DR. SUSAN LOVE
RESEARCH FOUNDATION

www.drsusanloveresearchfoundation.org
E-mail: info@dslrf.org

How to Talk to Your Doctor About Menopause
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Moderator
Susan Love, MD
President and Medical Director
Dr. Susan Love research Foundation

With Guests:
Marcie Richardson, MD, FACOG—Chief, Harvard Vanguard Beth Israel
Alice Lotto Stamm—Women's Health Advocate, Founder of the Power Surge Community for Women at Midlife

Dr. Susan Love: Welcome to SusanLoveMD.com and the third in our series of webinars, "Powering Informed Choices," sponsored by an unrestricted educational grant from GlaxoSmithKline, the US distributors of Remifemin Menopause. We just heard that Maud Purcell will not be able to join us this evening. However, we have some great guests and are happy to welcome Dr. Marcie Richardson, a practicing gynecologist from Boston and a board member of the North American Menopause Society, and Alice Stamm, the founding mother of power-surge.com, the first online community of menopausal women.

We welcome any or all of your questions for any of our panelists. We have received many questions over the week and I want to spend most of the hour answering them, but to set the stage I would like to ask Marcie Richardson to give us the top concerns about menopause from the gynecologist's point of view.

Dr. Marcie Richardson: Well, Susan, this is a difficult question for me because I'm a perimenopausal woman myself. But, I think the top concerns for the gynecologist are managing the symptoms of the transition—which are mostly hot flashes, mood swings, and bleeding problems—and then trying to prepare our patients for the last half to third of their lives and the effects of not having estrogen around.

Dr. Susan Love: Or having less estrogen around?

Dr. Marcie Richardson: Yes. I'll stand corrected.

Dr. Susan Love: I'm a few steps ahead of you in the menopause transition, Marcie, but not much. We are all representing the menopausal woman. Alice, what do you think are the top concerns about menopause from the woman's point of view?

Alice Stamm: It's a tough one to answer because there are so many concerns for women going through perimenopause. I think part of it is there's a lot of sensationalism, a lot of scare tactics out there. You hear a theory on Monday and by the following Monday it's been disproved and another theory has come out. The greatest concern I've heard expressed during the seven years I've been doing Power Surge would have to be all the conflicting opinions about hormone replacement therapy (HRT) among the experts in women's health. In the final analysis, women ask, "If we can't rely on our healthcare providers, who can we rely on for accurate answers?"

Dr. Susan Love: I think one of the problems, and I'll have Marcie speak to this as well, is that it's not so much that we're trying to make things confusing, but this is a work in progress and the research is going on as we speak. So we are learning a lot and the things that we thought were true may not be.

Dr. Marcie Richardson: I agree. And, I say probably two or three times a week to my patients that we have the privilege of being in a generation where we're learning about the menopausal transition and how to best manage it. We don't know all the answers and anyone who thinks they do is mistaken.

Alice Stamm: I was offering my opinion for all the women I communicate with on Power Surge; we're just really confused about what to do.

Dr. Marcie Richardson: I think it is distressing for patients and women to see so many conflicting messages, but I really feel strongly that we've got to underline that we don't have all the answers as experts.

Dr. Susan Love: Here's a question from our audience that can get us started. "I want to know how to deal with hot flashes."

Dr. Marcie Richardson: There are many ways to deal with hot flashes. It usually takes me about 45 minutes to give this lecture. But, I think that the first part is to recognize them as normal. And the second step is to try to identify your triggers so that you can avoid them. And then, you can approach it with diet and exercise. Diet, specifically phytoestrogens which are most present in soy, or actually estrogen is a very good medicine for helping with hot flashes. There are other medicines that aren't estrogens that help with hot flashes as well. Hot flashes last on the average for three to five years in American women and 85 percent of American women have them.

Dr. Susan Love: I personally found that the worst part of menopausal symptoms was their unpredictability. You never know whether you are going to have hot flashes for

three months or three years. Is there any way to know how long things are going to last?

Dr. Marcie Richardson: No. (laughs)

Alice Stamm: I want to interject an expression I use a lot: The most consistent thing about menopause is that it's consistently inconsistent.

