To Be or Not to Be—

On Hormone Replacement Therapy

A Workbook to Help You Explore Your Options

This workbook was developed by investigators at Group Health Cooperative's Center for Health Studies and at the Centers for Disease Control and Prevention as part of a study looking at preventive care in older women. Its development was completely funded by the Centers for Disease Control and Prevention. Participants included:

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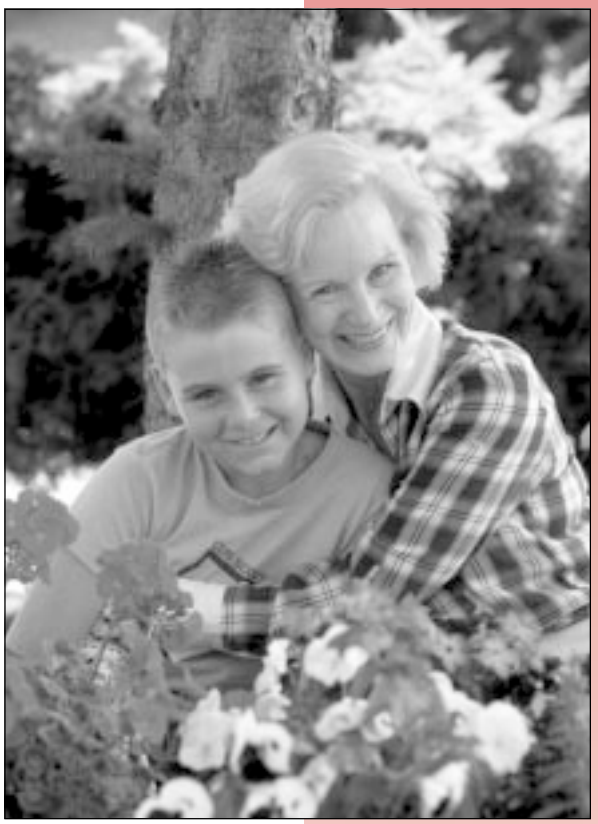
For more information, visit www.cdc.gov/nccdphp/women.htm.

Why Read This Book?

As women pass beyond their childbearing years, they are faced with

new issues and decisions about their health, such as how to manage menopausal symptoms, whether to take **hormone replacement therapy** (HRT), and how to deal with increasing risks for conditions like osteoporosis, heart disease, and breast cancer. The purpose of this workbook is to provide information and guidance that can help you make a decision about whether HRT would be a good choice for you. **In addition, going through the workbook should prepare you to discuss HRT with your healthcare provider.**



There has been an explosion of new research on women's health. What we learn from ongoing research will continue to affect women's healthcare decisions. Although many of our questions remain unanswered, we know quite a bit more than we did a few years ago. This workbook focuses on making choices about whether to use HRT. The decisions you make will probably be influenced by information about three important diseases that relate to the use of HRT: **osteoporosis**, **heart disease**, and **breast cancer**. This book can help you assess your risks for each of these diseases. With information about your personal risk factors, you should be better equipped to make up your mind about taking HRT.

Even if you are already taking HRT, you may want to browse all or parts of this workbook. You may be interested in the latest information about benefits, risks, and alternative strategies for preventing disease and relief from menopausal symptoms. For many women, decisions about taking hormones are made not once, but many times.

The purpose of this workbook is to provide information and guidance that can help you make a decision about whether HRT would be a good choice for you.

How to use this workbook

1. You do not need to read this workbook from beginning to end.
2. Use the table of contents and the quizzes on pages 6 and 7 to guide you to the areas that interest you.
3. Use the quiz on page 8 to evaluate your menopausal symptoms.
4. Read and complete the quizzes on osteoporosis, coronary heart disease, and breast cancer (pages 18, 22, and 25) to evaluate your personal risk of these conditions.
5. Summarize your personal attitude and risks in the section "Putting It All Together" (page 26).
6. Review the section "A Guide to Talking With Your Healthcare Provider" (page 27) for helpful hints about how to get the most out of this discussion.

Contents

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Where Do You Stand?

PART 1. Healthcare preferences: These questions are intended to help you think about your personal preferences regarding long-term prevention of chronic illnesses. Your preferences may guide your decision about whether to take HRT. There are no wrong answers.

Your Healthcare Preferences:	Circle Your Response
1. I am willing to take medication to prevent a disease I might get in the future.	Agree / Disagree
2. I would rather exercise and eat better than take medicine to prevent a disease I might get in the future.	Agree / Disagree
3. I am willing to take extra time to talk to my healthcare provider for preventive healthcare.	Agree / Disagree
4. I like to hear about the choices other women make regarding the prevention of diseases like osteoporosis, heart disease, and breast cancer.	Agree / Disagree
5. I like to consider the pros and cons before I make any health decision.	Agree / Disagree

PART 2. Concerns about HRT: Many women have questions about the pros and cons of taking HRT. Having answers to these questions may help you in making a decision.

Which of the following concern you?

Your Concerns About HRT:	Does This Concern You?	More Information on Page:
1. Will taking hormones give me bothersome side effects?	Yes / No	10–11
2. Will taking hormones help me to control menopausal symptoms?	Yes / No	9–10
3. Will hormones increase my risk of cancer?	Yes / No	9, 14, 25
4. I have a chronic disease: Are hormones safe for me?	Yes / No	11
5. If I start taking hormones, how long will I have to take them?	Yes / No	10, 12
6. Aren't there other things besides taking hormones that I can do to control menopausal symptoms or decrease my risks of heart disease and osteoporosis?	Yes / No	12–13, 19, 22–23

PART 3. Myths and realities: There are some common myths and misconceptions about women's health and HRT. Use this section to test your knowledge. They are discussed more fully on the pages indicated next to each question.

Myths and Realities About Women's Health and HRT	Circle Your Response (True/False/Uncertain)	More Information on Page:
1. Nearly half of all women aged 50 will someday have a broken bone due to osteoporosis (fragile bones).	T / F / U	17
2. The most common cause of death for women aged 65 and older is heart disease.	T / F / U	15
3. More women die of breast cancer than lung cancer.	T / F / U	23
4. HRT is just one of many ways a woman can reduce her risk of fracture.	T / F / U	19
5. Women who take HRT can reduce their risk of heart disease.	T / F / U	21
6. Women can lower their risk of fracture by taking HRT for many years.	T / F / U	10
7. HRT causes breast cancer.	T / F / U	25
8. Natural products are as good as HRT for treating menopausal symptoms.	T / F / U	14

Brief answers to these true/false statements are given on page 34.

Menopause

What is menopause? Menopause—the time when a woman stops having menstrual periods—is a natural process. All women go through menopause, but they may experience it quite differently. Some women welcome it, while others feel sad at the passing of their childbearing years. It is important to remember that although women share similar experiences in going through menopause, each woman is unique.

All women go through menopause, but they may experience it quite differently. Some women welcome it, while others feel sad at the passing of their childbearing years.

Around the time of menopause, a woman's ovaries gradually stop making estrogen and progesterone, the hormones that prepare the body for pregnancy. As these hormones change, a woman's periods may get heavier or lighter. Sometimes periods get more frequent or are skipped. Eventually periods stop altogether. A woman is considered menopausal when she has not had a period for 12 months.

When does menopause happen? The average age at menopause is 51.4 years. Most women go through menopause between the ages of 45 and 55. Women whose periods stop before the age of 40 are said to have a premature menopause, while some women's periods continue into their late 50s.

What are the symptoms of menopause? Some women have no symptoms, some women have symptoms but are not bothered by them, and still other women have symptoms that they find quite troubling. The most common symptoms of menopause are listed on the next page. Symptoms such as memory problems or feeling sad could have causes that are unrelated to menopause. If you are having these symptoms, it is important that you discuss them with your healthcare provider.

Evaluating your menopausal symptoms

Symptoms	Never	Mild	Moderate	Severe	How Much Does It Bother You?				
Hot flashes/ sudden flushes of warmth	❑	❑	❑	❑	1	2	3	4	5
Night or day sweats/cold sweats	❑	❑	❑	❑	1	2	3	4	5
Trouble sleeping or awaking too early	❑	❑	❑	❑	1	2	3	4	5
Painful intercourse, dry vagina	❑	❑	❑	❑	1	2	3	4	5
Memory loss/ forgetfulness/ difficulty concentrating	❑	❑	❑	❑	1	2	3	4	5
Depression/feeling sad or blue/ mood swings	❑	❑	❑	❑	1	2	3	4	5
					1= **not at all**			5 = **very much**	

Some women have no menopause symptoms, some women have symptoms but are not bothered by them, and still other women have symptoms that they find quite troubling.

If you are having other symptoms or feelings that you think may be related to menopause, write them here:

_____

_____

_____

_____

_____

You may want to discuss these symptoms with your healthcare provider at your next visit. Pages 10–14 of this workbook describe how HRT and other strategies might help you manage or relieve bothersome menopausal symptoms. If you would like more detailed information on menopausal symptoms, refer to pages 33 and 34 at the end of the workbook.

What is perimenopause? Perimenopause is the entire length of time that it takes for a woman to experience the physical and emotional changes associated with menopause. Perimenopause starts with the very first menopausal symptoms and lasts until all symptoms have ended, usually some time after a woman is "officially" menopausal. For some women the perimenopause lasts only a few months — but the average length of perimenopause is about 4 years. It is important to remember that these "symptoms" are a normal part of the process we call menopause.

