

A survey of physicians' attitude and approach to hormone replacement therapy during menopause

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Summary

Objective: A major problem with postmenopausal hormone replacement therapy (HRT) is its relatively low long-term continuation rate. The aim of the present study was to assess the contribution of physicians to the low long-term continuation rate by surveying their attitude and approach to the use of HRT in postmenopausal women.

Patients and Methods: A questionnaire was sent to registered members of the North American Menopause Society. Data were collected on demographics, medical education and affiliation, attitude to the use of HRT and its contraindications, and follow-up strategies.

Results: The response rate was 21% (n = 218). Sixty-six percent of the physicians recommended HRT for every postmenopausal woman with no contraindications, and 11% also took age and/or time since menopause into consideration. Eighty-six percent claimed they would try to persuade symptom-free women not interested in HRT into changing their minds. There was no correlation between the time since completion of residency or affiliation with a medical school and physicians' attitude to prescribing HRT or contraindication to HRT, or management strategy. However, type of specialty was significantly correlated with physicians' tendency to recommend HRT. Specialists in menopause showed a lower tendency to unconditionally recommend HRT (in the absence of contraindications) (67%) than specialists in reproductive endocrinology (90%), infertility (90%), gynecology (83%), and perinatology (84%) (p < 0.006, C-measure = 0.25).

Conclusions: The attitude toward HRT and the management strategies of members of the North American Menopause Society correlate with contemporary recommendations in the literature, indicating good training of young physicians and adequate updating of older ones. Thus, to increase the continuation rate of HRT, educational efforts should be directed primarily to the public rather than to medical professionals.

Key words: Menopause; Hormone replacement therapy (HRT); Compliance.

Introduction

With an estimated 36 million American women reaching menopausal age within the next decade [1], the issue of hormone replacement therapy (HRT) has taken on increasing importance. The decision to use HRT is difficult for both patient and physician, who need to carefully weigh its benefits (decreased risk of osteoporosis and cardiovascular disease) [2] against its hazards (increased risk of breast cancer) [3] and side-effects [3]. The latter are probably responsible for one of the major problems of postmenopausal hormone therapy, namely, the relatively low long-term continuation rate.

The aim of the present study was to assess the physician's contribution to the low long-term continuation rate of HRT.

Patients and Methods

A simple questionnaire, formulated especially for this study, was sent by post to registered members of the North American Menopause Society during 1999. The questionnaire consisted of items on personal data, year of graduation from medical school, medical education background, main specialty, medical

school affiliation, attitude to the use of HRT and its contraindications, and follow-up strategies.

The data were analyzed with the chi-square test and Student's t-test; a p value of less than 0.05 was considered significant. We also used the contingency coefficient (C-measure) as appropriate, where a value of 0.5 or more predicted a linkage (the closer the value to 1, the poorer the linkage).

Results

Only 218 physicians completed and returned the questionnaire, for a response rate of 21%. Twelve percent of the respondents had completed their residency within the last 10 years, 32% 10 - 20 years ago, and 56% more than 20 years ago. Their main specialties were reproductive endocrinology (13.5%), menopause (26%), gynecology (46.5%), perinatology (6.5%), and others (7.5%). Sixty-seven percent were affiliated with a medical school.

With regard to attitude to the use of HRT during menopause 66% of the physicians recommended HRT for every postmenopausal woman without contraindications, and an additional 11% did so in the absence of contraindications and with consideration of the woman's age and/or number of years elapsed since menopause; 23% did not recommend HRT. Sixty-eight percent claimed

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that they would try to persuade a symptom-free women not interested in HRT to change her mind, whereas 32% would not.

Breast cancer was considered a main contraindication to HRT by 79% of physicians, followed by gynecological cancer, by 45%. Only a minority of respondents included other conditions, namely, ischemic heart and cerebrovascular diseases (4%), hypertension (18%), hyperlipidemia (3.8%), diabetes (7.5%) varicose veins (10.4%), fibroid uterus (4.2%), and smoking (1.4%).