Dr. Susan Love: Exactly. And you can have hot flashes for three months and have them go away for three months, and then have them come back again and it doesn't seem like we ever get over with this.

Alice Stamm: It can go away for six months. Women come into my group who are technically postmenopausal, haven't had a period for one year, yet are still experiencing symptoms. And then they can have periods and sometimes it seems as though the process starts over again.

Dr. Susan Love: Well, I often tell people it's puberty in reverse.

Alice Stamm: (laughs) Even with the pimples!

Dr. Susan Love: Here's another question from our audience. "What are some alternative methods for hot flashes?" Marcie?

Dr. Marcie Richardson: There are many alternatives. You can start with vitamin E, which in one quite good, controlled study did show a little bit of effect 400 milli-international units up to 1,200 milli-international units a day; although you shouldn't take it if you have bleeding tendencies. There's a Native American herb, black cohosh, which is now distributed by our sponsor in the form of Remifemin, which has been shown to help with hot flashes. It's been around for a long time. Remifemin is a standardized product and so quite honestly I've been recommending it to my patients for a few years now, and that can be helpful. There are other herbs that some people claim to have gotten some positive effects from, although there is less data to support that. Alice, what have I forgotten?

Alice Stamm: I think you might mention evening primrose oil, chaste berry (vitex) is helpful for some women. You mentioned soy isoflavones, which I'm a strong advocate of and I've been using high doses of isoflavones for two and a half years and I've found them very helpful in eliminating many of my perimenopausal and even postmenopausal symptoms. Flaxseed is also very helpful. Are you specifically talking about hot flashes, Susan?

Dr. Susan Love: It's very hard to differentiate the symptoms because sometimes if you're having hot flashes you might get insomnia. And if you've got insomnia you get mood swings, so it's hard to differentiate. So I think we need to look at the whole

constellation of perimenopausal symptoms.

Alice Stamm: I would suggest magnesium. You hear a lot about magnesium and calcium. And I learned from you, Susan, that when you take calcium you must take vitamin D with it, because it aids in the absorption. Magnesium is an underrated mineral and it's very important. I heard some physicians talking on a radio show, and they said if it spasms, give it magnesium. It's helpful for treating palpitations, which are commonly associated with menopause, as well as migraines. You mentioned black cohosh or Remifemin, St. John's wort for depression, chamomile, dong quai, melatonin for insomnia, vitamin E; the list is endless, but there are very effective alternative methods for treating all of these lousy symptoms.

Dr. Susan Love: What about insomnia or anxiety?

Alice Stamm: That would be valerian root. Melatonin I have found is excellent.

Dr. Marcie Richardson: I have to disagree. I mean, I'm not sure melatonin is that good in the long run for insomnia. The data I've seen agrees with you about valerian. A lot of people advocate kava kava for anxiety, but I personally worry a little bit about kava kava.

Alice Stamm: I do, too. When I was talking about melatonin it's not something I would personally take on a daily basis. I only take it occasionally when insomnia is very bad.

Dr. Susan Love: Let me just warn you about melatonin. It's made from the pineal gland from cows. They sweep up the brains in the slaughterhouses, and they get it mostly from Europe. So there's a concern about mad cow disease and melatonin. I would not take melatonin right now; you just don't know where they're getting it from. Last week we chatted with Dr. Fredi Kronenberg, and she gave us that caution.

Alice Stamm: I don't think I'll be taking melatonin again.

Dr. Susan Love: Marcie, can you comment on the study last week on the increase in ovarian cancer deaths in women on HRT?

Dr. Marcie Richardson: Well, there was a study published in the *Journal of the American Medical Association* which showed that for women who'd been on hormone replacement in the 10-year range, there was an increase in the risk of ovarian cancer. The incidence about doubled, as I recall. Of course, this is very concerning. In terms of how I view this, the incidence of ovarian cancer is overall quite low. So, I still think there are enough unanswered questions about hormones in general that this doesn't make me feel like we should stop using them. It makes me feel this is one more small piece of the equation on the negative side.

When we're making a decision, I spend a lot of time with my patients going over their individual risk/benefit ratio for taking hormones as well as how hormones may make

them feel. And I think it needs to be reevaluated on a regular basis. At your yearly visit you should be saying, am I still on hormones? If so, why? If not, why?