What about blood tests to confirm menopause? The most common blood test used to confirm menopause is an FSH level. FSH, or follicle-stimulating hormone, is made in the pituitary gland in the brain. During a woman's reproductive years, FSH circulates in the blood and stimulates the ovaries to make estrogen and progesterone. As the ovaries gradually stop making these hormones, the pituitary works harder for a while, producing an excess of FSH. FSH levels greater than 25 to 40 are considered a sign of menopause.

For women 45 years of age or older, healthcare providers usually rely on a woman's report of her symptoms to determine when she reaches menopause. In younger women who may be having early menopausal symptoms, and in women who have had a hysterectomy but still have one or both of their ovaries, the blood test may be particularly useful. FSH levels fluctuate, however, so the test can sometimes be misleading. A low or normal FSH level does not mean that a woman with menopausal symptoms is *not* going through menopause. HRT for menopause is most often started according to a woman's symptoms rather than her FSH levels.

Surgical menopause. A woman who has both of her ovaries removed before her natural menopause (whether her uterus is removed) is said to have a surgical menopause. Because of the sudden withdrawal of ovarian hormones, women with a surgical menopause sometimes experience more severe menopausal symptoms than women who go through a natural, more gradual menopause.

When a woman has her uterus removed (hysterectomy) but does not have both ovaries removed, her ovaries usually continue to produce hormones until the time when her natural menopause is reached. Sometimes, however, a hysterectomy can change the blood flow to the ovaries, so a woman may have menopausal symptoms even though she still has one or both of her ovaries.

Hormone Replacement Therapy

What Every Woman Should Know

What Is HRT?

HRT refers to the use of prescription drugs to "replace" the hormones that the ovaries quit making at the time of menopause. These hormones are estrogen and progesterone. Estrogen is made synthetically from plants and other sources or obtained from the urine of pregnant horses. Two main types of progesterone are available. The most commonly used forms are made synthetically and called "progestins." A form of progesterone that is nearly identical to the hormone made by the ovaries is also available and called "natural progesterone" or "micronized progesterone."

Women who still have a uterus usually take both estrogen and progestin. If taken without progestin, estrogen makes the lining of the uterus (the endometrium) grow and can cause endometrial, or uterine, cancer. Women who take estrogen without progestin must have a yearly endometrial biopsy, in which tissue from the lining of the uterus is evaluated for cancer.

Women who do not have a uterus can take estrogen alone. This is often referred to simply as estrogen replacement therapy, or ERT. Estrogen is most often taken orally, as pills, or absorbed from skin patches placed on the abdomen.

Why take HRT? HRT (or ERT) is commonly prescribed to relieve menopausal symptoms. HRT may also be used to treat osteoporosis or to reduce a woman's chances of getting osteoporosis, and there is a possibility that HRT may reduce

the risk of coronary heart disease. On the other hand, HRT may increase a woman's chance of getting breast cancer.

What are the effects of HRT on menopausal symptoms? HRT is extremely successful at relieving menopausal symptoms, such as hot flashes, night sweats, and sleep disturbances. When taken only to relieve menopausal symptoms, HRT is used for a relatively short period of time—typically from several months to several years.

What are the long-term health effects of HRT? In addition to relieving the symptoms of menopause, HRT reduces bone loss and helps prevent thinning of the walls of the vagina. *Remember, though, if you are taking HRT for prevention of osteoporosis, it helps the most if you take it for many years.* Once you stop taking HRT, you start losing bone again. However, if you begin (or resume) using HRT later in life, it protects against further bone loss. The effect of HRT on heart disease is uncertain, and HRT may also increase your risk of breast cancer.

In addition to relieving the symptoms of menopause, HRT reduces bone loss and helps prevent thinning of the walls of the vagina.

What are the side effects of HRT? The most common side effects of HRT, and the percentage of women in the United States who experience them, are listed below. If you experience any of these, discuss them with your healthcare provider.

Common Side Effects of HRT	Percentage of Women Who Develop This Side Effect:
Monthly bleeding (from cyclical estrogen and progestin)	Most women
Irregular spotting (from daily estrogen and progestin) *(Women who are having heavy periods and irregular bleeding or bleeding between periods should see a healthcare provider.)*	30%–50% (stops permanently for most women within a year)
Breast tenderness or enlargement	12% on unopposed estrogen 33% on estrogen & progestin
Fluid retention	1%–10%
Headaches, including migraine	1%–10%
Dizziness	Less than 1%
Skin discoloration	Less than 1%
Nausea	Unknown

Changing either the type of HRT you are taking or the dose may reduce side effects and improve HRT's acceptability to you.

Women sometimes worry that HRT will make them gain weight. We now know that this is not true. Some women gain weight after menopause. This is most likely because the metabolism gradually slows down with increasing age. Some women find that they retain water or feel "bloated" while taking HRT. This is different from true weight gain.

Is HRT safe? In general, HRT is a safe and effective way of managing menopausal symptoms and preventing osteoporosis. However, some women should not take HRT, or if they decide to take it, they should be monitored closely by their healthcare providers. HRT is generally *not* recommended for women who have any of the following conditions:

- Vaginal bleeding of unknown cause (this should be evaluated before HRT is initiated).
- Suspected breast cancer or a history of breast cancer.
- History of endometrial cancer or cancer of the uterus.
- History of—or active—venous thrombosis (blood clots in the veins of the legs or in the lung). This includes women who have had thrombosis or blood clots during pregnancy or when taking birth control pills. Although the risk of blood clots in women is very low, HRT increases the risk of blood clots in the legs and lungs.
- Chronic disease of the liver.

In some women, HRT can cause gall bladder disease or gallstones that may require surgery. Women with uterine fibroids (benign or noncancerous tumors of the uterus) should know that HRT may make fibroids grow larger (ordinarily the withdrawal of estrogen after menopause causes them to shrink). However, most women with fibroids can take HRT safely.

Are there different ways to take HRT? There are many different ways to take HRT. Estrogen is typically taken by pill or skin patch, and progestin is almost always taken by pill. The estrogen from either pills or patches is absorbed into the blood stream, and in general the effects are similar. However, most studies have been done on women taking estrogen pills, so scientists are not certain that estrogen from the patch affects disease risks in the same ways as estrogen taken by pill. While the pill is taken just once a day, the patch releases estrogen at a steady rate throughout the day and night.

There are also differences in the mix of hormones and in the scheduling of the medication. When discussing HRT with your healthcare provider—if you decide to take HRT—you can talk about which of these schedules is best for you. These differences are described briefly here.

Unopposed estrogen: Women who have had a hysterectomy typically will take estrogen alone—with no progestin.

I started doing research a year or two ago, reading every book I could get my hands on, magazine articles, talking to other women—because I knew I was going to have to make this decision at some point. And I've learned a lot, and you know, it's still not an easy subject. I am concerned about taking drugs for the rest of my life. After all the research, I think the conclusion I've come to is that I want to try natural methods first.

Cyclical estrogen and progestin: With cyclic HRT a woman usually takes estrogen every day, adding progestin for 12 to 14 days a month, and then takes no hormone for 5 to 6 days per month. This regimen is often selected for women who are still having periods when they begin HRT. Most women have a light period or "withdrawal bleeding" during the time when they take no hormones each month.

Daily estrogen and progestin: With this regimen, often called "continuous combined HRT," a woman takes both estrogen and progestin every day. This regimen is usually selected by women who have had no period for at least 6 to 12 months. The major disadvantage is that 30% to 50% of women will have episodes of irregular bleeding or spotting. After 6 to 8 months, however, bleeding stops permanently for 75% to 80% of women.

I look forward to a long life. I want to be useful in my sixties and my seventies and my eighties and nineties. I think that is why I feel that being healthy is very very important now because I want to be useful in those ages.

Your dose and schedule may need to be adjusted. Let your healthcare provider know if you decide to take HRT and are uncomfortable with the regimen or are having unacceptable side effects. You may be able to try different combinations of drugs and/or schedules in order to minimize side effects.

HRT is not a one-time decision. Women may want to consider the pros and cons of HRT in several stages: first, at the time of menopause, as a short-term therapy for relief of menopausal symptoms; later, as the symptoms fade, as a longer-term regimen for prevention of osteoporosis. As new information about HRT becomes available, we are learning more about the effects of starting HRT some years after menopause. At the same time, new alternatives for preventing osteoporosis are being developed, so it's important to stay informed. Changes in your personal health may also lead you to re-evaluate your decision. For prevention of osteoporosis, women reap the greatest benefits if they start HRT around the time of menopause and take it indefinitely. But whenever a woman starts taking HRT, she will reduce her risk for further bone loss.

Are there other ways—besides taking HRT—to relieve menopausal symptoms?

Hot flashes: Hot flashes are sometimes brought on by specific things, such as a hot environment; eating or drinking hot or spicy foods, alcohol, and caffeine; and stress. Some women find they can decrease hot flashes by avoiding these "triggers." You may want to dress in layers. If you are having hot flashes at work, you may want to bring a small fan to your workplace and keep ice water at your desk. Some women find that a program of regular exercise brings relief of hot flashes and other menopausal symptoms.

Vaginal dryness: Some women find that vaginal lubricants relieve vaginal dryness. Estrogen *cream* may also help relieve vaginal dryness and painful intercourse. Although estrogen creams are absorbed into the blood in smaller amounts than similar doses of estrogen pills, remember that you are still taking estrogen. If you use estrogen creams regularly and you still have a uterus, the creams could affect the uterine lining in the same way that estrogen pills do. Your doctor may recommend that if you use vaginal estrogen, you take progestin pills for at least

10 days per month. If you have spotting or bleeding while using estrogen creams, you should have this evaluated by your healthcare provider.

