Hormone Therapy: When to Taper or Stop

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It was one of the few groups that had a higher mortality risk. Have you made it past menopause, or are you going through it now? I'm Dr. Pat McShane, and on the Women's Health Span Voices podcast, I'll guide you through the health challenges of the menopausal years and beyond, guiding the way to thriving in this powerful era of your womanhood.

Hello and welcome. I'm Dr. Pat McShane and I'm delighted to have with me today Dr. Nanette Santoro, who is a long standing colleague and friend and my boss at the moment.

She is a professor at the University of Colorado and the E. Stuart Taylor Chair of OBGYN, as well as the member of the Division of Reproductive Endocrine and Infertility and Reproductive Science.

Dr. Santoro is a well-known, internationally renowned researcher, especially in the area of menopause, which is what we're going to be talking about today.

And she's, besides all that, a wonderful clinician and a good colleague to have around to ask hard questions about difficult patients. So Nanette, great to have you with us.

Thanks so much. Thanks, Pat. You have been seeing clinically for many years menopausal women before and during the menopause transition, as well as some women who are post-menopausal, besides the other endocrine problems that we deal with in our unit on a frequent basis.

And so in addition to that, you've been a researcher in several large national studies funded by the NIH and other major funding agencies. So today we're going to ask you to draw upon both your clinical experience as well as your research knowledge.

I thought we would start with women who have been happy on their hormone replacement. And now the time has come to start thinking about stopping that replacement.

And the first question is, what age do you think that that normally should occur? The age that it should occur really depends on a number of different things.

First of all is when was it started? But one of the biggest factors is duration and also the type of hormones that patient was using. And then that's combined with some of her background risks.

So I can give you the first story I can give you is the generic story.

Vaginal Estrogen for Ongoing Symptoms

So this would be for the Jane average patient of average risk. If a woman is of average risk for breast cancer and has no other health problems, that would make hormones a bad idea for her.

Women that continue them from the onset of menopause up to about age 60. is reasonable. The average duration

of hot flashes is about seven years and for some women it lasts for 10. So usually after about five years on hormone therapy for women that have begun when they are, say, 50 years old, we start trying to wean.

So I'll have a patient say, you know, why don't you try cutting back on those hormones? You may be one of those people who has an earlier dissipation of your hot flashes.

If that's the case, you may not even notice that you've stopped them. There are theoretical benefits for women taking them in their 50s, but those are not proven by randomized trials.

So really the only thing that the patient is doing is A, relieving symptoms and B, increasing her breast cancer risk. That's what we have good data on.

So we want to balance those things. If symptoms aren't there anymore, then there's no reason to increase the risk part of that equation. And this is a woman who has a uterus who's taking estrogen and progesterone.

So at about that point, we'll start to try weaning. Often it doesn't work and we'll just continue to try every year or two. And sometimes my patients will tell me that, you know, I ran out of my prescription for a couple of weeks and we're not stopping this year.

We're just not going to stop. And that's not a terrible thing. I mean, breast cancer risk is a small incremental increase every year. But it does add up such that by the time a woman has been taking estrogen and progestin for 10 years, she has doubled her breast cancer risk.

If she's at lower average risk, that's acceptable to some of my patients because their symptoms are so bad. But if she's at very high risk, sometimes women will have a really pretty unacceptable risk of breast cancer after 10 years.

So we're going to want to stop that sooner. The case is a little bit different for women who've had a hysterectomy. They're taking estrogen only. And what we know from the Women's Health Initiative is that those women do not have an increased breast cancer risk.

And when they took the preparation in the WHI, which is Premarin, they actually had a decreased breast cancer risk that hung on through the whole study.

Finding Menopause Expertise and Second Opinions

From the original report at five or six years after starting, now to 20 years later, they have a lower breast cancer risk and lower breast cancer mortality.

So the risks to them are a slightly higher risk of stroke and possibly a higher risk of blood clots. Those are the women that tend to also have worse hot flashes that last longer.

So for those women, they can really pretty much safely stay on into their 60s as long as they don't develop another problem, such as high blood pressure, which puts them at a higher risk for stroke, or actually get a blood clot, then we just have to stop hormones.