Dr. Susan Love: As the news changes, as well. Here's another one from the audience. "What about pimples? I have them around my ears and neck now that I'm perimenopausal—what can I do?"

Dr. Marcie Richardson: I just have to say that this probably has to do with the ratio between your estrogen and your androgens that has to do with changes in your ovaries. And, I think you should see a dermatologist because they've made a lot of progress on this since we were in puberty. (laughs)

Dr. Susan Love: Here's another. "I've never skipped a period, but I've been experiencing night sweats during my period recently and increased stress incontinence. I'm 50 in May. Do I sound perimenopausal?"

Alice Stamm: Absolutely, unmitigatedly, yes. I also want to go back to one thing that Marcie was talking about on hormones for the women out there. Are we talking about the same rules and regulations for naturally compounded, bio-identical hormones?

Dr. Marcie Richardson: You've brought up an important point that was made about the study on estrogen and ovarian cancer. We've really changed in the way we do hormones over the last two decades, so to draw any definitive conclusions about what the data says today only tells us about the hormones we were using 10 and 20 years ago and that's not what we're using today. I think the bio-identical hormones may have risks, but we don't know.

Dr. Susan Love: I think to assume they don't is also probably not correct.

Here is a question that I received by email. "I like the alternative approach for dealing with menopause. I am now using Remifemin for symptoms with good results. I am 53 years old, started with night sweats and insomnia for the past two months. Basically when alternative methods are discussed, does it cover all women with natural flow of menopause, partial hysterectomy as well as total hysterectomy folks? Is a woman with a partial hysterectomy more prone to diseases than a woman who goes into menopause naturally?" Marcie, do you want to differentiate for us?

Dr. Marcie Richardson: I think we need some definitions here. Partial hysterectomy usually means that the uterus has been removed and not the ovaries. And, if that's how this is meant, then there is one difference when the ovaries are removed, which is that the ovaries continue to make low-level testosterone postmenopause. And, if a woman has a hysterectomy with her ovaries removed, then she has no testosterone from the ovaries and that's a different hormonal situation than natural menopause. Sometimes people say partial hysterectomy referring to not taking the cervix, and that doesn't make

any hormonal difference.

One other thing I'd like to say about perimenopause is that I think to put a beginning and end to it is very difficult. My own opinion is that women notice symptoms probably 8 or 10 years before their last period which are related to the hormonal aging of the ovaries. One of the things that irritates me the most is when a woman comes in and says, "I'm having periods and I had a blood test done and my doctor says I'm not in menopause." The premenopausal changes go on for many years and a blood test can't tell you if you're in it because the hormones are so variable. What tells you whether you're in it or not is your age and your symptoms.

Alice Stamm: I want to make a comment about women who've had hysterectomies. What I've been noticing is that there are so many younger women who are going into premature menopause or who've had hysterectomies. My experience in communicating with them is that other than the social implications of very young women in their late 20s and early 30s becoming menopausal, the things women experience and the remedies they are using are pretty much the same. This is not from a medical point of view but just my experience.

Dr. Susan Love: Okay. Here's another question from our audience. "Is there anything you can recommend for extreme dryness?" Marcie?

Dr. Marcie Richardson: Well, do you mean dryness of the vagina? Or dryness of your skin?

Dr. Susan Love: I think dryness of the vagina, probably.

Dr. Marcie Richardson: I can recommend several things. There are some very good over-the-counter lubricants. Astroglide is my personal favorite. But, there are others you can try. And I have to say, local estrogen therapy is very effective and has the advantage in some cases of not being very much absorbed. This especially applies to a device called the Estring, which is a diaphragm-like device delivering a very small amount of estrogen to the vagina. You put it in for three months and then replace it for three months. That's a very effective method of treating vaginal dryness resulting from falling estrogen levels.

Dr. Susan Love: I also feel that's one of the ones for women who've had breast cancer and are leery of taking hormones, that's probably the best choice. Here's another question that might be from a breast cancer patient. "How do you feel about drugs such as Effexor for menopausal symptoms?" I know that's been studied recently.