Difficulty sleeping: There are many "home remedies" to promote a good night's sleep. Regular exercise—such as walking 30 minutes a day—can help promote a good night's sleep. However, you should avoid vigorous exercise too close to the time you plan to go to bed. Some women sleep better after drinking something warm, such as herb tea or a glass of warm milk (milk has the added advantage of calcium). *Other tips:* Keep your room a comfortable temperature; avoid caffeine, alcohol, or large meals close to bedtime; avoid working right before bedtime; define the amount of sleep you need and then go to bed and get up at the same time every day to get the right amount of sleep; don't nap in the daytime if you are having trouble sleeping at night.

Hot flashes are sometimes brought on by specific things, such as a hot environment; eating or drinking hot or spicy foods, alcohol, and caffeine; and stress. Some women find they can decrease hot flashes by avoiding these "triggers."

An important message about uterine cancer and HRT: It has been proven that in women who still have a uterus, taking estrogen without progestin dramatically increases the risk of endometrial cancer (cancer of the uterus). Women with a uterus should take estrogen with progestin unless they are followed closely (at least once a year) by a healthcare provider and have a yearly endometrial biopsy.

Unresolved issues and misconceptions about HRT:

I've found doctors that I can work with. And they know that I'm going to do what I think is best. You know, I'll listen to them and what they have to say, and then I'll decide what I'm going to do.

How early to start HRT: Some women believe they cannot begin taking HRT until their periods have completely stopped. This is not the case. Women may have menopausal symptoms for several years before they stop menstruating. In this case a healthcare provider may suggest some kind of hormonal regimen to help manage symptoms and regularize menstrual periods.

HRT's effects on Alzheimer's disease, memory, and colon cancer: You may have heard that HRT prevents Alzheimer's disease, improves memory, and decreases the risks of colon cancer. Although there have been encouraging results from some studies, very little is known, and at this point we do not have scientific evidence that HRT is beneficial for these conditions.

Herbal remedies and plant estrogens for menopause: You may wonder if herbal remedies for menopause are safer than HRT. You may also want to know if certain estrogen-like chemicals in plants (called phytoestrogens) can help with menopausal symptoms. Many over-the-counter herbal remedies are available to help women through menopause (for example, black cohosh or Remifemin®*). Unfortunately, at this time there is little more than anecdotal evidence that these remedies are effective. The observation that women in Japan and China, where traditional diets are higher in soy, are less likely to suffer from menopausal symptoms suggests that phytoestrogens found in soy products might be beneficial. So far, some studies show that soy estrogens decrease hot flashes, but many studies have found no difference with soy. Some over-the-counter herbal remedies contain progestins or estrogens. We know very little about their effects on the body. If you choose to use alternative botanical remedies, we recommend that you see a health professional who is familiar with them and can monitor their effects.

Natural versus artificial hormones: The estrogens and progestins in currently used pills come from a variety of sources. Some, for example the estrogens in Premarin®*, come from the urine of pregnant horses (mares). Others are mostly synthetic. Still others, "natural" estrogens and progestins, are made from plant sources. For example, the estrogen in Cenestin®* is synthesized from Mexican yam and soybeans. Some women believe that "natural" estrogen and progestin may be safer than artificial (synthetic) hormones. However, natural and synthetic sources of estrogen and progestin are believed to be equally safe and effective. Some women react differently to different sources of estrogens and progestins. If this is an issue for you, discuss it with your healthcare provider.

*Use of trade names is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

As you read this workbook, you will notice that

HRT may decrease the risk of some diseases and increase the risk of others. The conditions and diseases that are discussed here—osteoporosis, heart disease, and breast cancer—were chosen because using HRT can affect your risk of developing these illnesses.

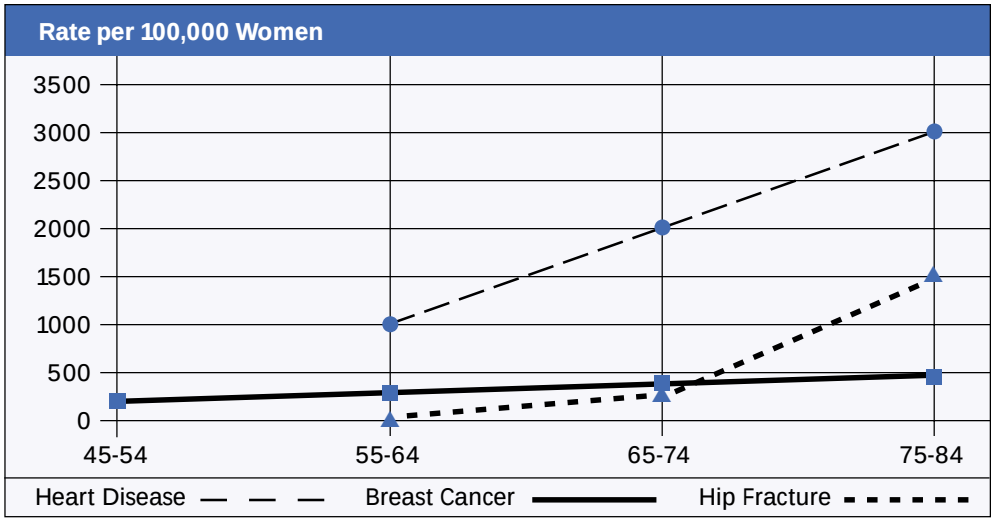
We cannot perfectly predict who will get osteoporosis, heart disease, or breast cancer. However, we know that women with certain characteristics are more likely than others to develop specific diseases. The characteristics that increase a person's likelihood of getting a particular disease are known as *risk factors*. Risk factors can be aspects of personal behavior and lifestyle (for example, eating or exercise habits), the environment (such as air pollution or secondhand smoke), or inborn characteristics (biological predispositions carried in the genes).

Understanding your own risk factors may help you think about whether HRT is a good idea for you. *Explore the following sections to:*

It is important to keep in mind that even women with no known risk factors get these diseases. And women with many risk factors for a disease may never get it. Risk factors simply tell us if your chances of getting the disease are higher or lower compared to other women your age. Knowing your risk factors can help you make decisions about your health. You may learn of actions you can take to lower your risk.

How many women get these diseases? As women age, heart disease becomes the leading cause of disability and death in women. The figure on this page shows, by age, out of 100,000 women, how many develop heart disease, hip fracture (generally because of osteoporosis), and breast cancer each year. This graph clearly demonstrates that after the age of 55, heart disease is far more common than either breast cancer or hip fracture.

Incidence of heart disease, breast cancer, and hip fracture in women in the United States, by age



Risks Women Worry About

- ***Learn more about osteoporosis, heart disease, and breast cancer.***
- ***Evaluate your risk for each of these conditions.***
- ***Learn about how taking HRT may affect your risks for osteoporosis, heart disease, and breast cancer.***
- ***Find out about strategies other than HRT for preventing and managing these conditions.***

What is osteoporosis? Osteoporosis is defined as fragile bones

or bones that can be easily broken. While human bones may appear to be as hard and stable as the steel or stone used to support structures, bones actually undergo constant change. Our bones grow and strengthen from early childhood through early adulthood. Specialized cells break down older bone and use calcium to form new bone—a process that allows us to grow and to heal when a fracture occurs. After age 35, this process changes, and bones gradually lose their strength and become increasingly brittle. Gradually less new bone is formed. During menopause, estrogen production falls, leading to a period of faster bone loss. Because weak bones are more likely to fracture, osteoporosis presents a significant danger to health. Hip fractures are more common in white women than women of any other racial or ethnic origin, and hip fracture rates increase dramatically when a woman enters her 80s.

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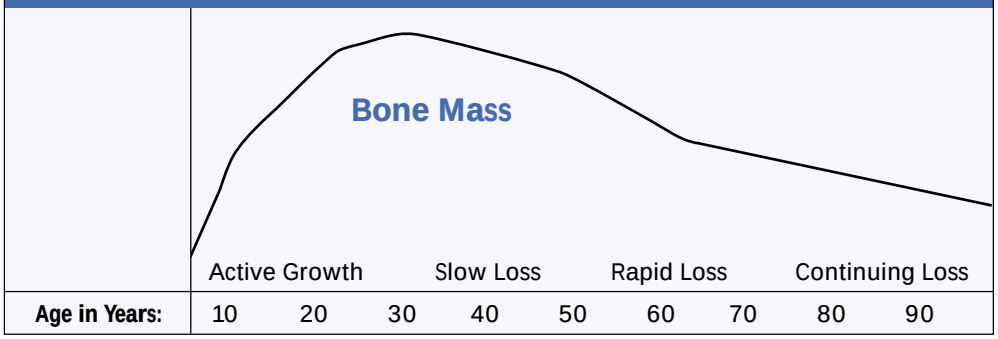
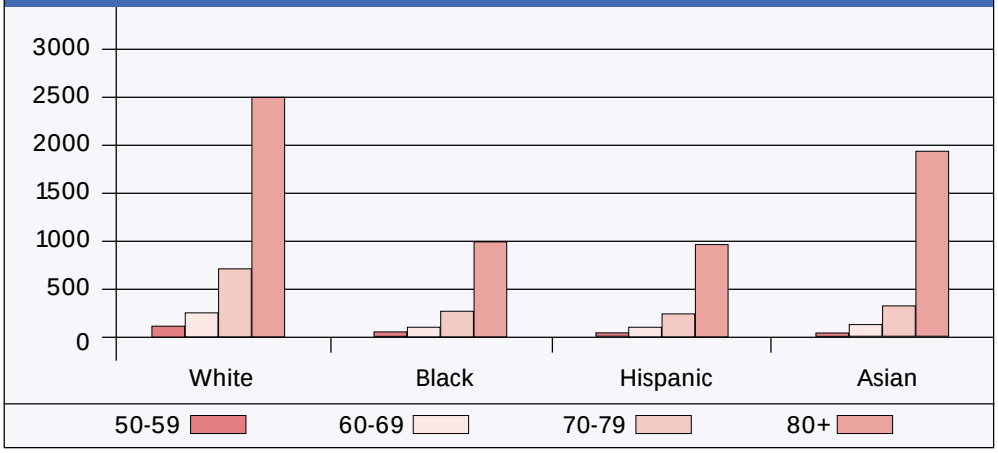
Bone Mass in Women, by Age



