrombin or that for estrogen receptor - might predispose women to cardiovascular harm or benefit from hormone therapy. Nonetheless, our current ability to identify "good candidates" for hormone therapy is too rudimentary to support differential prescribing. Thus, the prudent approach is to avoid hormone therapy for the purpose of long-term prevention of disease.

The WHI findings have led some younger women who use oral contraceptives or who use hormone therapy after premature menopause to wonder whether they should stop. Studies of hormone therapy in women 50 years of age or older, however, cannot be generalized to these groups.

In response to the WHI, other hormonal regimens or preparations have been



touted as alternatives ~~Stellenbosch University~~ <http://scholar.sun.ac.za> progesterone. Estrogen therapy alone (without a progestin) is not recommended unless a woman has had a hysterectomy, because it is associated with increased risks of endometrial hyperplasia and cancer. More information about the long-term effects of estrogen alone after hysterectomy should be forthcoming from an ongoing part of the WHI study. Different formulations (including "natural" estrogens or progesterone) or transdermal administration has also been suggested. However, their long-term effects have simply not been studied. On the basis of available data, the Food and Drug Administration recently recommended that labeling for all postmenopausal estrogen and estrogen-progestin products include a boxed warning emphasizing the associated risks of coronary disease, stroke, and breast cancer. What should postmenopausal women do now? Women older than 65 years of age or younger women with other risk factors for osteoporosis should have their bone mineral density measured. Women should routinely be advised to consume adequate calcium and vitamin D and to engage in weight-bearing exercise. For women who have osteoporosis, the bisphosphonates alendronate and risedronate substantially reduce the risk of both hip and vertebral fractures. The selective estrogen-receptor modulator raloxifene (discussed in this issue of the Journal [pages 618-629]) also reduces the risk of vertebral fracture, although it has not been shown to reduce the risk of hip fracture. In contrast to estrogen, it appears to reduce the risk of invasive breast cancer but does not improve (and may cause) menopausal symptoms. Raloxifene also increases the risk of venous thromboembolism, although its effects on cardiovascular disease remain uncertain. To reduce cardiovascular risk, coronary risk factors should be assessed, including reevaluation of the lipid profile, which may worsen after the cessation of hormone therapy. A healthful diet, exercise, and smoking cessation should be encouraged; medications including statins and antihypertensive agents should be used in appropriate patients. The combination of these approaches is much more likely than estrogen-progestin therapy to optimize health and longevity in postmenopausal women.

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# UNDERSTANDING THE RESULTS OF THE WHI STUDY<sup>[1]</sup>

	Increased	Decreased	Relative Risk (95% Confidence Interval)
	Absolute risk per 10 000 women per year		
Heart disease	7		1.29 (+29%)
Stroke	8		1.41 (+41%)
Pulmonary embolism	8		2.13 (+100%)
Breast cancer	8		1.26 (+26%)
Hip fractures (osteoporosis)		5	0.66 (-33%)
Colon cancer		6	0.63 (-37%)

With these figures reported in the WHI study the additional risk of breast cancer for white mid-aged women is actually very small. It translates into 1 extra cancer per 260 women over 10 years – an equal risk for breast cancer to that caused by drinking units of alcohol a day, or smoking cigarettes, or being obese after menopause, or delaying one's first pregnancy from 20 years of age to 30.

**The South African Society of  
 Obstetricians and Gynaecologists (SASOG)<sup>[1]</sup>  
 and The South African Menopause Society (SAMS)<sup>[2]</sup>  
 recommendations post-WHI study**

- Short term benefits of HRT clearly outweigh the risks
- Good reason to suspect that risk in the first 5 years after menopause is small
- Undisputed scientific evidence supports the fact that only HRT is successful in the alleviation of vasomotor symptoms
- Use of HRT for longer periods needs to be assessed with each woman individually and this repeated annually
  - All women should be informed about the WHI results so they can make an informed decision
- Should a woman wish to stop HRT, this must first be discussed with her doctor
- HRT should not be used for the sole purpose of primary prevention of CHD

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Contemporary Issues in Ob/Gyn & Women's Health

Reflections on the WHI Findings: Avoiding a Pill Scare and Taking Sensible Steps Forward

**Paul D. Blumenthal, MD, MPH**

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A little more than 25 years ago, the heretofore complacent world of estrogen replacement therapy (ERT) was rocked by papers indicating that unopposed estrogen, when provided over a long period of time to postmenopausal women, resulted in an increased risk of endometrial cancer.<sup>[1,2]</sup> This amounted to a "pill scare," which more commonly results after the publication of a study finding some adverse event in connection with oral contraceptives. Patients called their physicians in panic, the media was filled with fear-mongering articles, prescriptions for exogenous estrogen plummeted, and clinicians went to great lengths to provide symptomatic postmenopausal women with anything *but* an estrogen-containing compound. Similar to what happens in a contraceptive pill scare, women who were candidates for ERT even in the face of the newly reported results were denied access by their providers.