In that group, that was one of the groups that should not be on them forever because between ages 70 and 80, women that were taking hormones in the Women's Health Initiative and who had a hysterectomy and who were taking estrogen only had a higher mortality.

It was one of the few groups that had a higher mortality risk. So after age 70, that really becomes more risky for that patient and we try to get them off.

So again, we'll go through the usual maneuvers, try cutting back on the hormones. How bad are your symptoms? Let's try substituting other meds. And if nothing works, then for some women they will just stay on.

So it sounds like for most people something can be worked out in terms of tapering, gradually discontinuing, and then ultimately stopping. But many people still do have hot flashes after they discontinue, which is the major symptom.

If people are having vaginal symptoms, what is the recommendation at that point? But they're no longer on oral meds.

What SWAN Reveals About Menopause Timing

Yeah, if a woman can withdraw from body-wide estrogen but still has vaginal symptoms, giving topical vaginal estrogen is a pretty safe bet. There's very good data on some of the newer preparations, the tablets.

So we're getting data on the tablets and the inserts. The ring has very good data using what we call mass spectrometry, very accurate estrogen measurements.

And the measurements of estrogen in the bloodstream on women using those methods is very, very little increase. It's not even known if that's biologically significant.

When you look at the long-term outcomes of those women, they seem to be very benign. There are no increased problems. So the risks of things like breast cancer, blood clots, stroke don't seem to apply at all when we're talking about vaginal estrogen.

But they're very effective, the preparations in reversing the vaginal symptoms. So it's a win-win for that group. Yes, and that's particularly important because hot flashes for most women, but not all, will go away.

Vaginal symptoms never go away. In fact, they can get worse as people are older and older. More years, 10 years, 20 years out from having natural estrogen or or estrogen replacement, and those tissues just seem to get thinner and more fragile, and urinary symptoms, sexual symptoms, and so on.

So, well, that's great. Thank you. If you obviously have tremendous experience and tremendous knowledge of the literature, The typical OB-GYN who has, what, 10 minutes to see a woman might not have as much knowledge and background as you do.

What would you tell someone who says, my doc isn't listening to me, I'm not happy with what she or he has been telling me about managing this tapering of my hormone replacement?

What would you tell that patient? Many women can seek second opinions. There are some great sources of information online. Reproductive endocrinologists do have training in menopause, but many of them now are focusing practice on infertility.

So finding a reproductive endocrinologist who will also see menopause patients is important. If you're just go to the reproductive endocrinologist, don't assume that they're able to treat you.

There's also the North American Menopause Society. That's menopause.org. And at that website, they will give you a list of menopause practitioners. What that means is that these are people who read a book of guidelines on menopausal management, a pretty extensive clinician's guide, and had to take a test.

And from that, they got a certification. So that is a group that tends to be knowledgeable with the most up-to-date information on menopause and has taken the trouble to make steps.

And that includes OBGYNs, reproductive endocrinologists, it includes family medicine physicians, nurse practitioners, PAs, and others who have taken a special interest.

So that is available on the web, and there's a heat map that can show you geographically where to find someone near you. I'll put that information in the show notes below this link.

So that's great. Thank you so much. I want to just step back now and talk more about the meaning of menopause in a broader scope for women's health and some of the some newer information, some older information that has come out.

that puts an emphasis on the timeline of menopause to really take stock of your cardiovascular and other risk factors and try to do the best that you can to have a nice healthy life expectancy.

Maybe you could tell us a little bit more about some of that research. Sure. So in the SWAN study, which is the study of women's health across the nation, we began with about 3,000 women.

from five different racial and ethnic groups. So we had white women, black women, Hispanic women. Most of the Hispanic women were either Puerto Rican, Dominican, Cuban, or Central and South American.

So Mexican women are not well represented in SWAN. Fortunately, we tried. We also have Chinese American women and Japanese American women. And those groups were at different sites around the country.

We are what we call community based. So these women are a lot like you and me. They're free ranging and did not have any particular medical problems at the beginning of the study.

So we did an observational study that's now been going on for 25 years. Women were begun recruitment around age 45 to 55. And we have followed them every year for the first 12 years and then every couple of years after that.

