SUSAN Baxter and Jerilynn C. Prior. The Estrogen Errors: Why Progesterone Is Better For Women's Health

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BOOK REVIEW


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Susan Baxter and Jerilynn C. Prior have co-authored a volume designed to stimulate thinking about the widespread use of estrogen therapy and simultaneous underuse of progesterone for managing symptoms during the perimenopause (menopausal transition and early postmenopause). In The Estrogen Errors: Why Progesterone Is Better For Women’s Health, the authors invite us to rethink the role of progesterone as a therapeutic agent as well as an endogenous hormone.

Beginning with a review of the history of hormone therapy, the authors remind us of the influence of the book, Feminine Forever, in which Robert Wilson encouraged clinicians to prescribe estrogen “replacement” therapy for women as a means of preserving their youth. From the mid-1960s the use of estrogen therapy grew, and in its wake so did the discoveries of increased incidence of endometrial cancer and breast cancer among hormone therapy users. Until the Women’s Health Initiative clinical trial of hormone therapy for prevention of heart disease was stopped prematurely in 2002, based on the higher incidence of cardiovascular disease among women treated with estrogen and progestin, the use of hormone therapy was believed to reduce cardiovascular disease by nearly half. In addition, the promise of prevention of cognitive impairment and dementia was not supported by the Women’s Health Initiative Memory Study publications, in which investigators revealed instead an increased incidence of dementia among women treated with hormone therapy.

These series of discoveries each led to controversy about withholding hormone therapy from women, a treatment that so many
clinicians believed had healthful outcomes. The authors of *The Estrogen Errors* point out correctly that as ovulation occurs less frequently and eventually ceases during the perimenopause, progesterone is no longer produced by the corpus luteum. They speculate that the reason that the absence of progesterone has been ignored has been the marketing of the use of estrogen to clinicians and directly to women. The medicalization of menopause emphasized the decreased production of estrogen and ignored the absence of progesterone as women cease ovulating.

In a series of chapters, the authors address the dilemmas related to respectively heart, bone, and breast health during the perimenopause and the potential consequences of using hormone therapy. They examine evidence for the efficacy of progesterone therapy for hot flashes and other symptoms experienced during the menopausal transition, and as a prevention strategy for osteoporosis and consider the relationship of progesterone treatment vs. estrogen therapy with respect to adverse effects.

The role of progesterone in hormone therapy has largely been to protect the endometrium from hyperplasia and endometrial cancer resulting from estrogen exposure. To date, there has been little research exploring the application of natural progesterone for symptom management. However, the Postmenopausal Estrogen and Progestin Intervention trial did examine the role of natural micronized progesterone in comparison with medroxyprogesterone acetate (MPA), indicating favorable effects on lipid profiles, suggesting potential benefit of micronized progesterone.

Aside from this large prevention trial, there has been limited attention to this type of progestogen for reducing cardiovascular disease risk. The use of micronized progesterone as an agent in hormone therapy (along with estrogen) for symptom management has been studied and there is evidence of fewer side effects associated with its use than with use of other progestins (Goletiani et al. 431). Moreover, there have been studies of the role of MPA and micronized progesterone as part of an estrogen and progestogen regimen with indications that the latter is associated with more efficient nocturnal sleep (Montplaisir et al. 8). In another study, women treated with different hormone therapy regimens that each included an estrogen plus varying progestogens and a testosterone were evaluated after exposure to a laboratory stress-testing regimen. Of all the groups exposed to different treatments
for symptoms, the group treated with Estratab (esterified estrogen) plus Prometrium (micronized progesterone) experienced diminished systolic and diastolic blood pressure in response to the stressor exposure (Matthews et al. 42). These examples of benefit of micronized progesterone compared to other progestogens all include use of estrogen preparations: none involved testing a progestogen alone.

At this point, there are few published clinical trials examining the efficacy of micronized progesterone alone on symptoms women experience during the menopausal transition and early postmenopause or on its adverse effects. The Food and Drug Administration, which regulates prescription drugs in the U.S., has not approved micronized progesterone alone for the management of hot flashes or other menopause-related symptoms with the exception of inducing withdrawal bleeding.

Currently, use of micronized progesterone alone for symptoms management is considered an off-label use in the U.S. Women who cannot or do not wish to take estrogens may be cheered by Prior’s ongoing research on micronized progesterone. Unfortunately without evidence for the use of micronized progesterone alone (without an estrogen) for symptom management or as a preventive agent, it is difficult to argue confidently for benefits and risk from empirical evidence. Instead we are reminded that absence of data cannot be equated with either absence of therapeutic effect or absence of adverse effects.

Works Cited