Hip fraction rates for women, by age and race, California, 1989–1991

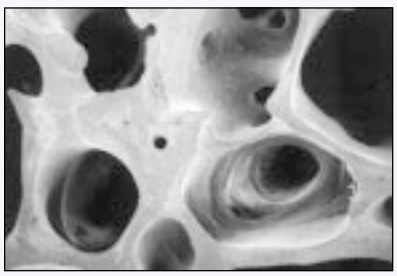
Hip Fracture Rates per 100,000 Women



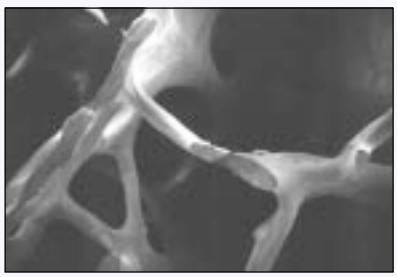
Osteoporosis and fractures are more common among women than men. This gender difference is primarily due to two factors: (1) By young adulthood, males generally have higher bone density than females, so they have a natural advantage when bone mass starts decreasing; and (2) Women go through menopause, which causes an accelerated period of bone loss that may continue for several years. Nearly half of all women aged 50 will someday have a broken bone due to osteoporosis. Bone loss associated with aging is universal. Therefore, regardless of their measured bone density, all women can benefit from effective preventive therapies and risk factor reduction programs.

What happens if you get osteoporosis? Weaker bones are more likely to break. Wrist, hip, and back (spine) fractures are all more common in people with osteoporosis. The main outward sign of osteoporosis is the occurrence of fractures with minimal trauma. If a simple fall to the ground causes a fracture in an older person, when in most younger people such a fall would only result in a bump or bruise, then osteoporosis is a likely explanation. Fractures of the spine or vertebrae can cause people to lose height as they age, and cause the bent-over look (dowager's hump) in elderly people. Bone fractures that result from osteoporosis often cause disability and sometimes death. Osteoporosis can affect your quality of life. Fractures can cause chronic pain, disfigurement, and/or disability. After a hip fracture, approximately 50% of people have difficulty walking without assistance. In the year following a hip fracture, 12%–20% of people will die as a result of the fracture. Overall, up to 33% of hip fractures lead to individuals requiring long-term care in nursing homes.

What about bone density testing? An X-ray technology called dual energy X-ray absorptiometry (DEXA) is used to detect low bone density. Clinically, this type of testing can be useful in women who are trying to decide whether they should take medications to reduce bone loss. DEXA scans can be useful in assessing the effectiveness of osteoporosis treatment. If you think you might benefit from bone density testing, speak with your healthcare provider.



Normal bone is dense and strong.



Bone with osteoporosis is porous and weak.

From Dempster D.W., et al, *Journal of Bone Mineral Research*, 1986; 1:15-21

My doctor gave me literature to read, and we talked about it for over a year. And I felt very comfortable when we finally got to that point where we decided together that HRT would be a good decision for me. She started me on the lowest dose to see what the side effects would be. And I feel comfortable with that. I'm having hot flashes, but it's not incapacitating like it was before. And my body feels like it is more normal than it did before.

How likely are you to get osteoporosis? *Evaluate your risk:* The checklist below contains a list of items that are associated with risk of osteoporosis and fractures. First, in each row, fill in the points that apply to you. Next, add up your score and evaluate your fracture risk.

Evaluate Your Risk for Osteoporosis	Points	Fill in Points Here
I would rate my health as:		
Good to excellent	0	
Fair, poor, or very poor	1	
I am black	-1	
My mother or sister had a hip fracture	1	
I weigh less now than I did at age 25 (when not pregnant)	1	
My height at age 25 was more than 5 feet 6 inches	1	
I have been clinically diagnosed with apparent dementia	1	
I am currently using oral corticosteroids (such as prednisone)	1	
I am currently taking medicine to prevent or control seizures (such as Dilantin®* or phenobarbital)	1	
I am currently using benzodiazepines (such as Librium®*, Librax®*, Dalmane®*, or flurazepam)	1	
I do not walk for exercise	1	
I cannot get up out of a chair without using my arms to help me	1	
I had a fracture at age 50 or older	1	
I am 80 years old or older	1	
I am postmenopausal and I do not take HRT	1	
I am up on my feet less than 4 hours per day	1	
My heart rate (pulse) when I am sitting quietly is more than 80 beats per minute (heart rate = number of heartbeats in one minute)	1	
Your osteoporosis score (add up your points)		

If your score is:	**Your risk of fracture is:**
0 to 2	Low
3 to 4	Medium
5 or greater	High

*Use of trade names is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The effect of HRT on osteoporosis: HRT reduces the amount of calcium that is lost from the bones after menopause. It is one of the most effective ways that women reduce their chances of getting osteoporosis.

Different ways to prevent and manage osteoporosis: If you are prone to osteoporosis, there are several things you can do to prevent or manage osteoporosis regardless of whether you decide to use HRT or not.

Lifestyle changes that can help prevent and manage osteoporosis

Stay physically active: Inactivity produces rapid bone loss, so remain as active as possible. All weight-bearing activities, such as walking, gardening, and vigorous housework, help keep your bones healthy and strong. It's never too late to start. Try to do some physical activity for at least 30 minutes, three to five times a week. This will also increase muscle strength and coordination and reduce your chances of falling. If you plan to begin a vigorous physical activity program (for example, jogging, dancing, or aerobics), consult your healthcare provider to make sure you don't have health problems that might get worse if you exercise.

Get enough calcium: Evaluate your calcium intake and, if necessary, take calcium supplements. After menopause, women should have 1,500 mg of calcium per day if they are not on HRT. If they are on HRT, they should have at least 1,000 mg of calcium per day. Food lists are available to help you evaluate the calcium in your diet. There are several kinds of calcium supplements. Calcium carbonate works quite well for most people; calcium citrate is another alternative. Calcium is best tolerated and absorbed in doses of 600 mg or less and when taken with food. Calcium may cause constipation, so drink lots of water. If you decide to take calcium supplements, you should also take 400 iu of Vitamin D each day. This vitamin helps the body absorb calcium. Women over the age of 75 should take 800 iu of Vitamin D daily, especially if they rarely go outdoors.

Quit smoking: Smoking significantly increases your risk for osteoporosis. Talk to your healthcare provider about a smoking cessation program.

Avoid excessive weight loss: Although maintaining a healthy, normal weight is important, excessive dieting may weaken your bones.

Prevent falls: While osteoporosis weakens bones, a fall is often what causes them to break. High-heeled or loose fitting shoes, loose throw rugs, slippery bathtubs, and wet, mossy steps can all cause falls.

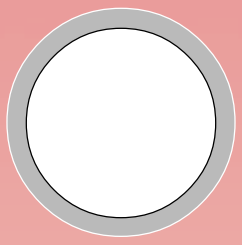
Medications to treat and prevent osteoporosis: No medication will prevent all fractures. **Etidronate** and **calcitonin** are medications that have been available for many years. They are primarily used to treat women who already have osteoporosis, rather than for prevention of osteoporosis. Several new medications that help reduce bone loss are now available.

Alendronate, a drug in the same family of medications as etidronate, is a potent medicine that can increase bone density by 6%–8%, similar to HRT. When they used alendronate, women with osteoporosis or low bone density reduced their risk of hip, spine, and other fractures by about half.

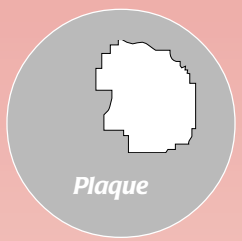
Raloxifene is an estrogen-like medication. It is in the SERM (selective estrogen receptor modulators) family. It increases bone density by about half as much as HRT. Raloxifene use lowers risk of spinal fractures but doesn't reduce the rates of hip or other fractures. Both alendronate and raloxifene are so new that the long-term risks and benefits are unknown.

I went through menopause in my early fifties. It was beautiful. The periods stopped, no other symptoms, and no periods. I wasn't interested in doing anything unusual to my body. I'd age naturally. Then about a year ago I volunteered for a study and they did a bone scan and I was depleted. So I started on estrogen and progesterone.