So this gave us a very good picture of what the transition to menopause looks like in terms of symptoms. in terms of biological markers. And one of the most striking findings is that women will go through predictable patterns.

So while menopause seems sort of unpredictably unpredictable, some things happen that are milestones that a woman can pretty readily recognize.

Cardiovascular Health and Takeaway Advice

So if you are having regular menstrual periods and you're not taking hormones like birth control and using an IVD that's going to mask your cycle, most women will notice a skip.

They'll skip the cycle. And now that we have smartwatches and fancy devices to measure our cycles more carefully, a more than seven-day difference in the menstrual cycle length, meaning the beginning of one period to the beginning of the next, perils that entry into the transition.

The median age that that happens is about age 47, but it can be much earlier. An earlier entry into the transition usually means that it's going to be longer and probably more symptomatic and bothersome.

So I know when a patient comes in my office and she's 37 and she's reporting these symptoms already, she's probably going to have a rough time. She's probably going to wind up needing some treatment.

But, you know, let's see how it goes and how the discussion goes. By age 49, women begin to skip for longer and longer periods of time. So that 60 days or more of amenorrhea marks the entry into the late transition.

And from that point, it's 95% likely that within the next four years, That woman is going to have her final menstrual period. Could be earlier, could be a little bit later.

But for the most part, final menstrual period four years later. And that's right at around age 51, 52 in the population. So most, that's the median age at menopause.

And it's unlikely that women have menopause after age 54. That's a late menopause. That's beyond the 95% sort of limit of age. And a late menopause carries some issues with it, but in general, it's a marker of good health.

While we tracked women in swine, we looked at their tendency for diabetes. We looked at heart markers. We looked at their cholesterol levels. We looked at the thickness of the arteries in the neck using ultrasound.

It's a marker of atherosclerosis or hardening of the arteries. And what we found is that that late transition seems to be the flashpoint where pretty much everything takes a turn for the worse, even in the healthiest women.

So that is when the most mischief happens. Hot flashes get worse. The thickness of the carotid arteries increases at the most rapid pace. Bone loss begins to occur rapidly, and we'll do that for the next five to seven years, and then it levels off again.

So that's where we really want to watch what's happening with the women. That's when women will notice that their waistline starts to expand. It's almost universal.

There's an increase in sub mid-body fat. And there's a small decrease in lean body mass. And that levels off again when the transition is done. So some of these things are attributable to age.

Some are attributable just to hormones like estrogen, but it's overly simplistic to think that everything is hormone related. There may be an interaction also hormones and with symptoms or symptom susceptibility.

That's great. That's great information. Thank you. Those are kind of the main messages that I wanted folks to be able to get from you today. And I think I like to end my videos with a kind of to do what's the take home message from all of this.

And based on what you have told us today, I think my take home message would be to stay linked in with your primary care doc during this time and be watching your blood glucose levels, your cholesterol levels, your blood pressure, your weight, and exercise of course underlies prevention of many of these other conditions that do seem to increase as women go through their menopausal transition.

Is there anything else that you would like to add that is a take-home message for people today? Well, I think that's your last part is the most important.

It's really, it's the simple stuff. And I also think that women at this time of life tend to neglect that sometimes. But the American Heart Association used to have what they called Life's Simple Seven.

And now they made it Life's Simple Eight. So they went up eight to include sleep, I think. But it's just all the things that you're saying, you know, check, have your cholesterol checked.

This is when it changes. This is when high blood pressure may, become evident if it runs in your family. This seems to be the point in life where women will express that problem even if they haven't had it before.

So it's good to stay connected. And also, I think an important aspect is to treat symptoms. Don't suffer in silence. Hormones are not as dangerous as they have been portrayed.

Many women can very safely take them. And it can make this ride a whole lot easier. Hormone treatment is going to make any of those other outcomes change, but it'll certainly help you sleep and make it easier to stick to a healthy regimen.

Great. Well, thank you. I think this was very comprehensive and easy to understand, hopefully. And as I always say at the end of my videos, if you have things that you would like me to cover, please put it in the comments and I'll do the best I can.

Otherwise, please take some of Dr. Santoro's great advice to heart, and I hope you're having a long, healthy lifespan. Thank you so much. Thank you, Pat.

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It helps more women find us.