Use of hormone replacement therapy

Evidence on risk of breast cancer associated with hormone replacement therapy is still inconclusive

EDITOR,—As a female doctor who has a specialist interest in the menopause and hormone replacement therapy, I was interested to read Elizabeth H Price and Helen Kaye Little's letter about hormone replacement therapy.¹ I agree that women need to be informed about the risks associated with such treatment. I disagree, however, with the authors' statements about the increased risk of breast cancer.

The epidemiological evidence on the effect of combined treatment with oestrogen and progestin on the risk of breast cancer is still too limited to be conclusive: neither a protective nor a detrimental effect has been reliably shown. The largest case-control study (from the Centers for Disease Control²), the largest cohort follow up study (the nurses' health study³), and the most recent case-control study⁴ failed to find a link between breast cancer and use of oestrogen up to 20 years. Lower doses of oestrogen, which protect against osteoporosis and cardiovascular disease, are not known to be associated with an increased risk of breast cancer. A recent meta-analysis detected a small increased relative risk of breast cancer being diagnosed in women taking combined oral contraceptives.⁵ This study, however, was not free of selection and detection bias or of the risk of a positive result emerging owing to the heterogeneity of the studies included. Only a randomised clinical trial will provide definitive information on this issue.

It is my practice to give patients evidence based information about the risks and benefits of hormone replacement therapy. The evidence overwhelmingly supports the protective effects of such treatment on the cardiovascular system and against osteoporosis; it remains equivocal on the risks of breast cancer. I do not believe that it is appropriate to make either positive or negative statements about the effects of hormone replacement therapy on health on the basis of single references, as Price and Little do. No treatment is without risk, and I regard my patients as responsible adults who will make their own decisions on the basis of the best information I can provide. I encourage the provision of information by groups such as DASH (Doctors Against Abuse from Steroid Sex Hormones)¹ if that information is complete and unbiased.

KAREN MCKINNEY
Senior registrar

Department of Obstetrics and Gynaecology,
Queen's University of Belfast,
Institute of Clinical Science,
Belfast, BT7 1NN

- 1 Price EH, Little HK. Women need to be fully informed about risks of hormone replacement therapy. *BMJ* 1996;312:1301. (18 May.)
- 2 Wingo PA, Layde PM, Lee NC, Rubin G, Ory HW. The risk of breast cancer in postmenopausal women who have used estrogen replacement therapy. *JAMA* 1987;257:209-15.
- 3 Colditz GA, Hankinson SE, Hunter DJ, Willett WC, Manson J, Hennekens C, et al. The use of estrogens and progestins and the risk of breast cancer in postmenopausal women. *N Engl J Med* 1995;332:1589-93.
- 4 Bergkvist L, Adami H-O, Persson I, Hoover R, Schairer C. The risk of breast cancer after estrogen and estrogen-progestin replacement. *N Engl J Med* 1989;321:293-7.
- 5 Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast cancer and 100 239 women without breast cancer from 54 epidemiological studies. *Lancet* 1996;347:1713-27.

May depend on whether the menopause is regarded as physiological or pathological

EDITOR,—Elizabeth H Price and Helen Kaye Little voice concern about the "considerable pressure" that may be exerted on women to use hormone replacement therapy.¹ The perceived risks and benefits should be fully discussed with each woman so that she can make an informed choice. Whether a doctor promotes the use of such treatment for asymptomatic women is likely to depend on his or her philosophical view of the menopause as either a physiological or a pathological state.

Price and Little consider the menopause to be physiological and hormone replacement therapy to be a drug that should not be offered to a general population. This view requires the belief that an event that potentially affects all women must be part of the normal aging process. This fact alone is not irrefutable evidence that the menopause is a physiological process. This century, average female life expectancy has risen from 45 to 83 years. This is almost entirely related to considerable improvements in social conditions and means that a woman may now spend almost one third of her life in the postmenopausal state. If we look at other mammals we find that reproductive capacity is maintained until death. Perhaps we can regard the menopause as the onset of a pathological state to which women are exposed only because of socially induced longevity.

Overall, epidemiological studies have shown low dose natural oestrogen to have significant

protective effects against cardiovascular and cerebrovascular disease (major causes of death in our society). Continuing research suggests a protective influence in Alzheimer's disease.² The risk of breast cancer remains uncertain, with two recent reports coming to opposite conclusions.^{3,4}

Price and Little refer to a paper by Hunt *et al.*,⁵ quoting a 50% increase in the risk of breast cancer with use of hormone replacement therapy for more than five years. This is exactly the sort of selective quotation that must be avoided. They fail to highlight the fact that use of hormone replacement therapy was associated with a significant reduction in all cause mortality (relative risk 0.56 (95% confidence interval 0.47 to 0.66)), including all deaths related to cancer (0.70 (0.55 to 0.85)).⁵

In promoting hormone replacement therapy we should all endeavour to explore the potential benefits, risks, and uncertainties with women, helping them to reach their own conclusions. Organisations such as DASH (Doctors Against Abuse from Steroid Sex Hormones)¹ are one source of information; I hope that DASH will offer counselling that is both balanced and evidence based.

KIM HINSHAW
Consultant obstetrician and gynaecologist

City Hospitals Sunderland NHS Trust,
Sunderland SR4 7TP

- 1 Price EH, Little HK. Women need to be fully informed about risks of hormone replacement therapy. *BMJ* 1996;312:1301. (18 May.)
- 2 Paganini-Hill A. Oestrogen replacement therapy and Alzheimer's disease. *Br J Obstet Gynaecol* 1996;103 (suppl 13):80-6.
- 3 Colditz GA, Hankinson SE, Hunter DJ, Willett WC, Manson JE, Stampfer MJ, et al. The use of estrogens and progestins and the risk of breast cancer in postmenopausal women. *N Engl J Med* 1995;332:1589-93.
- 4 Stanford JL, Weiss NS, Voight LF, Daling JR, Herbel LA, Rossing MA. Combined estrogen and progestin hormone replacement therapy in relation to risk of breast cancer in middle-aged women. *JAMA* 1995;274:137-42.
- 5 Hunt K, Vessey M, McPherson K. Mortality in a cohort of long-term users of hormone replacement therapy: an updated analysis. *Br J Obstet Gynaecol* 1990;97:1080-6.

Authors gave distorted view through selective citation

EDITOR,—What women most certainly do not need is Elizabeth H Price and Helen Kaye Little's highly selective citation of the literature.¹ The authors refer to an editorial by McPherson, which stated that five years' use of hormone replacement therapy is associated with a 50% increase in the risk of breast cancer.² They express surprise that research in which McPherson participated should have found that 55% of postmenopausal female doctors choose nevertheless to take hormone replacement therapy.³ They explain this figure as being the result of "considerable pressure [on women] to use hormone replacement therapy." This implies a contempt for their female colleagues, which would rightly be condemned as sexist and patriarchal if it originated from a male doctor.

McPherson's editorial drew heavily on the latest report from the nurses' health study,⁴ in which women who had stopped taking hormone replacement therapy two years previously were found to be at no higher risk of breast cancer, regardless of the duration of use, than women who had never used it. In the Iowa women's health study mortality from breast cancer was increased by 45% in

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.