What is coronary heart disease? Coronary heart disease is due to



Normal arteries are smooth inside

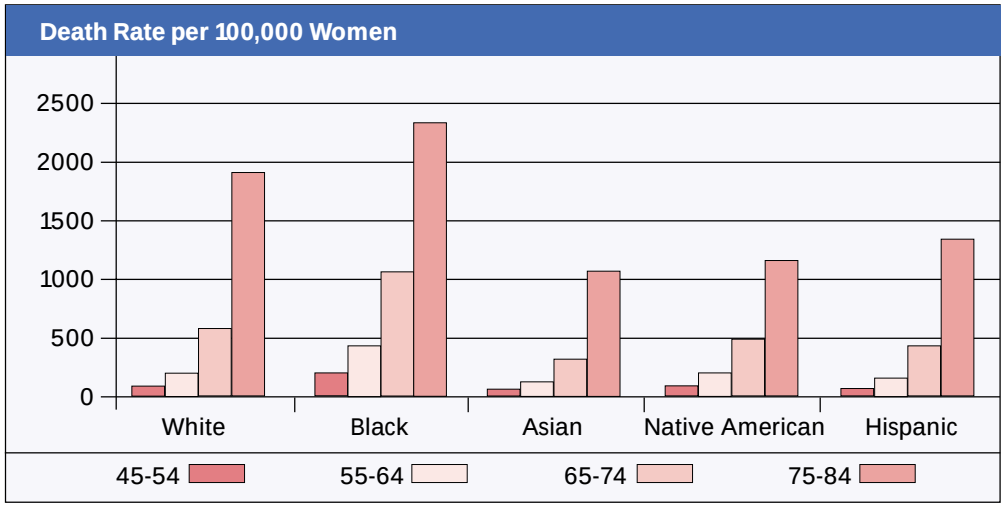


Atherosclerosis makes arteries clogged and brittle

Quitting smoking is probably the single most important thing you can do to protect yourself from heart disease.

atherosclerosis, the thickening and hardening of the arteries. Atherosclerosis is the buildup of fat, cholesterol, calcium, and extra muscle cells in the lining of the arteries of the body. This buildup is called plaque. Beginning in childhood and continuing over many years, the arteries gradually become clogged with stiff, brittle plaque. When this happens in the coronary arteries of the heart, it is called coronary heart disease or coronary atherosclerosis. About 226,000 women in the United States die of coronary heart disease every year, and of these, 96,500 women die of a heart attack. The chart below shows, out of every 100,000 women in the United States, how many died during a 3-year period from all diseases of the heart. Diseases of the heart cause more deaths among white and black women than among Asian, Native American, and Hispanic women. However, in all groups, the rates increase with age.

Death rates from diseases of the heart for women, by age and race, United States, 1989-1991



Many factors are known to increase the risk for coronary heart disease. The good news is that many of the most important risk factors, such as cigarette smoking, eating a high-fat diet, and being too sedentary, can be changed. There is proof that changing these factors can decrease your risk of heart attack and may even reverse coronary heart disease. You can use the assessment form on page 22 to evaluate your risk for coronary heart disease.

What happens if you get coronary heart disease?

Heart attack: For many people, the very first sign of coronary heart disease is a heart attack. A heart attack happens when the blood supply to part of the heart becomes completely cut off, usually from a clot that forms in an area already clogged with plaque. The part of the heart muscle supplied by the artery dies. About one third of people who have a heart attack die from it. Many people could

be saved by prompt medical help to treat irregular heartbeats that can be fatal. Drugs can also be given to stop a heart attack, but they must be given quickly (within 1–3 hours). Getting immediate medical help is extremely important. If you think you or someone you are with is having a heart attack, don't drive to a doctor's office, and don't wait! Call 911 or your local emergency number. Doctors also recommend that the person with chest pain chew one adult-strength uncoated aspirin (325mg). *Warning signals of a heart attack:*

- ***Uncomfortable pressure, fullness, squeezing, or pain in the center of the chest that lasts more than a few minutes or goes away and returns***
- ***Pain that spreads to the shoulders, neck, or arms***
- ***Chest discomfort with lightheaded-ness, fainting, sweating, nausea, or shortness of breath***
- ***Unexpected sweating, tiredness, or upset stomach***

Depending on the amount of muscle damaged, the heart may not work as well as it did before the heart attack. However, most women who survive a heart attack continue to lead active and productive lives.

Angina: Another symptom of coronary heart disease is pain or discomfort, called angina. Angina occurs when narrowed arteries cannot supply enough blood to the heart—for example, during physical exertion or at times of stress. Angina typically feels like pressure or discomfort in the chest, neck, back, or arms. It usually lasts less than 15 minutes and is relieved when the event that triggered it is stopped.

Many drugs are available to help manage angina. Nondrug treatments include coronary artery bypass graft surgery and balloon angioplasty. In coronary artery bypass graft surgery, the surgeon uses a blood vessel from another part of the body (leg or chest wall) to build a detour around the blocked coronary artery. In balloon angioplasty, the cardiologist guides a thin plastic catheter into the blocked artery and inflates a small balloon on the tip of the catheter to compress the plaque. This allows blood to flow more easily through the artery.

How likely are you to get coronary heart disease? To evaluate your risk of heart disease, complete the assessment on the next page. Family history of coronary heart disease is not included in this assessment. A history of coronary heart disease in your parents, brothers, or sisters—especially if it occurs at a young age (before age 50 in men, before age 60 in women)—does increase your risk of coronary heart disease. One reason for this is that families often share genetic and lifestyle risk factors, such as cigarette smoking, high blood pressure, and the tendency to be inactive. These factors are already included in the risk factor assessment.

The effect of HRT on coronary heart disease: Many studies have found that women who take HRT are 25%–50% less likely to have a heart attack than women who don't. However, these studies may have been biased because women were not randomly assigned to take HRT or a placebo medication (sugar pill). In August 1998, scientists published the results of a study of women who already had heart disease. They found that HRT did not protect these women against further heart attacks. In fact, during the first year of the study, women who took HRT had a greater risk of heart attack and death than women taking the placebo. By the 4th year of the study, however, the risk of heart attack and death for women on HRT was lower than that for women on the placebo. Because of this new study and the shortcomings of earlier studies, scientists are not certain about the effects of HRT on heart disease.

RISKO: A Heart Health Appraisal

1. Systolic Blood Pressure *(the highest number)*

If you **are not** taking anti-hypertensive medications and your blood pressure is...

125 or less	0 points
between 126 and 136	2 points
between 137 and 148	4 points
between 149 and 160	6 points
between 161 and 171	8 points
between 172 and 183	10 points
between 184 and 194	12 points
between 195 and 206	14 points
between 207 and 218	16 points

SCORE:

If you **are** taking anti-hypertensive medications and your blood pressure is...

117 or less	0 points
between 118 and 123	2 points
between 124 and 129	4 points
between 130 and 136	6 points
between 137 and 144	8 points
between 145 and 154	10 points
between 155 and 168	12 points
between 169 and 206	14 points
between 207 and 218	16 points

SCORE:

2. Blood Cholesterol

Locate the number of points for your total and HDL cholesterol in the table below.

TOTAL	HDL 25	30	35	40	50	60	70	80
140	2	1	0	0	0	0	0	0
160	3	2	1	0	0	0	0	0
180	4	3	2	1	0	0	0	0
200	4	3	2	2	0	0	0	0
220	5	4	3	2	1	0	0	0
240	5	4	3	3	1	0	0	0
260	5	4	4	3	2	1	0	0
280	5	5	4	4	2	1	0	0
300	6	5	4	4	3	2	1	0
340	6	5	5	4	3	2	1	0
400	6	6	5	5	4	3	2	2

SCORE:

3. Cigarette Smoking: If you...

do not smoke	0 points
smoke less than a pack a day	2 points
smoke a pack a day	5 points
smoke two or more packs a day	9 points

SCORE:

4. Weight

Locate your weight category next to your height in the table below. If you are in...

weight category A	0 points
weight category B	1 point
weight category C	2 points
weight category D	3 points

FT	IN	A	B	C	D
4	8	up to 139	140-161	162-184	185+
4	9	up to 140	141-162	163-185	186+
4	10	up to 141	142-163	164-187	188+
4	11	up to 143	144-166	167-190	191+
5	0	up to 145	146-168	169-193	194+
5	1	up to 147	148-171	172-196	197+
5	2	up to 149	150-173	174-198	199+
5	3	up to 152	153-176	177-201	202+
5	4	up to 154	155-178	179-204	205+
5	5	up to 157	158-182	183-209	210+
5	6	up to 160	161-186	187-213	214+
5	7	up to 165	166-191	192-219	220+
5	8	up to 169	170-196	197-225	226+
5	9	up to 173	174-201	202-231	232+
5	10	up to 178	179-206	207-238	239+
5	11	up to 182	183-212	213-242	243+
6	0	up to 187	188-217	218-248	249+
6	1	up to 191	192-222	223-254	255+

SCORE:

TOTAL SCORE:

What Your Score Means

Note: If you are diabetic, you have a greater risk of heart disease. Add 7 points to your total score.

0-2: You have a low risk of heart disease for a woman of your age.

3-4: You have a low-to-moderate risk of heart disease for a woman of your age. That's good, but there's room for improvement.

5-7: You have a moderate-to-high risk of heart disease for a woman of your age. There's considerable room for improvement in some areas.

8-15: You have a high risk of developing heart disease for a woman of your age. There's lots of room for improvement in all areas.

16 and over: You have a very high risk of developing heart disease for a woman of your age. You should act now to reduce all your risk factors.

Alternatives for prevention and management of coronary heart disease: You can do many things to reduce your risk of heart disease.

Quit smoking: Quitting smoking is probably the *single most important thing you can do* to protect yourself from heart disease. Your risk starts to go down as soon as you quit. Talk to your healthcare provider about a smoking cessation program.

Have your blood pressure checked regularly: If you have high blood pressure, do whatever your healthcare provider recommends to bring it down. High blood

pressure significantly increases your risk for coronary heart disease. It also greatly increases your risk for stroke. If you have high blood pressure, treating it properly can greatly reduce your risk for both heart attack and stroke.

