EDITORIAL

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OBG MANAGEMENT

Overgeneralizing WHI: What are they thinking?

A 44-year-old woman is bothered by hot flashes and sleep disturbance. She is a healthy nonsmoker. Five years earlier, her gynecologist prescribed oral contraceptives (OCs) upon diagnosis of premature ovarian failure (POF). She took OCs until last year, when her primary care physician told her that she should stop because they "might cause breast cancer," noting that the Women's Health Initiative (WHI) had definitively shown that estrogen-progestin therapy was linked to breast cancer in postmenopausal women. Confused and worried, she stopped OCs. She soon developed hot flashes and sleep disturbance, and wonders what she should do. She is seeking a second opinion.

Some doctors, especially internists, overgeneralize and apply WHI findings to all menopausal women, regardless of age and clinical situation. Many clinicians also assume that findings seen with 1 estrogen-progestin formulation apply to all estrogen and estrogen-progestin formulations. Both tendencies are scientifically unsound, and may compromise care. The preponderance of evidence suggests that symptomatic women with POF should not be denied estrogen-progestin treatment.

In the WHI, the average age of women entering the study was 63 years. Treatment of these women for 5 years with 1 specific combination of estrogen and progestin resulted in a small increase in the risk of breast cancer and coronary heart disease.[1] In the same study, treatment with an estrogen-only preparation for 7 years did not increase the risk of breast cancer or coronary heart disease.

These data are not generalizable to women under 52 years of age, at low risk of heart disease, and who, had they not become prematurely menopausal, would have continued to produce relatively large amounts of estrogen and progestin until menopause, at about age 52. Treatment with estrogen-progestin probably does not markedly increase their lifetime exposure to estrogen and progesterone above what they would have experienced with normal ovarian function. Estrogen-progestin therapy is unlikely to significantly increase their risk of breast cancer or coronary heart disease above the baseline risk for similarly aged women without premature ovarian failure.

Withholding estrogen-progestin from healthy, nonsmoking young women with hot flashes and a history of POF does not properly balance the benefits and risks and should not become the standard of care.

This patient's gynecologist discussed the risks and benefits of estrogen-progestin, and dose and route of therapy options. After a bone density test revealed osteoporosis, she decided to restart estrogen-progestin. Her hot flashes ceased and her sleep improved. Her doctor advised follow-up densitometry in 1 to 2 years.

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REFERENCE

1. Writing Group for the Women's Health Initiative Randomized Controlled Trial. Risks and benefits of estrogen plus progestin in healthy postmenopausal women. *JAMA.* 2002;288:321–323.