Preface

Women’s health issues

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Guest Editor

This issue of the Medical Clinics of North America begins the journey into a new era of women’s health and issues critical to the care of women for the present and the future. In recent years, the fields of women’s health and gender-based biology have undergone tremendous change. The advent of clinical trials such as the Heart and Estrogen/progestin Replacement Study (HERS), the Estrogen Replacement and Atherosclerosis Trial (ERA), the Women’s Health Initiative (WHI), and other meta-analyses have radically shifted long-held beliefs and paradigms for the approach and options to the postmenopausal woman [1–8]. Research has consistently and convincingly shown that the combination of estrogen and progestin use, whether for primary or secondary prevention of cardiovascular disease, poses a risk for myocardial infarction, stroke, and death, even in the absence of other risk factors [6].

A randomized trial of estrogen (estradiol valerate) alone did not result in risk reduction in those with cardiovascular disease [5]. Neither estrogen alone nor estrogen in combination with progestin decreased progression of the angiographic lesions of coronary disease [2]. It is important to note that in the WHI trial the risks of adverse cardiovascular outcomes with hormone replacement therapy were not different in women whether or not a prior history of coronary heart disease existed [8]. Hormone use at menopause appeared to be as hazardous as use in older women and led to risk even if women had not previously been hormone users [9]. Earlier observational data that suggested cardiovascular disease benefit with hormone replacement acknowledged
increased stroke risk with estrogen/progestin [10]; an additional randomized trial documents increased stroke risk with hormone replacement therapy [11].

Other areas of assumed benefit of estrogen such as cognitive benefits and global quality of life impact have also been delivered a hard blow. Recent data revealed a higher risk of dementia in women treated with estrogen and progestin in the WHI study, with no benefit in preventing cognitive impairment; in addition, there was no effect on health-related quality of life, which is certainly disappointing [12,13].

These findings point out that results of data not well grounded in randomized controlled trials may lead to widely held preconceived beliefs that may not, in the end, turn out to be supported by more rigorous trials. The results from well-conducted randomized clinical trials are at the top of the hierarchy of evidence, whereas observational data, expert opinion, and case reports have a much higher probability of producing misleading information. This appears to be especially true with hormone replacement, in which so many potential biases may be involved in a woman’s choice to engage in long-term estrogen treatment. Clearly, evidenced-based medicine needs to be incorporated not only into our thought processes but, more importantly, into our shared decision-making with our patients.

What we see in the field of medicine is continued growth of knowledge; however, the willingness to accept, incorporate, and use new information, always questioning suppositions based on the best scientific data available, is far from being a uniform standard. Data should always be our guidepost; we must recognize gaps, flaws, and missing links and ask that they be filled in by information that will facilitate our knowledge and options for the best therapy for our patients.

The need to always consider, reconsider, and change the practice of medicine based on appropriate data cannot end. As James Russell Lowell noted, “The foolish and the dead alone never change their opinions.” The information flow (which becomes torrential at times) will continue to challenge us and provoke discussion; in addition, it may sometimes provoke ire when our long-held beliefs and hopes do not translate into data. We will, in the long run, be judged individually and as a group of professionals by which data we consider and how we act on those data. To ignore information or hope that somehow the mantle of positive findings can be shifted to other formulations or therapeutic agents should not be done in a data vacuum. If nothing more, our eyes and minds must remain open; if we cannot yet bring ourselves to openly embrace change, at least acknowledge the information to ourselves and our patients.

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References