Exercise regularly: Regular exercise (ideally, at least 30 minutes most days of the week) is good for your health. Not only does it help prevent coronary heart disease; it also helps prevent osteoporosis, high blood pressure, and diabetes. If you plan to begin a vigorous physical activity program, you should consult your healthcare provider to be sure you don't have any health problems that might get worse if you exercise.

Eat a healthy diet: Maintaining a healthy diet is important in preventing coronary heart disease. Try to eat at least five servings a day of fruits and vegetables. Increasing your intake of fruits, vegetables, and grains and reducing your intake of foods that are high in cholesterol, fat, and salt is one of the best ways to prevent heart disease.

What about alcohol? You may have heard that drinking alcohol can prevent heart disease. Some studies do show lower rates of heart disease among people who have one drink a day (one drink = 12 oz. of beer, 4 oz. of wine, or 1.5 oz. of liquor). However, many health problems are related to excessive alcohol consumption. We do not recommend that all women drink alcohol regularly or that women who do not currently drink begin to do so.

Breast Cancer

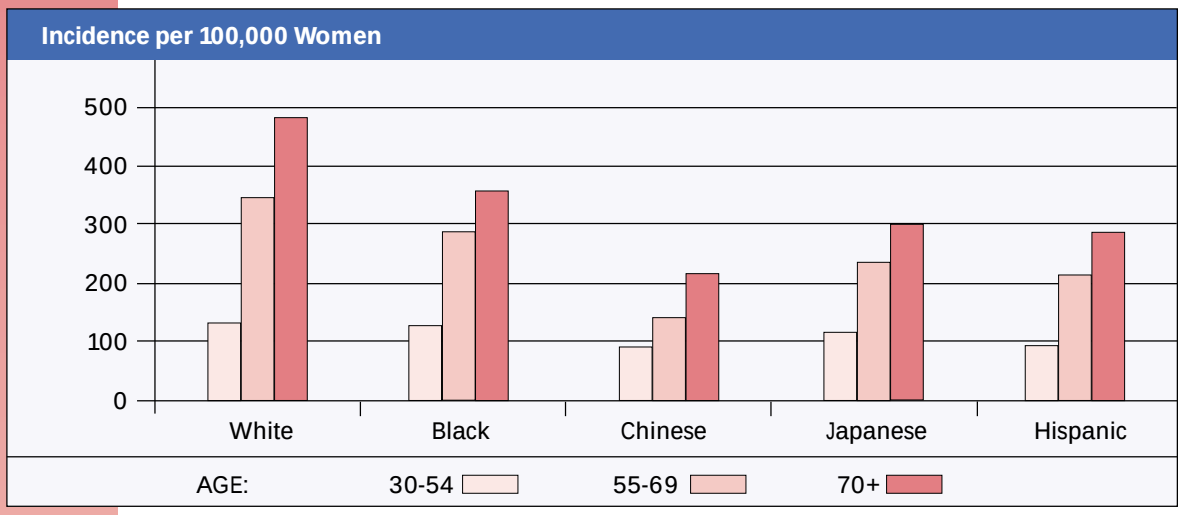
What is breast cancer? Breast cancer is a disease caused by

uncontrolled growth of abnormal cells in the breast tissue. One or more risk factors acting together over a lifetime can trigger growth of these abnormal cells. Breast cancer is typically slow-growing and can take many years to develop.

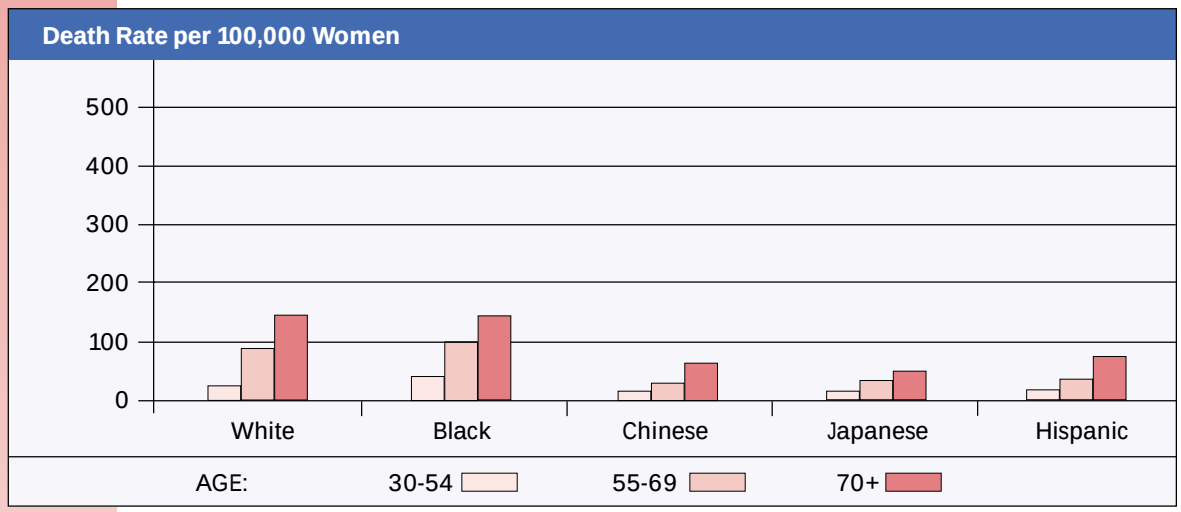
Breast cancer is the most common cancer among women in the United States and the second leading cause of cancer death (lung cancer kills more women than breast cancer). Breast cancer is not the leading cause of cancer death because, although more women *get* breast cancer than lung cancer, *more women also survive it*. Breast cancer is the leading cause of cancer death among women who do not smoke. One out of every nine American women (11%) is expected to develop breast cancer at sometime during her life. A woman's risk of developing breast cancer increases with age, until around age 75, when the risk levels off. The two charts on page 24 show (1) the rate of women, out of 100,000 women, diagnosed with breast cancer during a 5-year period and (2) breast cancer deaths for U.S. women during the same period. Comparing these two charts shows the difference in the number of women who get breast cancer (incidence) and the number of women who die from it.

Breast cancer can be detected through breast self-exams and routine cancer screening, which includes both mammography and exams by a healthcare professional.

Breast cancer incidence for women, by age and race, United States, 1988–1992



Breast cancer death rates for women, by age and race, United States, 1988–1992



The best defense against breast cancer is early detection.

What happens if you get breast cancer? Breast cancer can be detected through breast self-exams and routine cancer screening, which includes both mammography (special X-rays of the breast) and exams by a healthcare professional. The earlier breast cancer is detected, the greater the chance of survival. This is because small tumors, detected at an early stage, can be treated before they spread to vital organs. Treatments for women with breast cancer include lumpectomy (removal of the tumor), hormonal therapy, chemotherapy, radiation therapy, and removal of the breast (mastectomy). Most women with breast cancer survive their illness. Overall, 84% of white women, 69% of black women, and 70% of Hispanic women survive more than 5 years after being diagnosed with breast cancer. We don't now know the percentage of Asian women who survive more than 5 years.

How likely are you to get breast cancer? Despite intense research efforts, few risk factors have been found that predict which women are at high risk for breast cancer. Many women who develop cancer have none of the known risk factors.

However, if you have *any* of the following, you are considered at *high* risk—that is, two to four times more likely to develop breast cancer than women without these factors:

- A first-degree relative (mother, sister, or daughter) diagnosed with breast cancer before age 50
- Previous breast cancer
- Abnormal (atypical) breast tissue that, after a biopsy, is diagnosed as benign breast disease (having been told—without a biopsy—that you have "fibrocystic breasts" does not increase your risk)

In addition to the risk factors listed above, increasing age is one of the biggest known risk factors for breast cancer. As you age, your risk gradually increases (see graph on page 15).

You are at *medium* risk of breast cancer (about one-and-a-half times as high as women without these risk factors) if you have a first-degree relative (mother, sister, daughter) diagnosed with breast cancer *after age 50*, or if you have *two or more* of the following risk factors:

- Aunt or grandmother with history of breast cancer
- History of primary cancer of the uterus or ovary
- First menstruation before age 11
- Menopause after age 54
- No children or birth of first child after age 30
- Never having breast-fed

The risk factors listed above predict only about 55% of all breast cancers. Because of this, all women should follow their healthcare providers' recommended schedules for breast cancer screening (breast self-exam, breast exams by professionals, and mammography). *The best defense against breast cancer is early detection.* If you have none of these risk factors, your risk of breast cancer is low, but your risk will still continue to increase with age.

The effect of HRT on breast cancer development: Scientists are uncertain about the evidence linking HRT to increased risk of breast cancer. They don't know for sure—if at all—how much HRT increases breast cancer risk. However, when many studies are combined, the results show that breast cancer is increased among women who have been using HRT for 5 or more years. This increase in breast cancer risk seems to occur only in women of low or moderate weight. Heavier women do not appear to be at increased risk.

Alternatives for prevention and management of breast cancer: Because most risk factors for breast cancer cannot be changed (i.e., age at first menstruation or at menopause), the best strategy is to focus on early detection. Perform monthly breast self-exams and have routine mammography and a yearly breast examination by a healthcare provider. Some studies have shown that exercising regularly and eating a diet that is low in saturated fats may decrease a woman's risk of developing breast cancer, but these findings have not been consistent. However, since exercising and eating low-fat, high-fiber foods (like fruits and vegetables) have many health benefits, it makes sense to adopt these behaviors.