Dr. Marcie Richardson: I think Effexor seems to work well for some women; and especially for breast cancer survivors who are reluctant to take estrogen. It's not as effective as estrogen in treating hot flashes and does have some side effects. But, very good studies show it's effective 60 to 70 percent of the time and I definitely think it's

worth trying for women who are suffering from their hot flashes. And there are several other drugs—Paxil, Neurontin, clonidine—that have been shown in controlled studies to have hot flash reduction effects.

Dr. Susan Love: I think we're finally looking beyond just hormones. Since hot flashes are really generated in your head, it makes sense to change the chemistry around.

Alice Stamm: I'd like to go back to the vaginal dryness question. Many women don't know the vitamin E capsule can be inserting intra-vaginally for lubrication and to ease the pain of dryness. Also vitamin A helps, beta-carotene.

Dr. Marcie Richardson: Do you recommend breaking the capsule or just inserting the capsule intact?

Alice Stamm: Insert the capsule intact and it will just dissolve.

Dr. Susan Love: I've heard good results about that as well.

Dr. Susan Love: We have two questions about progesterone cream. "What is your opinion of Pro-Gest or similar progesterone creams? Can we benefit from these creams if not on HRT and at what dosing? Would we need to use these creams forever? Do these creams affect breast tissue at all?"

Let's start with Marcie. Then Alice and I will butt in.

Dr. Marcie Richardson: You know, the progesterone creams have gotten a lot of press, but they're generally unencumbered by data. I think transdermal progesterone may have a role in hormone replacement. Progesterone can definitely treat hot flashes, but I think the claims that have been made for progesterone creams are as yet unjustified and I would not recommend them, especially for prevention. If you're trying to use them for symptom treatment, you can see if the symptoms get better. But again, you're not sure what experiment you're participating in.

Dr. Susan Love: There's one randomized control study that looked at both bone density and hot flashes and showed some benefit for hot flashes and no benefit for bone density.

Dr. Marcie Richardson: Which is sort of what I said.

Dr. Susan Love: There's a claim it will prevent breast cancer, but if you look at the biology of progesterone it works differently in the breast than the uterus. In the uterus, progesterone counteracts or balances estrogen. In the breast, they work synergistically. As far as we can tell, it's not a good way to prevent breast cancer.

Dr. Marcie Richardson: Progesterone does prevent cancer of the lining of the uterus or the endometrium, but I worry about women, some of whom I care for, trying to use transdermal progesterone to balance estrogen that they're taking because there is really very little data on how much is absorbed. I just think we need some good studies before we can make any statements based in science.

Alice Stamm: Maybe we are doing a little too much doctoring ourselves.

Dr. Susan Love: I think we confuse the term *natural* with *safe*. There are things that are natural that are not safe; we need to be cautious about that.

Alice Stamm: I have women in my groups who talk about natural and you've heard the expression that more is not always better. Women claim that vitamin E is helping. I've seen vitamin E in doses of 1,000 international units in one capsule; this is absurd because vitamin E has the ability to elevate your blood pressure and is not good for women with a history of hypertension. What I learned years ago from a wonderful nutritionist named Adelle Davis was take vitamin E moderately in dosage of 200 international units at a time and spread it out over the course of a day. Even vitamins in too high a dose can make you toxic. You can get very sick from a lot of natural things.

Dr. Susan Love: I have a number of questions related to women on tamoxifen and are wondering about symptoms. Here's one: "I'm a two-and-a-half-year breast cancer survivor, age 53. I'm taking tamoxifen and have gained 35 pounds. I'm in the Women's Healthy Eating and Living Study, so I'm very aware of proper diet. Any tips on losing this weight?"

Dr. Susan Love: Exercise!

Dr. Marcie Richardson: Yeah. And, she should read [Debra] Waterhouse's book, *Outsmarting the Midlife Fat Cell*.

Alice Stamm: I just had her as a guest on the Power Surge and she's great.

Dr. Marcie Richardson: I do think that it's a combination of exercise and diet and accepting the fact that after the menopause your body is going to change. In just the same way you don't look the same after you go through puberty, after you go through menopause you may gain some weight unavoidably.

