Controversies in Primary Care
Pros and Cons of HRT on patients with CHD

Claire Bellone MSc
Clinical Nurse Specialist – Menopause
Nottingham
Declaration

• Honorariums & Sponsorship from
  – Bayer, Novonortis, Wyeth
Women’s Perceptions of Their Greatest Health Problems

Cardiovascular Disease
~ 46% of all female deaths - the biggest killer in UK and most Western Countries*

*Percentage of total deaths in 1999 among women aged 65 years and older.

CV Risk Factors: 90% of cardiovascular disease is Preventable

<table>
<thead>
<tr>
<th>Non-Modifiable</th>
<th>Modifiable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Age</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Family history</td>
<td>Cigarette smoking</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Abnormal lipid profile</td>
</tr>
<tr>
<td></td>
<td>Menopause</td>
</tr>
<tr>
<td></td>
<td>Sedentary lifestyle</td>
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<tr>
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<td>Obesity</td>
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</table>
# Controversies x 4

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<table>
<thead>
<tr>
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<tr>
<td><strong>A</strong></td>
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<td>HRT can not be initiated after the age of 60?</td>
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1=YES  2=NO
Case Study

- 86 Post menopausal
- Symptomatic
- Intact uterus
- x4 MI in 2 years
- Controlled hypertensive
- Continuous combined HRT
- Under shared care with the Royal Brompton Hospital
HRT and Regulatory guidance
MHRA, BMS (NICE - 2015)

• No age limit, No time limit
• Licensed for symptomatic menopausal women & osteoporosis prophylaxis

• INDIVIDUALISE
• LOWEST EFFECTIVE DOSE
• RISKS Versus BENEFITS
WHI – discredited by the authors themselves

- Years after the menopause increases population risk of CHD
  - WHI study average age 63.5 and unhealthy American population
  - Probable class effect of E+P
  - VTE risk +3/1000 in 5 years (Population risk 6)

- WINDOW OF OPPORTUNITY
- Titrate dose with transdermal patch or gel
HRT: CHD and VTE

- HRT is cardio-protective: but not a licenced indication
- Oral estrogen
  - Pro-thrombotic: first pass effect on liver
  - Increases triglycerides
  - Increases BP +/-
- Transdermal estrogen
  - No effect on clotting
Prevalence of hypertension in UK 2002

Percent of population

Age

<30-50 % Hypertensive

British Heart Foundation Statistics database [www.heartstats.org](http://www.heartstats.org) 2004 Page 157
Data derived from: Health survey for England 2002Department of Health, UK
Systolic BP>140; Diastolic BP>90mmHg
Association of hypertension with absolute and relative risk of stroke and MI

Diastolic BP ↓ 5-6 mmHg
Systolic BP ↓ 9-10 mmHg

↓ Stroke 40%
↓ CAD 25%

Collins R. Lancet 1990; 335:827
HRT: Bioidentical v Synthetic

- All HRT Estradiol is BIOIDENTICAL
  - Plant based
  - Exception Equine Estrogens (WHI study)

- Class effect exists with Progestogens
  - MPA (WHI study): increased breast cancer
  - NET: androgenic side effects
  - Dydrogesterone: none significant breast cancer risk

- BIOIDENTICAL progesterone: no significant VTE or breast cancer risk
In a group of 1,000 women aged 50-59 years who have never taken HRT, 3 women would be at risk of stroke. If all were using combined HRT for 5 years, then 1 more woman would be at risk.

Adapted from: CSM Vol 30 October 2004
Recommended prescriptions

1st choice: Transdermal bioidentical

Estradiol
- Evorel 50mcg BiWkly
- Sandrena Gel 1mg OD
- Oestrogel 2-4/day

Progesterone
- Utrogestan 100mg nocte CCHRT
- Utrogestan 2x100mg nocte SCHRT

2nd Choice

Femoston combined oral pill
(Estradiol + Dydrogesterone)
- Femoston Conti PO
- Femoston Conti 0.5/2.5mg PO
- Femoston 1/10 or 2/10 PO

Evorel combined patch
(Estradiol + Norethisterone)
- Evorel Conti BiWkly
- Evorel Sequi BiWkly
Coronary Heart Disease
Effect of Body Mass Index

BMI RR relates to risk of nonfatal myocardial infarction and fatal CHD combined, (adjusted for age and smoking). HRT RR relates to risk of CHD.

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<th>Relative Risk</th>
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<tr>
<td>BMI &lt;21(^1)</td>
<td>1</td>
</tr>
<tr>
<td>BMI 21&lt;25(^1)</td>
<td>1.3</td>
</tr>
<tr>
<td>BMI 25&lt;29(^1)</td>
<td>1.8</td>
</tr>
<tr>
<td>BMI &gt;29(^1)</td>
<td>3.3</td>
</tr>
<tr>
<td>HRT User(^2)</td>
<td>1.23</td>
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Ideal BMI 18.5-25

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Thank you