Julia Cormano: In this episode of Motherhood TV, we are fortunate to have Dr. Kathryn McCaulay, clinical professor of obstetrics, gynecology, and reproductive sciences here at UC San Diego Health and the director of the menopause program, to talk with us about hormone therapy for menopause. Dr. McCaulay is who I turn to with all of my most complicated questions about menopause hormone therapy, and I'm so glad she's here. Dr. McCaulay, would you tell us what is menopause, and what is hormone therapy?

Dr. Kathryn McCaulay: Menopause is the cessation of menstrual cycles. It's the end of the reproductive time period for women. It's defined as a clinical diagnosis defined as 12 consecutive months without a menstrual period in a woman who's in the appropriate age range for menopause, which is anywhere from over 40 to late 50s, but typically between about 45-58, with the average age being around 51-52 years old. Twelve consecutive months without a period, that defines that we say that one has then reached the menopause. After that time point, we refer to it as postmenopause.

Julia Cormano: What is hormone therapy?

Dr. Kathryn McCaulay: Hormone therapy is using estrogen products or end progesterone products, depending on whether or not progesterone is needed. If one has had a hysterectomy, they don't need to use the progesterone. But it's basically a formulation of estrogen. Different types. We typically use estradiol, which is structurally similar to what the ovary produces in different formulations. It can be in pill form, transdermal patch or transdermal gel form, even a vaginal ring form. Progesterone is typically oral, but we do have some progesterone- and estrogen-containing patches with different versions of progesterone.

Julia Cormano: When should a patient be considering hormone therapy for menopause?

Dr. Kathryn McCaulay: A woman who is either in the menopause transition or has now stopped menstruating, she's reached menopause and is having bothersome vasomotor symptoms, that's hot flashes and night sweats. That's our primary indication for using hormone therapy. Treating those symptoms, hot flashes are very common. It can happen up to 75-85% of women could experience hot flashes or night sweats or both. Those are the women who I think will most likely be seeking treatment for those types of disruptive symptoms, particularly when the night sweats start disrupting sleep. Women can come in for other reasons, too, sometimes related to the hot flashes. Depression has been related to hot flashes, sleep disturbances, as I mentioned, mood changes, brain fog, fatigue. There can be a whole constellation of symptoms. But, primary indication is to treat Bs and motor symptoms. Another indication is to prevent osteoporosis. Some women who are at particularly high risk for osteoporosis may be seeking guidance regarding using hormone therapy to prevent osteoporosis.

Julia Cormano: I'm so glad you brought that up. I feel like we hear frequently from patients the idea or the question, should I be taking hormone therapy just for general health as I transition into postmenopause? What are your thoughts on that?

Dr. Kathryn McCaulay: We really individualize our recommendations to women. As of currently, the current guidelines, the national guidelines for prescribing menopausal hormotherapy, don't really highlight using hormone therapy for disease prevention. For osteoporosis, there can be an exception there, I think, because it is one of the FDA-approved indications for using certain estrogens to prevent osteoporosis. But primarily for symptom treatment is what we're recommending. Though there is a lot of talk about, possibly, should we be using hormone therapy to prevent heart disease, to prevent dementia? But I don't think we're really there yet with all the clinical trials to support that.

Julia Cormano: Got it. What are some of the risks that a patient should consider before starting hormone therapy?

Dr. Kathryn McCaulay: Risks are, for the most part, low, and that's why the FDA has recently taken the black box warning off of hormone therapy because in the younger symptomatic woman who's otherwise healthy, who doesn't have any contraindications to using hormone therapy, the risks are really quite low. There is a concern based on data from the Women's Health Initiative trial and other studies that there may be a small increase in breast cancer risk, particularly depending on which formulation of hormone therapy you use. But overall, that's not a high risk in a woman who's not at high risk for breast cancer. I would caution a woman who has any contraindications to hormone therapy that she should be looking at nonhormonal treatment options for her vasomotor symptoms. Unfortunately, we have several nonhormonal treatments. The contraindications would be somebody with a history of an estrogen-sensitive cancer, such as breast cancer. A patient with a history of a venous thromboembolism, like a DVT or pulmonary embolism or a stroke, a woman who has active liver disease, and a woman who has undiagnosed vaginal bleeding. You'd want to evaluate that first before starting hormone therapy.

Julia Cormano: That makes sense. If a patient has initiated hormone therapy, how long should they expect to need that hormone therapy? What would your advice be?

Dr. Kathryn McCaulay: It's individualized. Even the menopause society has a statement published that we don't recommend that women just routinely have a stop age, that they have to stop at 65 or they have to stop at 60. Because some women may have hot flashes lifelong. Ten percent of women continue to have hot flashes more than the average duration of 7.5 years. I think it's a case-by-case situation. We don't necessarily tell women all women need to be on it for life, but there are some women who may need to be on it really long term. But most women, in my experience in my practice, may take it for the 10 years during their 50s during the worst part of the menopause transition and then reassess around 60. But it's again going to be individualized.

Julia Cormano: That makes sense. What are things for a patient to consider if they're thinking about stopping hormone therapy?

Dr. Kathryn McCaulay: I think one thing to consider is how they want to stop the hormone therapy. For most patients, if there's no immediate indication, no contraindication that's come up such as breast cancer, those patients obviously would quickly stop the hormone therapy or just abruptly stop, which there's no physical risk to doing that, but there's psychologically, or concern about vasomotor symptoms returning more quickly. Women do get concerned about that. If there's not any immediate need to stop abruptly, I'll usually recommend just a slow wean. Fortunately, we have a variety of doses of estrogen, so we wean down patients to lower dosages over time and see how they do in terms of their hot flashes. But I think return of symptoms is something that women would want to be looking out for. Then also recognizing that for vaginal health, if they're using a very low dose of a vaginal estrogen for, say, vaginal dryness or painful intercourse, that's actually something that can be safely used for life long-term. They can continue on that formulation. That's localized, even if they're stopping their systemic hormone therapy for hot flashes.

Julia Cormano: That makes sense. We're so fortunate to have so many choices to be able to offer patients. Thank you for your expertise today and sharing that with us.

Dr. Kathryn McCaulay: Absolutely.