Section of General Practice

President E M Shipsey MRCGP

Meeting 16 February 1977

Hormone Replacement Therapy and the General Practitioner [*Report*]

Today, the media keeps the public well informed about the value of hormone replacement therapy (HRT) for the relief of menopausal symptoms, the incidence of which has been estimated as varying widely between 10% and 100%. Dr Mary Hollington, in a retrospective survey questioned postmenopausal patients in her practice and found that 25% were unable to recall menopausal symptoms, and a further 55% considered it a bothersome time of their life, but not of sufficient severity to seek medical assistance. There were also 20% of women who, finding the menopausal symptoms incapacitating, had sought medical help. These tended to be the 'fat-folder' patients recognized as constant attenders and she wondered whether their difficulties could be attributed to an inadequate personality rather than a hormonal imbalance. (During the discussion mention was made of the curious occupational incidence of menopausal symptoms being high among semiskilled textile workers and low among clerical workers.)

The human species is unique in having a menopause, i.e. an end to reproductive life, but this is a relatively modern experience. Few women lived long enough to experience the menopause in the seventeenth century, as only 28% of women reached the age of 50, while a mere 5% attained 75 years. By 1970 the expectation of life for women had risen so markedly that 95% reached the age of 50 and 55% reached 75 years. Indeed, in Britain today, 30% of women are over 50 years of age.

The new vista opened by HRT needs careful evaluation in terms of the medical advantages and disadvantages and consideration of the financial burden it could impose in the search for eternal youth. There is a danger that the liberated woman of today, after 35 years on oral contraception and 35 years on HRT, may become the over-medicated woman of the future. Nor must it be forgotten that it is the women themselves who set the pace.

The possibility of an increase in the incidence of endometrial carcinoma, breast changes, alteration in blood lipids and cholesterol, increased gall bladder disease and weight changes are all factors to be included on the adverse side of the balance sheet. Factors on the other side include the relief of menopausal symptoms, improved psychological outlook, reduction in incidence of ischæmic heart disease and osteoporosis (responsible for increased fractures of the neck of the femur, crushed vertebræ and Colles fractures), and also the saving on the cost of hospitilization for curettages and breast biopsies. The cost to the National Health Service of giving synthetic œstrogens was estimated by Dr Jean Ginsburg at about £2 million annually, compared with the cost of natural œstrogens at £80 million annually. However, she did emphasize that the so called 'natural' œstrogens in common use contained œstradiol as their main component, whereas the main œstrogen production in the postmenopausal woman is œstrone, a weaker œstrogen.

The menopausal symptoms which respond dramatically to HRT include hot flushes and night sweats; vaginal atrophy which causes loss of libido; urethral syndrome and pruritus; pains in muscles, joints and bones; and the psychological symptoms of fatigue, insomnia, irritability, depression, headaches, palpitations and vertigo. In the subsequent discussion the possibility that loss of memory does not improve on œstrogens was questioned and assurance given that ongoing double blind trials suggested that the mental tonic effect of œstrogens was confirmed and loss of memory was indeed restored.

The hormonal changes occurring at the time of ovarian regression include an altered steroid balance and an increase in gonadotrophin hormones. When ovarian function has been abruptly curtailed by oophorectomy it is found that within two weeks there is a marked rise in the levels of follicle stimulating hormones. Among the synthetic œstrogen preparations in current use are those which include sedatives (these are not advised as it is

preferable to titrate the selected sedative for each individual and reduce it as early as possible); those combined with androgens, which are particularly helpful in restoring loss of libido; and œstrogens with progestogens, useful because they cause endometrial bleeding at the end of each three-week course and thus afford protection against the possible development of endometrial carcinoma. These were not needed by those who had an artificial menopause for they can have continuous œstrogen therapy. Œstrogen cream, applied locally, is helpful for the relief of vaginal symptoms. Œstrogens are contraindicated for those with a history of thrombosis, embolism or phlebitis and those with hypertension. In discussion, it was suggested that œstrogens should be used with care in those already addicted to tranquillizers and/or antidepressants. The menopause is a period of life when the incidence of other hormonal disturbances and of carcinoma is raised, and a time when differential diagnosis needs to be considered for all apparently trivial symptoms. In the discussion it was emphasized that whereas œstrogens were the hormones of choice in the menopause, progesterone was the preferred hormone in women suffering from an increase of premenstrual syndrome in the premenopausal era and for those who had an artificial menopause and were still suffering from symptoms at the times of their missed menstruation.

Mrs Jean Robinson, of the Patients Association, stated that letters about menopausal patients represent a heavy load in her daily postbag. The letters told of the years of misery and 'absolute hell' and suggested that too few doctors were aware of the severity and duration of menopausal symptoms nor of the full effects resulting from mental confusion, which can lead to episodes of shoplifting or of sexual difficulties with their effect of marital harmony. The public needs to be educated to appreciate that all these menopausal symptoms can be eased and at the same time the medical profession requires more training in the recognition and treatment of menopausal symptoms.

In discussing menopausal clinics the meeting was unanimous that the prime need is for more research into menopausal symptoms, the biochemical and hormonal changes, and for the conduct of controlled trials. Such clinics are of value to the pharmaceutical industry in its search for new products. Women should be free to attend without reference to their general practitioner.

KATHARINA DALTON
Vice-President
Section of General Practice

Meeting 20 October 1976

Dr J G R Clarke delivered his Valedictory Address, entitled **We Run Because We Must: A Look at Some of the Factors Influencing One's Career**

Meeting 15 December 1976

The subject was **Europe and the Future of Primary Care,** and the main speakers were Dr E Gambrill (*Crawley, Sussex*), Dr E V Kuenssberg (*Edinburgh*), and Dr R Glyn Thomas (*WHO, Copenhagen, Denmark*)