The routine examinations required by most of the physicians before prescribing HRT were PAP smear (93%), mammography (97%), and blood lipid profile (69%). Other tests were complete blood count (25%), coagulation test (8%), pelvic ultrasound (9%), endometrial biopsy (16%) and bone density measurement (16%). Eighty-eight percent recommended a follow-up time for these tests of 12 months and 6%, 24 months; 6% of the physicians did not perform these tests routinely.

Physicians were asked for their recommended cut-off point for endometrial thickness on transvaginal ultrasound for performing an endometrial biopsy. For asymptomatic postmenopausal women not receiving HRT, 12% used 4 mm, 47% 5 mm, 19% chose 6 mm, and the remainder ≥ 7 mm. The corresponding rates for asymptomatic patients receiving HRT were 8%, 35%, 17%, and 40%. For symptomatic postmenopausal women not receiving HRT 64% considered 3 mm the optimal cut-off, 10% 4 mm, 14% 5 mm, 7.5% 6 mm, and the rest considered ≥ 7 mm. Corresponding rates for patients receiving HRT were 48%, 10%, 25%, 9%, and 8%. Most physicians (88%) preferred the pipelle for endometrial biopsy, and 12% preferred traditional fractionated curettage.

No correlations were found between years elapsed since completion of residency training or affiliation with a medical school and attitude to prescribing HRT or contraindications to HRT, or management strategy. While medical specialty, too, was not correlated with contraindications to HRT or management strategy, it was found to be significantly correlated with attitude to prescribing HRT. Specialists in menopause had a lower tendency to prescribe HRT to every menopausal woman without contraindications (67%) than specialists in reproductive endocrinology (90%), gynecology (83%), or perinatology (84%) ($p < 0.006$, C-measure = 0.25).

Discussion

Reports of a possible association of HRT with breast cancer have led to a high attrition rate from HRT protocols. Only 1 - 20% of all eligible women in the USA and Europe currently use HRT [4].

Furthermore, the rate of HRT use has been found to decline with age, from 35% in women aged 40 - 60 years to 7% in women older than 80 [5].

Several researchers have examined the influence of environmental factors on the continuation rate of HRT. Karakoc and Erenus [6] found that patient educational status was directly related to the incidence of beginning HRT, but not to its discontinuation. Continuation was

also significantly more common in women with surgical menopause than in those who started HRT either on their physician's recommendation or because of concern about osteoporosis. The authors concluded that the education of menopausal women about long-term benefits of HRT is critical for improving compliance. Others, however, have found that physicians are the major culprit [7-12]. Exline *et al.* [9], found that providers' beliefs the benefits and risks of HRT differed by specialty and gender of physicians. Gynecologists were significantly less concerned about the potential risks of breast cancer and thromboembolic events compared to family physicians. Female providers were significantly different from their male colleagues in their concern about the benefits of HRT with the reduction in risk of heart diseases and osteoporosis.

Rolnick *et al.* [10] performed a study aimed to survey providers' attitudes and practice patterns related to counseling women about HRT. Gynecologists were more likely to report the benefits of HRT for Alzheimer's than were internal medicine clinicians or family practice physicians and women providers were more likely than men to report that. There was no statistical difference based on years in practice. Providers did not vary significantly by specialty or sex in their concerns of risk for development of breast or endometrial cancer. However, those family practice or internal medicine physicians were significantly more likely to report concern about thromboembolism. Only 42% of physicians claimed to initiate discussion regarding HRT usage with their patients more than 75% of the time. The two factors most often mentioned as barriers to counseling were lack of time and adequate knowledge. It seems that providers want to be an integral part of their patient's education regarding HRT; however, time constraints and a need for adequate information make this difficult.

MacLennan *et al.* [13] claimed that the doubling of postmenopausal hormone use in Southern Australia from 1991 to 1995 was attributable to educational efforts addressed to both medical professionals and the public.