In the case of a contraceptive pill scare, what usually results is an increase in subsequent rates of unintended pregnancy and abortion. In the menopause setting, an ERT/hormone replacement therapy (HRT) pill scare is likely to mean that women with menopausal symptoms who could be helped through this life phase by low-dose, relatively short-term hormone therapy, which has not been implicated as being risky or dangerous, will be shifted away from the most effective means of treatment toward less effective modalities. This may satisfy a risk-averse medical community. However, clinicians, the media, and the general public should all be aware of the variety of effective alternative hormone regimens that are actually available.

To be sure, the Women's Health Initiative (WHI) results are noteworthy, and changes in clinical practice are indeed both likely and warranted. But health professionals, healthcare providers, the lay public, and the media need not panic. The media in particular need to put these results into perspective and avoid the temptation to create even more controversy and consternation than is necessary. No doubt, this week's top story will be replaced by a new crisis before you can say "hormone replacement therapy," but the crisis in confidence produced by reporting that is designed more to attract



attention than to provide guidance will last for years.

In addition, as with any good study, the results presented this week generate more questions than hard answers, and both clinicians and the media need to be responsible in profiling the implications of the WHI results to their patients and to the public, respectively. The commentaries appearing in this journal by Dr. Randolph, Dr. Notelovitz, and Dr. Kaunitz are exactly what is required to provide the necessary perspective (absolute as opposed to relative risk) and to identify solutions (lower dose, different progestin, more counseling) instead of simply amplifying the problem.

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## WHI Findings Summary

### Estrogen plus Progestin Effects on Bone Density and the Risk of Fractures

In the October 1 issue of the Journal of the American Medical Association (JAMA), WHI published the final fracture results for the Estrogen plus Progestin (E+P) study. The updated results include information on risk factors for fracture, additional fracture cases, and the bone density results for women in this part of the study.

The updated analysis shows that after an average of 5.6 years, 733 (8.6%) women in the E+P group and 896 (11.1%) women taking placebo (inactive) pills experienced a fracture.

- Overall, there was a 24% reduction in all fractures and a 33% reduction in hip fractures in women assigned to E+P.
- Hip bone density increased 3.7% after 3 years of taking E+P compared to 0.14% in the placebo group.

E+P reduced the risk of fracture to a similar degree in women who were considered to be at high or low risk of fracture.

WHI reported in July 2002 that the overall risks of E+P outweighed the benefits, including the fracture benefits. This new report examined whether the balance of risks and benefits, summarized in a global index, differed in women considered to be at high or low risk of fracture. The global index is a number that represents the combined risks and benefits for the major outcomes studied in WHI. There was no evidence of an overall benefit. Even in the group of women at increased risk of fracture, who would benefit most from the prevention of fractures, the risks of E+P outweigh the benefits.

In conclusion, treatment with E+P should not be recommended for the prevention and treatment of osteoporosis in women who don't have menopausal symptoms. Other medicines for osteoporosis should be considered. If E+P is prescribed to prevent osteoporosis, women need to be informed of the risks of taking E+P.

- [Abstract of scientific paper in the Journal of the American Medical Association](#)

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## WHI Findings Summary

### Estrogen plus Progestin and Risk of Coronary Heart Disease

In the August 7 issue of the New England Journal of Medicine, WHI published the final coronary heart disease (CHD) results for the Estrogen plus Progestin (E+P) study. The findings suggest that E+P does not protect the heart and may even increase the risk of coronary heart disease (CHD).

In final analyses, E+P use was associated with:

- A 24% overall increase in the risk of CHD (6 more heart attacks annually per 10,000 women using E+P)
- An 81% increased risk of CHD in the first year after starting E+P

Women who had higher baseline low-density lipoprotein (LDL) cholesterol levels at the beginning of the study were at particularly high risk of CHD with E+P use. No other factors significantly changed the risk of CHD while using E+P.