Dr. Susan Love: Here's another tamoxifen question; this one's an easy one. "I started taking tamoxifen in January and have not had a period since. I'm 47 years old and I have no other menopausal side effects. My oncologist says this is normal. Do you think I will experience any side effects as I get older?"

Dr. Susan Love: Not having any side effects is a very good sign. Maybe you want to

comment, both of you, on the fact that not everybody gets symptoms at menopause.

Alice Stamm: I haven't met them.

Dr. Susan Love: Maybe they don't need a website!

Alice Stamm: Everyone out there drop by power-surge.com and post something. I did put up a message board called "The Positive Side of Menopause." I'm trying to utilize the acceptance factor. There are so many dynamics associated with this transitional time of life. It's not just a matter of losing a period. You come into this transition with a whole mind-set, a history and emotional baggage. Negative things are exacerbated during this process. I think it's important to communicate with other women and that's why I think these support communities are wonderful for women to air their grievances and get others' opinions. But I have as yet not met a woman who has not had any menopausal or perimenopausal symptoms.

Dr. Susan Love: I have.

Dr. Marcie Richardson: I have too. And the Massachusetts Women's Health Study suggests that it applies to about 15 percent of women in the US and it's higher in China and Japan, at least on the hot flashes front. I do see patients in my practice, Alice, who've said, I had my last period and that was that.

Alice Stamm: I hate them! For the most part, the women who come to my community have issues or they wouldn't be coming to my community.

Dr. Susan Love: Here's another question I want to ask. "What do you do if your doctor dismisses your interest in using alternatives for menopausal symptoms?" This is especially for Marcie.

Dr. Marcie Richardson: I think you find another doctor. I think doctors need to be able to say, "I don't know very much about that," or "I'm not sure that's a good idea." But, I don't think they should be really dismissive of anything. And, I do think that there are a lot of doctors who aren't that knowledgeable about the menopausal transition. And, if you're having a difficult one (not for everyone), finding a doctor who can talk with you in the language you want is important, to give you the expertise you'd like.

Alice Stamm: Let me ask you, Marcie, if this entire transition could last up to about 12 to15 years, from beginning to end; if it takes a good 15 years of a woman's life, that's a big chunk of time and I wonder why the medical school curriculums don't include some kind of course on menopause. I had a doctor tell me, just what you said, that he didn't know much about menopause. I told him I had a history of thrombophlebitis (just after stopping birth control pills in the '70s) and I still walked out of his office, believe it or not, with a prescription for Premarin or Provera. Why are these doctors not educated in a

subject that consumes 15 years of a woman's life?

Dr. Marcie Richardson: I can't even go there (laughs). I think that over the last decade we've seen an enormous explosion in information. I was sure this would happen when our generation hit menopause and I think it will take another five or ten years to filter down through the medical educational process.

Alice Stamm: Doesn't it sound like a viable question?

Dr. Susan Love: And it will come with the demand. As baby boomers grow in numbers, doctors will learn because they have to. Here's another question: "'Can you take alternatives and HRT together? Can you take Premarin and black cohosh?"

Dr. Marcie Richardson: You can. There's not much data about it. And, I also wonder if we're sort of thinking part of the way. Some of the alternative work is by a weak estrogenic effect; could these be working at cross-purposes? Alice, does this come up on your chats?

Alice Stamm: Premarin and black cohosh?

Dr. Susan Love: Or any combination.

Alice Stamm: It has come up in the area mostly as soy, phytoestrogens or isoflavones. There have been tests done that show that taking 50 to 60 milligrams with the HRT, a lot of women have reported this, that they had better results. As far as I know there is no danger of taking the two together because soy is a natural food supplement.

Dr. Susan Love: As long as it's the food and not augmented.

Dr. Susan Love: Here's another question. "I went to Memorial Sloan-Kettering and spoke to a nutritionist and she told me not to take any soy supplements. They do not recommend any supplements. She said you can get all your nutrients in whole foods. My tumor was ER/PR-positive, and I am on tamoxifen." This is a question I get all the time. There is one study in rats showing that if you take soy and tamoxifen together they work synergistically; it does not block the effects of the tamoxifen. I'm not sure we know how soy works and I think we oversimplify it by calling it a plant estrogen. I think it's more of a plant selective estrogen receptor modulator than a phytoestrogen.