In the present study we applied a questionnaire to assess the physician's contribution to the low long-term continuation rate associated with HRT. We found that the majority of physicians (66%) unconditionally recommend HRT to every postmenopausal woman who has no contraindications, and an additional 11% also take patient age and/or time since menopause into account. Indeed, 68% would even try to persuade symptom-free patients who were disinclined to use HRT to change their minds. This positive attitude corresponds with studies from the USA showing a high rate of eligibility of American women for HRT (71% for African American women and 58% for white women) concomitant with its substantial underuse and low compliance rate [14]. Furthermore, it may suggest that in contrast to the Australian experience [13], educational efforts in America need to be directed primarily at the public rather than at medical professionals. Interestingly, our survey revealed that specialists in menopause tend to recommend HRT less (67%) than experts in reproductive endocrinology and infertility (90%) or gynecology (83%) and perinatology (84%) ($p < 0.006$, C-measure = 0.25). This observation may be explained by

the greater familiarity of menopause specialists with up-to-date information in the field. According to the 1999 Clinical Synthesis Panel on HRT held by the European Institute of Oncology [15] in Milan, HRT must be tailored to the needs and desires of the individual patient and based on good physician-patient relations. Appropriate decision-making depends on physicians providing good quality information that covers both the risks and benefits.

Until recently, breast and endometrial cancers were widely regarded as absolute contraindications to HRT. The view is reflected in our findings as well (79% and 45% of physicians, respectively). However, some directly nonsupportive data have been published, and the issue remains unresolved. Only a minority of the physicians regarded other disorders, such as ischemic heart and cerebrovascular diseases, hypertension, hyperlipidemia, diabetes, etc., as a contraindication, again indicative of the good training and adequate updating of the screened physicians [15, 16].

The 1998 guidelines of the ACOG [1] recommend that women receiving HRT should undergo annual pelvic and breast examinations and routine blood pressure measurement, PAP test, lipid profile, and mammography. In the present study, most physicians recommended PAP tests (93%), mammography, and blood lipid profile prior to commencing HRT, but only a minority performed other tests, such as complete blood count, coagulation test, pelvic ultrasound, endometrial biopsy and bone density measurements. Most of the respondents recommended annual or biennial follow-up, again in accordance with the ACOG [1] recommendations.

Endometrial thickness is used as a criterion for endometrial disease in the evaluation of symptomatic and asymptomatic postmenopausal women. In a meta-analysis of 5,892 women, Smith-Bindman *et al.* [17] established that 96% of women with endometrial cancer and 92% with other endometrial disease (polyps, atypical hyperplasia, cancer) will have an endometrial thickness of at least 5 mm on transvaginal ultrasound. Lesser thicknesses point to the need for only conservative management [18]. The 5 mm cut-off is reliable also in patients receiving sequential HRT, in whom endometrial thickness can be affected by the day in the treatment cycle, provided that the ultrasound is done towards the end of the progestational interval [19]. However, in the present study, only 47% of the physicians considered 5 mm as the preferred cut-off in asymptomatic postmenopausal women not receiving HRT and 41% opted for a higher one. For patients receiving HRT, only 35% considered 5 mm the preferred cut-off. Use of a higher cut-off point can lead to misdiagnosis. Thus, our findings indicate the necessity of further discussion by the medical profession of this issue.

Eighty-eight percent of the physicians preferred the pipelle for endometrial biopsy, and only 12% opted for fractionated curettage. According to recent reports, the pipelle is more efficacious, accurate, and cost-effective than fractionated curettage [20].

In summary, the attitude and approach to HRT of members of the North American Menopausal Society

correlate well with opinions and findings in the contemporary literature. This apparently indicates that young physicians today receive good training and older physicians successfully keep abreast of new developments in the field. Nevertheless, there are still enough physicians that adhere to contrary approaches to perhaps explain the discrepancy between the low rate of HRT use in the USA and its apparent benefits as cited in the literature.

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