

Revisiting the WHI

Is there a role for hormone therapy post-menopause?

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Objectives:

At the end of this presentation, participants will be able to:

- Explain the major limitations of the WHI, particularly with respect to patients earlier in their menopause.
- Identify patients who might significantly benefit from HRT to treat their menopausal symptoms.
- Discuss with patients the important potential pros and cons of HRT for the treatment of menopausal symptoms.
- Utilize formulations of HRT that are lower risk than those used in the majority of patients in the WHI.

Disclosures

- Abbott: Ad board

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 - 2. Identify patients who might significantly benefit from HRT to treat their menopausal symptoms
 - 3. Discuss with patients the important potential pros and cons of HRT for the treatment of menopausal symptoms
 - 4. Utilize formulations of HRT that are potentially lower risk than those used in the WHI

Key Points

- Vasomotor symptoms occur in up to 80% of menopausal women
 - Mean duration is 7-9 years
- HRT remains the most effective treatment available for these symptoms
 - Reduced symptom frequency by approximately 75% in both WHI trials
- Despite this, HRT usage dropped dramatically after WHI trials were published in 2002 and 2004 despite two key limitations:
 - Mean age at study entry was 63 years
 - Only 33% of the women in E+P trial and 30% in E alone trial were between the ages of 50-59 years

Key Points II

- When looking at the 50-59 age cohorts, the risk/benefit calculation in both arms of the study had some notable differences compared to each study population as a whole
 - Potential risks in women less than 60 include rare risk of breast CA (in E+P), endometrial hyperplasia and endometrial CA (if inadequately opposed estrogen), VTE and gall bladder disease
- It is therefore very important to consider an individual's baseline health history, age, severity of symptoms and time since the onset of menopause when discussing possible HRT for symptom relief

Key Points III

1. WHI only used CEE (conjugated equine estrogen) and medroxyprogesterone (synthetic progestin) were used as these were the common formulations when the trials were being designed in 1991/1992
2. Bioidentical hormones have been commercially available for over 20 years in Canada
 1. 17-beta Estradiol (tablets, patches, gel, vaginal tablets/rings)
 2. Micronized progesterone (tablets)
 3. Studies have suggested that transdermal estradiol (as compared to oral) and micronized progesterone (as compared to synthetic progestins) may not increase the risk of venous thromboembolism
 - In observational studies, no direct RCT comparative data

How do I prescribe Systemic HRT

1. Bioidentical 17-beta estradiol, preferably transdermally
 - Consider severity of patient symptoms and response to therapy when choosing a dose or making dose adjustments
 - No need for lab investigations to determine dosing
2. Micronized progesterone when intact uterus
 - Cyclic progesterone 200mg daily x 12-14 days each month or
 - Continuous progesterone 100mg daily
3. Reassess need for HRT every 3-5 years with trials of gradual estradiol dose reduction, if tolerated

Final Key Points

- HRT more than 10 years after menopause or in those over age 60 have higher risks
 - If considering continuing HRT in this population for persistent significant symptoms, very important to have clear discussion about risks/benefits so patient can make an informed decision
 - If continues, important to continue to periodically reassess need for therapy
- The Menopause Society: www.menopause.org
 - An excellent resource for patients and practitioners