Dr. Marcie Richardson: It's far more complicated than that because there are different isoflavones and not only that, how soy is metabolized in your individual gut is somewhat variable. I think this is an incredibly complex area that we're going to have to wait quite a while until we get it sorted out.

Dr. Susan Love: I think the closer you can get to eating soy as food, either as food or as

one of the protein supplements, the better. I'm very nervous about the isoflavone pills, because I think you're getting a lot more than the typical Japanese.

Alice Stamm: It's my understanding that there's not that much data about the isoflavone pills.

Dr. Marcie Richardson: Exactly.

Dr. Susan Love: Here's another question from the audience. "I've heard to take black cohosh for six months and then to take a break. How long a break is necessary?"

Alice Stamm: Why don't they offer us the same option for menopause (to take a break)?

Dr. Susan Love: The research that's been done on black cohosh was just done for six months, so that's where the label comes in. Marcie, do you have any comments?

Dr. Marcie Richardson: Just that, that there isn't any data to show that it's dangerous to take it for more than six months, just like there's no data to say that it's safe.

Dr. Susan Love: In fact, I think if you look at the package insert of Premarin, that also says to only take for six months.

Dr. Marcie Richardson: That I couldn't say.

Dr. Susan Love: The problem is that if you're old enough to take it, you can't read the fine print on the label.

Dr. Marcie Richardson: (laughs)

Dr. Susan Love: Here's an interesting question from the audience. "I was on birth control for 25 years, now off for three. I'm starting menopause and the doctor recommends HRT—is this too many years of hormone manipulation?" Actually, I saw one epidemiological study reporting an increase in breast cancer in women who had been on the pill for at least 10 years prior to going on HRT.

Dr. Marcie Richardson: That's intriguing. I don't know what to make of that. Theoretically the levels of estrogen you're exposed to on the pill aren't higher than the levels you're exposed to in the natural menstrual cycle. On the other hand, it's different because you're getting estrogen the whole month. I don't know the answer to that. It's a lot of hormones, I agree, but we can't give a special answer.

Dr. Susan Love: We're the first generation who had the opportunity to take both.

Dr. Marcie Richardson: Yep, that is for sure.

Dr. Susan Love: And what about alternative therapies? Do you think women are informed about herbal remedies for menopausal symptoms?

Alice Stamm: I think with the advent of the Internet, certainly women are being informed of a lot more than they were before the Internet. I think the baby boomers ask a lot of questions, do a lot of talking, and want a lot of answers. It's almost like there's an alternative medicine revolution out there with health food stores and integrative medicine.

Dr. Susan Love: The major concern in my mind is that we have no regulation of most of these alternatives so you don't know if there's ginkgo in your ginkgo, so to speak.

Alice Stamm: Right. Which means that at least if you're going to buy these things, don't buy them from your local supermarket just because there's a sale. Buy it from a reputable manufacturer.

Dr. Susan Love: And make sure you're getting some quality. Here's another question. "How soon after a hysterectomy should you be experiencing menopausal symptoms?"

Dr. Marcie Richardson: It depends on whether your ovaries were removed. If your ovaries are removed, you experience it immediately. If your ovaries aren't removed, then it depends on your age. The average age of menopause is 50. Some studies suggest that if you have a hysterectomy, you'll go through menopause a year or two earlier on average than you would if you left your uterus in. The other things that affect age of menopause are smoking, which reduces it a couple of years, and when your mother went through menopause can give you a bit of a clue. Again, if your ovaries were left in after a hysterectomy, when you experience menopause will depend on other history factors for a woman.

Dr. Susan Love: Here's another question. "I heard that body fat produces its own estrogen. Do you think women gain weight to compensate for estrogen loss? Are there alternative remedies to help with weight gain?"

Dr. Marcie Richardson: Weight does provide some protection against the conditions that are worsened by loss of estrogen, specifically osteoporosis. Women who are overweight have higher levels of estrogen in general and this may be related to why they have higher incidence of breast cancer. As far as alternative methods for weight loss, I don't know any. If you find one, let me know.