In conclusion, E+P does not protect the heart and may increase the risk of CHD among generally healthy postmenopausal women, especially during the first year after beginning hormones. E+P should not be started or continued to prevent heart disease.

- [Abstract of scientific paper in the New England Journal of Medicine](#)

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## WHI Findings Summary

### Estrogen plus Progestin Effects on Breast Cancer and Mammograms

WHI study findings on the risk of breast cancer in women taking combined estrogen plus progestin (E+P) were published in the July 2002 issue of the Journal of the American Medical Association (JAMA). The E+P study continues to be analyzed. Updated results (June 25 issue of JAMA) include data on additional breast cancer cases, their characteristics, and mammogram results for women in the study.

The 2002 report showed that more women taking E+P developed breast cancer than those taking placebo (inactive) pills. This updated analysis shows that after an average of 5.6 years, 245 of the 8,506 E+P women and 185 of the 8,102 women on placebo developed breast cancer. Of the total cancers, 349 cases were invasive, a type of breast cancer with a greater chance of spreading to other parts of the body. The conclusions below are based on the invasive breast cancer group.

- The increased risk of breast cancer due to E+P was eight additional cases of breast cancer for every 10,000 women over one year
- Overall, there was a 24% increase in the risk for breast cancer due to E+P

The breast cancers in the E+P group had similar characteristics (looked the same under a microscope) to those in the placebo group. However, the tumors in the E+P group tended to be larger and more advanced (had spread to the lymph nodes or elsewhere in the body). A more advanced stage is usually associated with poorer outcome. At this time, no direct statements can be made about the prognosis of the breast cancer found in women taking E+P until more follow-up information is collected.

After even one year, quite a few more women had abnormal mammograms in the E+P group (9.4%) compared to the placebo group (5.4%); this pattern continued until the study ended. An abnormal mammogram is a breast X-ray that results in a recommendation for additional medical evaluation (most often, a shorter time between mammograms, but sometimes, a breast biopsy or other tests). Although we have known from other studies that E+P use increases the density of breast tissue on mammograms, the increase in abnormal mammograms with E+P use seen in this study is a new finding.

Further WHI studies are being done to learn what happens to breast cancer rates and mammograms after E+P use is stopped.

- [Abstract of scientific paper in the Journal of the American Medical Association](#)

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## WHI Findings Summary

### Effects of Estrogen plus Progestin on Stroke in the Women's Health Initiative

JAMA May 28, 2003

While the world continues to discuss the **July 2002 findings from the WHI Estrogen Plus Progestin Study**, WHI investigators are busy analyzing the data in much more detail. Study findings on the risk of stroke in women taking combined estrogen plus progestin (E+P) were published in the May 28, 2003 issue of the Journal of the American Medical Association (JAMA). These updated results include data on additional strokes, information on types of stroke, and data on risk factors for stroke. As reported earlier, women taking active E+P developed more strokes than did those taking placebo (inactive) pills. This updated analysis showed that after an average of 5.6 years, 151 (1.8%) of the 8506 women on estrogen plus progestin and 107 (1.3%) of the 8102 women on placebo developed strokes. We can describe these same findings in several other ways:

- For every 10,000 women followed for 1 year, we would expect to see 31 strokes in women on E+P compared to 24 in women on placebo.
- The excess risk of stroke due to E+P was 7 strokes for every 10,000 women over one year.
- There is a 31% increase in the risk for stroke due to E+P.

Most of these strokes were caused by blood clots in the brain. This is the type of stroke affected by E+P. The less common type of stroke, caused by bleeding into the brain, did not seem to be affected by E+P. The increased risk of stroke due to E+P was seen in all groups of women studied, including those closest to the menopausal change and those with symptoms like hot flashes. The authors conclude that combined E+P should not be used to prevent cardiovascular diseases. The authors confirmed several risk factors for stroke that women can control: high blood pressure, smoking, and diabetes. They also suggest that exercise and taking vitamin C supplements reduce risk for stroke. Although the health benefits of exercise have been generally accepted, the benefits of vitamin C in reducing stroke risk will need to be confirmed by other randomized clinical trials. Further work is being done within WHI to learn more about the ways in which E+P affects cardiovascular disease.

- [Abstract of scientific paper in Journal of the American Medical Association](#)

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