I'm pretty much against putting anything in my body that's not going to be there just naturally. And when I went through menopause I decided I would see if I could get through this without any estrogen replacement. And, indeed, I had very mild symptoms when I went through menopause.

Putting It All Together

Now that you have reviewed this workbook, you can look through your worksheets and summarize the advantages and disadvantages of HRT:

Assessing your risks, preferences, and the advantages and disadvantages of HRT:
First, summarize your personal risk assessments here:

Risk Assessments	My Personal Risk Is :		
How did you rate your risk for?			
Osteoporosis (page 18)	**low**	**medium**	**high**
Coronary heart disease (page 22)	**low**	**medium**	**high**
Breast cancer (page 25)	**low**	**medium**	**high**

Now, summarize your personal preferences and attitudes about the risks and benefits of HRT by using the following forms adapted from Sadja Greenwood's book, *Menopause Naturally.*

Advantages of HRT	How Important Is This to Me?			
	Not At All Important			**Very Important**
Decreases hot flashes	1	2	3	4
Decreases night sweats and/or insomnia	1	2	3	4
Eliminates vaginal soreness	1	2	3	4
Reduces risk of broken bones	1	2	3	4
Possibly reduces risk of heart disease	1	2	3	4

Disdvantages	How Important Is This to Me?			
	Very Important			**Not At All Important**
May cause monthly bleeding or irregular bleeding	1	2	3	4
Possibly increases risk of breast cancer	1	2	3	4
Increases risk of gallbladder disease (particularly gallstones that may require surgery)	1	2	3	4
Possibly increases growth of uterine fibroids	1	2	3	4
May cause breast tenderness or enlargement	1	2	3	4
Requires taking pills most days or every day	1	2	3	4
Increases risk of blood clots in veins or arteries	1	2	3	4
Treats a natural physical process as if it were an illness	1	2	3	4

If most of your answers are 1 or 2, you are less likely to prefer or benefit from HRT.

← Less likely to prefer or benefit from HRT

More likely to prefer or benefit from HRT →

We hope this workbook has—

- Provided answers to some of your questions about HRT.
- Helped you think about whether HRT would be a good choice for you.
- Helped you prepare to have a meaningful discussion with your healthcare provider about HRT and other issues related to menopause.

Your provider may be a family practice doctor, internist, gynecologist, nurse practitioner, or physician assistant. The suggestions and ideas that follow may help prepare you to have a productive and successful conversation with your healthcare provider.

What is a meaningful discussion? A meaningful discussion of HRT is one in which you have an opportunity to—

A Ask all your questions.
B Obtain answers to your questions in terms you understand.
C Express your preferences.
D Receive information or advice that helps you make a decision.
E Share your beliefs, expectations, and concerns about HRT.
F Form a plan of action with your healthcare provider at the end of the discussion. This could be a plan about whether to use HRT. Or you might list specific actions that you and your healthcare provider will take to decrease your risk for a disease such as osteoporosis, or you may simply plan to revisit your HRT decision in a year.

Things you can do to help make the discussion with your provider go well. It is sometimes easy to get distracted, to forget to ask questions, or to bring up several issues that you want to discuss when visiting your healthcare provider. If you have many questions or issues to discuss, you might try making an appointment with your provider just to talk about HRT. The strategies listed below may help to have a successful visit:

A If you make a special appointment to discuss HRT, explain the purpose of the visit when scheduling.
B Use your appointment time wisely. Appointments rarely seem long enough, so be efficient and assertive in your use of time. Save friendly conversation for the end of your appointment, if there is time.
C At the beginning of the appointment, let your nurse or healthcare provider know the purpose of your visit. For example, you might say, "Hi Dr. Smith, I came in today because I think I'm going through menopause and I want to talk about it. I have three things I'm wondering about." If discussing HRT is not the main purpose of your visit but you want to bring it up, be sure to mention—at the beginning of your visit—that you would like to leave some time to talk about it.

(Additional strategies are on the next page.)

After reading this workbook, think about your personal preferences for taking HRT.

D Write down your questions and bring this list to your appointment. To make sure you'll have time to ask the questions that are most important to you, order your questions from most- to least-important.

E Take any materials that you have filled out in this workbook (such as risk-factor profiles) with you to your appointment.

F After reading this workbook, think about your personal preferences for taking HRT. For example, are you willing to take hormones for a long time to increase your chances of preventing osteoporosis, or are you simply interested in short-term therapy to relieve menopausal symptoms? Be sure to voice your preferences when you are talking with your provider about HRT.

G Practice or discuss your questions with a friend to help prepare for the discussion with your provider. This may also help you clarify what is really most important to you.

H If you do not get all the answers you need, ask your provider for a follow-up telephone call to discuss your questions, or schedule a second visit.

I'd very often have to make presentations and do things publicly, and I found it was pretty necessary for me to get the hot flashes under control, and so I chose to go on estrogen therapy, but I think it's purely an individual thing. I think you should read and research, and talk to more than one doctor, and do all the research you can, and then make your own decision about it.

What about unanswered questions? Questions may go unanswered for two reasons besides lack of time in the appointment.

First, as you can see beginning on page 10, many valid questions about the effects of HRT, and about various strategies for getting through menopause, are still unanswered. So don't expect definitive answers to all of your questions.

Second, it is important to realize that your provider may not know the answer to all of your questions. Remember that there are many helpful sources you can use to find up-to-date discussions of questions that your provider may not have been able to answer. (See pages 33 and 34 for a list of resources.)

How your healthcare provider can help you make a decision about HRT that is right for you: We encourage you to take time to discuss HRT with your healthcare provider. You might want to jot down your questions here. Sometimes it's hard to find time to discuss these issues during a regular visit with your healthcare provider. You may want to schedule a special visit for this purpose. At this visit you can show your provider what you have learned about your unique risks and preferences.

Your questions and your healthcare provider's responses—

Your Questions:	What Your Healthcare Provider Said:
1.	
2.	
3.	
4.	
5.	

How Other Women Have Taken the First Steps in Making Decisions About Whether to Take HRT

The stories of three different women are

summarized here. Each story is unique. Each woman had different concerns, and each made a different choice. After reading these stories, you may want to think about your own story. What are the most important issues for you? What are your preferences? You may even want to write down your own story to help you think through these issues. None of these stories is complete, and your own story may still be evolving.

Example 1: Betsy Smith

Betsy Smith is a 50-year-old woman who is wondering if she should take HRT. In general she dislikes taking pills and prefers other approaches to managing her health when possible. Her periods have been very irregular for about a year and are sometimes heavy. She sees this as a normal process and looks forward to the day when her periods end completely. More troublesome are her hot flashes, which wake her up at night and occasionally interrupt her work in sales. She has been struggling with the fatigue she feels due to her restless nights. Mrs. Smith exercises regularly and has been taking calcium since her mother was diagnosed with osteoporosis, as she wishes to avoid this problem. She is of normal weight for her height, and there is no history of heart disease in her family.

Mrs. Smith raises these issues with her healthcare provider when she goes in for her routine PAP smear. After some discussion, she realizes that she really does not want to take HRT because she is uncomfortable with the potential increase in breast cancer risk. She prefers to go through menopause naturally and re-evaluate her osteoporosis risk again in 5 or 10 years. After evaluating her home and work environments, she decides to buy a small fan for her desk at work and begins dressing in layers so she can change clothes as her temperature fluctuates. She and her husband decide to buy an electric blanket with dual controls, and she keeps a pitcher of ice water on her desk at work and on her bedside table at home.

Example 2: Jane Jones

Jane Jones is a 53-year-old woman with several worries about her health. Her periods stopped 6 months ago. Since that time, she has experienced severe hot flashes. She has also been struggling to control her weight, which contributes to her problems with borderline high blood pressure and elevated cholesterol. She is worried that taking HRT might make her gain even more weight. She rarely exercises or engages in much physical activity.

After reading the HRT workbook, Ms. Jones realizes she has a moderately increased risk for heart disease, and she thinks that HRT might be a good choice for her menopausal symptoms. She already gets regular mammograms. She makes an appointment to talk with her healthcare provider about her concerns, and she takes along the following list of questions:

1. Can I try using HRT for a while to see if it helps my symptoms?
2. Will taking HRT make me gain more weight?
3. What can I do about my risk for heart disease?

Ms. Jones and her healthcare provider discuss her concerns. The provider assures Ms. Jones that HRT does not cause weight gain. The healthcare provider is particularly interested in seeing Ms. Jones increase her level of physical activity, as this would address her concern about weight gain and could help both her blood pressure and her cholesterol. They agree that Ms. Jones will try HRT for 3 months, taking estrogen and progestin every day. Ms. Jones also agrees to schedule regular walking into her day. Her goal is to walk for 30 minutes, at least three times a week. The man she lives with has mentioned several times that he would like to walk more, and she is considering asking him to walk with her when they get home from work. Ms. Jones also decides to get off the bus four stops earlier on the way home, to get in a few more minutes of exercise. She schedules a 3-month return visit to discuss her progress.

One of my main concerns is, sure, you can take the hormones just to get you through hot flashes till that stops. But as soon as you stop… everything's going to come back just like it was before. So that means, am I going to have to take this the rest of my life? If it's the only solution to keep from being a little old bent-over lady, I'll do hormones rather than go through that, but I want to try and see if there are other things that might make a difference first.

Example 3: Marilyn Ishimoto

Marilyn Ishimoto is a small, slender, 63-year-old woman in good health. She had a hysterectomy at the age of 40. Her ovaries were not removed with her uterus. At about age 55 she began having mild hot flashes, which subsided within a year. She has never taken hormones. Her main concern is that intercourse has become increasingly painful for her over the past several years, and she has had several vaginal infections. She is also curious about her personal risk of heart disease because of her family history. Her father had a heart attack at the age of 49, and her mother died of heart disease at the age of 86.