Alice Stamm: Just be careful to stay away from herbs that contain ephedrine, which is dangerous for your heart. One thing about the weight, menopause for a lot of women is an emotional, physical, spiritual rough experience. If it's not a major weight problem, I don't necessarily think it's always essential that women diet, especially low-fat diets

during menopause. A lot of the fat we take in is important in keeping everything lubricated inside.

Dr. Susan Love: Everybody has to work through things their own way. I've actually become a born-again runner with menopause.

Alice Stamm: I heard you just ran a marathon.

Dr. Susan Love: Slowly. Here's another question from our audience. "For the woman who wants to avoid taking HRT, other than Evista and Fosamax, is there anything else besides calcium that can help the bones?" Actually, that feeds right into the exercise question.

Dr. Marcie Richardson: Exercise is the answer. I mean, calcium, vitamin D, and exercise. A wonderful book about bone maintenance is Miriam Nelson's book, *Strong Women, Strong Bones,* where she addresses all the lifestyle issues as well as having a chapter on the pharmacologic ones, and I would highly recommend that book.

Dr. Susan Love: She did a very interesting study on weight training. We always talk about walking improving bones, but she found that even in their 90s, if women started lifting weights, they could build bone and increase their bone density.

Dr. Marcie Richardson: Actually, Miriam doesn't really feel that walking is sufficient bone-trophic exercise. You've either got to walk really briskly or do running or weight training.

Dr. Susan Love: The other thing about osteoporosis worth pointing out is that there's so much current research into building bones, that pretty soon we'll have some better drugs.

Dr. Marcie Richardson: I agree, Susan. I think people have gotten interested in osteoporosis, but they've gone overboard and I think we need to not have women in their 50s taking Fosamax because their bone density is a little low. They need to be exercising and taking calcium and waiting for us to get some better drugs. (laughs)

Dr. Susan Love: Exactly. Who knows what these long-term effects are? Here's a good question that goes with that. "What damage am I doing to my body since I had menopause at age 26 because of my breast cancer?" That's an interesting situation. Marcie, do you want to comment?

Dr. Marcie Richardson: Well, I do think you need a bone density test to see how your bones are doing. And, I think this may have had some effect on your heart, but not necessarily. That depends on what the other heart-healthy parameters are for you—your cholesterol, your blood pressure. I hope you don't smoke. In terms of additional things to

your heart and your bones, those are much harder to measure.

Dr. Susan Love: I think the lifestyle issues are the key for all of us. We don't know, other than that.

Alice Stamm: I think it's probably the first time in our lives that we've become so familiar with our bodies, so aware of how our bodies function. Before menopause, how many of us ever thought about the whole process of getting older until we started going through it? You have to make a whole sweep of changes as far as the food that you eat, the exercise that you do, your mind-set. You have to change the way you think. It's not so much what happens to us in life but how we react to what happens. Menopause can be impacted by our thought processes as well.

Dr. Susan Love: I also think we don't know what chemotherapy-induced menopause is, but it's probably somewhere between surgical menopause and natural menopause in that it doesn't completely destroy the ovaries. The ovaries might still be producing some hormones. Some women on chemotherapy get their periods back and even get pregnant afterwards. We don't really understand that interaction.

Alice Stamm: I have a question that comes up frequently in Power Surge and I don't really know the answer to it. Women come into my group—women who have had breast cancer or some other form of cancer—and they're taking hormone therapy. I have a problem understanding this.

Dr. Susan Love: It's controversial. Certainly prior to the more recent data about heart disease, there was a moment that said risk of heart disease was higher than breast cancer risk. But that's being reevaluated now. And it's still controversial.

Alice Stamm: What are the preliminary results of the Women's Health Initiative regarding heart disease and hormone therapy?

Dr. Marcie Richardson: There have been some preliminary results that raised the question of an increased incidence of the women in the hormone arm of events, but it was not a statistically significant increase. I think we just have to keep waiting. I think on the question of taking estrogen in breast cancer survivors, Alice, some women really suffer from estrogen-deficiency symptoms. They suffer sexually; they suffer with debilitating hot flashes. And, some of them get to a point where they've tried all the things we've mentioned tonight unsuccessfully and they're willing to try hormone replacement. I actually have some patients that I write prescriptions for. It's a decision of risk/benefit like many that we make in life every day when we get into a car.

Dr. Susan Love: I agree, but I think as a general rule, it's probably better to try not to use estrogen since all of our evidence connects breast cancer and estrogen.

Dr. Marcie Richardson: I absolutely agree.

Dr. Susan Love: And this is the kind of person we might give it to. This is from NY Shopaholic: "What if you can't leave the house or get out of bed and you hate everyone and everything?"

Alice Stamm: Come to Power Surge first, please.

Dr. Susan Love: Some people do feel that badly, and in that situation estrogen sometimes can do the trick.

Alice Stamm: It really can and I mean I was not an advocate of HRT and I have spoken about the fact that I was dealing with an internal shaking that was defined in many different ways by different doctors, but nobody had an answer for it. I tried bi-est, which is a naturally compounded hormone combination of estradiol and estriol, and it helped a little in the beginning, then after a while it didn't help at all. And the bottom line for me, I was dead set against HRT, but here I was with an unbearable situation; I had tremors inside my body. So I do understand the mind-set of women who are suffering terribly. There are women who go through horrible isolation. I hope they get computers or have computers. The bonding that women do and the sharing of information and support is so important at this time in life.

Dr. Susan Love: Here's another question from our audience. "I'm 47 years old and have a fibroid as large as a cantaloupe. My MD says I need a complete hysterectomy and I'm scared to death to take hormones. My mom died of breast cancer at 66."

Dr. Marcie Richardson: Three things. Number one, removing your uterus doesn't mean your ovaries have to be removed. Number two, I don't know whether this fibroid is causing you any symptoms, but I would certainly get a second opinion. Number three, there's a procedure called uterine artery embolization, which some people use to treat large fibroids where they clot off the arteries to the uterus as an alternative to surgery and you might want to find if there is someone in your area who is doing that and see if you are an appropriate candidate.

Alice Stamm: How effective is that, Marcie? It's fairly new, isn't it?

Dr. Marcie Richardson: It's fairly new. The first cases were done early in the '90s. One of the doctors who I share call with has been doing them and many of his patients are very happy. But, we don't have much long-term data.

Dr. Susan Love: Again, as we said in the beginning, there are alternatives to estrogen. You don't have to do it, even if you have a hysterectomy. One last question here. "What do you do if alternative therapies haven't worked and HRT has relieved major hot flashes?"

Dr. Susan Love: Well, then you take HRT.

Dr. Marcie Richardson: And, reassess it on a regular basis.

Alice Stamm: It's not something that you're signing onto for life. I often say to women who are dead set against it but they don't know what way to turn, try it and if it works, take it to get you over the hump.

Dr. Susan Love: And if it doesn't work, stop. I've had people say to me, "I'm taking hormones and they're not helping me at all. What should I do?" and I say to stop.

Dr. Marcie Richardson: Or, try others. There are many, many hormone options and I think that's something else that women get stuck with, is the doctor gives them a prescription for Prempro and that doesn't work or has side effects and then they say hormones don't work. There are many different hormones and many people and sometimes you have to work to make an appropriate match.

Alice Stamm: Don't be afraid to ask your doctor questions.

Dr. Susan Love: I think it brings us to the conclusion or summary of the chat, which is that one size doesn't fit all. There are lots of alternatives and options that women can try for menopausal symptoms and you should be able to explore them all with your doctor. Give them enough time and really figure out what's going to work for you.

I want to remind everyone that if you have a personal question or have not had your question answered, please send it to us through "Personal Guidance" on the website and we will get right back to you with an answer.

Thank you all for joining us today. I want to especially thank our wonderful panelists, Marcie Richardson and Alice Stamm. It has been a wonderful hour. I also want to especially thank GlaxoSmithKline for the unrestricted educational grant that funded this series. GlaxoSmithKline is the US distributor of Remifemin Menopause, a unique extract of black cohosh. Thank you all very much. Please enjoy the website and ask us any questions. This subject is to be continued. Thank you, Marcie. Thank you, Alice. Good night.

Dr. Marcie Richardson: Good night.

Alice Stamm: Thank you. It was my pleasure.