You may even want to write down your own story to help you think through these issues.

Mrs. Ishimoto has not seen her healthcare provider in 4 or 5 years. She and her husband already eat a low-fat diet, but she smokes two packs of cigarettes a day and has long wished she could quit. She thinks maybe she should be using HRT, but she hates taking pills. After reading the workbook, she buys an over-the-counter, water-soluble vaginal lubricant but finds that intercourse continues to be painful. She is not sure that she has enough information to evaluate her risk of heart disease. She makes an appointment to see her healthcare provider and writes down the following list of questions and concerns:

1. Can I use vaginal estrogen cream to help relieve my pain with intercourse?
2. What is available to help me quit smoking?
3. I want to know my risk for heart disease. In connection with this, I'd like to know my blood pressure and my blood cholesterol levels.

Mrs. Ishimoto calls her healthcare provider and says she would like her blood-test results to be available at the time of her appointment. She learns that her cholesterol and blood pressure are both normal. After talking things over with her healthcare provider, she decides on two courses of action. Her provider gives her a prescription for vaginal estrogen cream, which she will use three times a week, along with the vaginal lubricant she bought. She also makes a firm commitment to give up cigarettes, because smoking is her strongest risk factor for heart disease. She contacts a smoking cessation program offered by her healthcare plan.

Books About Menopause and Women's Health

The following list was abstracted from information provided by the **North American Menopause Society** (NAMS) and is reprinted here with their permission. For their complete list of references, see their Web site at: http://www.menopause.org/consedu/reading.html#A

Menopause Guidebook
The North American Menopause Society, P.O. Box 94527, Cleveland, OH 44101-4527
This 50-page guidebook provides current, unbiased information on a wide variety of menopause issues—including perimenopausal changes, advice about postmenopausal health, and menopause treatment options. Consumers can receive the Menopause Guidebook *in the Society's MenoPak. This packet is free ($5 shipping/handling fee). Call toll-free 1-800-774-5342, or write and include a check or money order.*
Also available from NAMS is the new Induced Menopause Guidebook, *a 28-page resource written especially for women experiencing early menopause from a medical intervention. This booklet should be read with the* Menopause Guidebook. *It can be ordered directly from NAMS by writing to the post office box address above; enclose a check for $8.00 ($5.00 plus $3.00 shipping/handling), made payable to NAMS.*

The Complete Book of Menopause: Every Woman's Guide to Good Health
Carol Landau, PhD, Michele G. Cyr, MD, and Anne W. Moulton, MD
New York, NY: Perigee & Berkley, 1995
A comprehensive treatment of menopause as a normal stage of life. The inclusive tone is consistently supportive and pays special attention to the emotional and social aspects of midlife.

Could It Be . . . Perimenopause?
Steven R. Goldstein, MD, and Laurie Ashner
New York, NY: Little Brown, 1998
This chatty, informal book presents a New York gynecologist's personal approach to helping women through the perimenopause.

Menopause
Isaac Schiff, MD, with Ann B. Parson
New York, NY: Times Books (Random House Div.), 1996 (paperback)
In Canada: Toronto, ON: Random House of Canada Limited, 1996 (paperback)
This comprehensive and easy-to-read book guides readers through menopause and its effects, HRT, and alternatives.

Menopause, Me and You: The Sound of Women Pausing
Ann M. Voda, RN, PhD
Binghampton, NY: Haworth Press, 1997
This paperback book, written by a pioneer in women's health research, has a wonderful mixture of personal advice and anecdotes, combined with excellent discussion of reproductive aging and the menopause. It's especially good for women just approaching the menopause transition.

Menopause, Naturally: Preparing for the Second Half of Life
Sadja Greenwood, MD
Volcano, CA; Volcano Press, 1996 (paperback)
This updated paperback book suggests medical intervention only when the woman herself decides that it's needed and gives many useful suggestions for self-care. Also available in Spanish (published in 1997 by Panorama Mexico).

150 Most-Asked Questions About Menopause: What Women Really Want to Know
Ruth S. Jacobowitz
New York, NY: Morrow, 1996 (paperback)
The result of 35,000 questionnaires, this consumer-oriented book by an award-winning medical writer and lecturer provides answers to the most common questions about menopause in an accessible Q&A format. Translated into 16 languages.

No More Hot Flashes...and Even More Good News
Penny Wise Budoff, MD
New York, NY: Warner Books, 1998
This carefully written book by a well-respected gynecologist is a good reference for women seeking answers on a variety of health topics, including not only hot flashes but also musculoskeletal pain, osteoporosis, vitamins and minerals, urinary problems, cancer, and hysterectomy.

The PMS & Perimenopause Sourcebook: A Guide to the Emotional, Mental and Physical Patterns of a Woman's Life
Lori A. Futterman, RN, PhD, and John E. Jones, PhD
Los Angeles, CA: Lowell House, 1997
This book presents a thorough discussion of premenstrual syndrome (PMS) and the perimenopause transition that can help women in their 30s, 40s, and beyond take personal responsibility for their health through these physiologic and psychologic changes.

Transformation Through Menopause
Marian Van Eyk McCain
New York, NY: Bergin & Garvey, 1991
Considered mandatory reading by many, this timeless book does not deal with the physical changes and physiologic effects associated with menopause, but rather works through issues such as self-image and empowerment.

Understanding Menopause
Janine O'Leary Cobb
New York, NY: Plume, 1993
In Canada: Toronto, ON: Key Porter, 1996 (rev. ed.)
A bestseller in Canada since 1988.

The Canadian author has spent more than a decade gathering information about the menopause experience from thousands of women throughout the world who subscribe to the newsletter she founded, A Friend Indeed.

Women of the 14th Moon: Writings on Menopause
Dena Taylor and Amber Coverdale Sumrall (eds.)
Capitola, CA: The Crossing Press, 1991
This anthology of women's experiences of menopause provides a wide range of perspectives and a surprising amount of basic information about how to cope. Great bedtime reading.

Menopause: A New Beginning
The North American Menopause Society, P.O. Box 94527, Cleveland, OH 44101-4527
This consumer booklet presents the key points about menopause very clearly. It is a proven communication tool for those with a 5th-grade reading level, but anyone would enjoy and benefit from this resource. Now available in a cultural translation for women who read Spanish.

Books About Osteoporosis

Boning Up on Osteoporosis: A Guide to Prevention and Treatment
National Osteoporosis Foundation
1150 17th Street, NW, Suite 500
Washington, DC 20036-4603
202-223-2226
This comprehensive 70-page guide is available for $3. Individual copies of a smaller booklet, Menopause and Osteoporosis, *are available free. You may also join the organization ($15 annual dues) and receive both publications free, among other benefits.*

Stand Tall: Every Woman's Guide to Preventing and Treating Osteoporosis
Morris Notelovitz, MD, PhD, with Marsha Ware, MD, and Diana Tonnessen (Physical Therapy Consultant: Sara Meeks, PT, GCS)
Gainesville, FL: Triad Publishing, 1998 (2nd ed.)
This is an excellent current, comprehensive discussion that is well balanced and well referenced. Every aspect about the fragile bone disease is covered.

Books About General Health

Fit Over Forty: A Revolutionary Plan to Achieve Lifelong Physical and Spiritual Health and Well-being
James M. Rippe, MD
New York, NY: William Morrow and Company, 1996
Based on a landmark study that established the first-ever standards for persons over forty, this book (and the Quill paperback published in 1997) offer both women and men excellent, fun-to-read advice as well as ten self-tests for evaluating one's personal fitness level.

Our Bodies, Ourselves for the New Century
The Boston Women's Health Book Collective
New York, NY: Touchstone, 1998
Originally branded as radical and banned from library shelves, Our Bodies Ourselves*—the mother of modern-day women's health and wellness guides—has become nearly 30 years later a mainstream institution and bestseller worldwide. Here is the latest revision, still maintaining its strong feminist viewpoint and continuing to heighten awareness that it's OK to question and demand information and choices. Although it offers more than menopause-related information within its 700-plus pages, many believe it is "must" reading for any woman interested in learning more about her health.*

What Every Woman Should Know: Staying Healthy After 40
Lila E. Nachtigall, MD, Robert D. Nachtigall, MD, and Joan Rattner Heilman
New York, NY: Warner Books, 1996
Covering far more than menopause-related issues, this easy-to-read book emphasizes how women can preserve wellness through perimenopause and beyond.

Answers : Myths & Realities About Women's Health and HRT

1. **TRUE.** Nearly half of all women aged 50 will someday have a broken bone due to osteoporosis (fragile bones).
2. **TRUE.** The most common cause of death for women aged 65 and older is heart disease.
3. **FALSE.** More women die of lung cancer than breast cancer.
4. **TRUE.** HRT is one of *many* ways a woman can reduce her risk of fracture.
5. **UNKNOWN.** Though women who use HRT may reduce their risk of heart disease, more research is needed before we can say for sure.
6. **TRUE.** Women can lower their risk of fracture by taking HRT for many years.
7. **UNKNOWN.** Women who use HRT for 5 years or more may have an increased risk for breast cancer, but more research is needed before we can say for sure.
8. **UNKNOWN.** Almost none of the "natural" products on the market today for treating menopausal problems have been compared to regular HRT in studies. Studies on soy have had mixed findings—some have found that soy relieved hot flashes, and some have not. Although some herbs are currently being studied, the results are not in yet.