

## **Contradicting the Women's Healthcare Initiative 2004**

BioBalance Podcast — Dr. Kathy Maupin and [Brett Newcomb](#)

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Dr. Kathy Maupin: This is episode 29 of the BioBalance Health podcast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. Today we're going to be talking about a new article that came out in JAMA, the Journal of the American Medical Association, which contradicts what has been the perception of hormone replacement therapy for the past seven years. And that perception came from the Women's Healthcare Initiative (WHI) in 2004. It's really had a significant impact on the medical care that men and women receive as they reach later middle age and go through menopause and andropause. Kathy, you know all about this.

KM: This came out and I had my phones filled. Everybody was calling me because I then believed, and I still believe even more, that replacing hormones is very important to people being healthy. The headline was "Hormones Cause Breast Cancer". That's what they had in the headline. And throughout the paper it was like a press release from the people who did the WHI. But it was a misinterpretation.

BN: That was in 2004?

KM: Right, but now we have a revision of that which correctly evaluates the study, looks over all the things that were put out in the press, and interprets them in a way that is proper. Dr. LeCroix, a woman, was the researcher. She worked with a group of women that did this research. The Women's Healthcare Initiative did not tell us what it should have. The results were different than the press release.

BN: So why were the results different? The Women's Healthcare Initiative basically, as I remember it, as I understand it, made the announcement that hormone replacement therapy, particular for estrogen, was an unsafe medical practice, that it would lead to increased examples or incidents of breast cancer in women. And the current research says that's all incorrect and it's incorrect for some specific identified reasons. What are those reasons? What do women need to know today, and their doctors?

KM: Women need to know, and your doctors need to know, that estrogen is not the problem. Estrogen in this study was paired with a progesterone. So Premarin is estrogen and Provera is a progesterone. They were put together and in that part of the study where all the women took that, those people had a slightly higher risk of breast cancer. But in the arm of the study where the women who had hysterectomies only took Premarin, which is estrogen, they had a lower risk of breast cancer. For them to leap

from these results to the results that say estrogen causes breast cancer is absolutely wrong. That's not what the study said.

BN: Well there are two fundamental flaws in that. One is the sort of globalization or generalization to the term "estrogen". So, all the derivative forms of estrogen are labeled incorrectly in the mass media and mass communications.

KM: If you say "estrogen", it doesn't mean all estrogens because every single estrogen is different. Every single estrogen that you take is different in terms of what it's made of, it's different in terms of how you take it. So it could be bio-identical, that's much less risky than Premarin which is horse urine estrogen. I'm not saying anything about Premarin in terms of disliking it for that reason. However I didn't write it. But it's still very safe in terms of breast cancer and heart disease. That part of the study documented that, but no one in America was told that. So it's not just estrogen, they're not all the same. They're talking oral estrogen.

BN: Well that's the second issue, the delivery method.

KM: How they get it. If you take oral, that's a little more risky than transdermal which is more risky than vaginal, which is more risky than pellets. And pellets are the safest estrogen form, which is why that's what I use. Because it's the safest and most effective.

BN: What makes it safest? Why are pellets safe?

KM: Because it doesn't go through your stomach. Because you aren't taking it orally. We call it the "first-pass effect". If it goes through your stomach, it's absorbed by the liver and changed into multiple things. Then when it comes out . . .

BN: So the metabolic process from taking it orally is different from the metabolic process from the pellets that are injected under the skin?

KM: Right. They're under the skin and your body picks up pure estrogen or pure estradiol, excuse me, and pure testosterone from the pellets and it takes it to your body, it crosses the blood-brain barrier as a pure form. When you take it as a pill it goes through your liver and makes all kinds of other forms of estrogen and it's not good for you.

BN: So the digestive process and the chemistry process of the liver for what it normally functions to do impact on the estrogen if you take it orally and they don't impact on it if you take it under your skin as a pellet.

KM: Right, and that's documented in many studies. In between those two generalizations, I mean the oral verses the pellets, between those is transdermal which is much safer than oral because when it goes through your skin . . .

BN: So, transdermal is a lotion or a cream that you rub on your skin?

KM: Or a patch.

BN: Or a patch that you wear and it's absorbed through your skin tissues. And how do the breakdowns on that compare to the pellets that are inserted?

KM: That creates a lot more of the estrone which is an old lady estrogen which is the source of breast cancer. And blood clots. So, that's why the risk.

BN: It's a higher risk. Is that what the Women's Health Initiative was actually referring to?

KM: That's what they were referring to. But really what they found was just a slight elevation. It was amazing. It was really due to the Provera. They gave estrogen a bad name because Premarin was in the study. But truly what was really wrong was the pill going through the stomach with a progestone in it (that was Provera). That was changed into all kinds of other metabolites that created a higher risk of breast cancer.

BN: So initially in 2004 why did the medical community take that at face value and why did the "bad rap" for estrogen or for hormone replacement therapy continue for seven years?

KM: The medical community got kind of blindsided. We didn't get the information on the WHI study until it was out to the public. They sent a press release that was absorbed by everyone before it came out in the Journal of the AMA. So doctors didn't even know it was coming. We usually get information a week ahead so we can research it and give our patients the proper advice.

BN: You know they used to do that in the early days of television when Marcus Welby was a national show, doctors were told about the Marcus Welby syndrome because it would run on Sunday night and then every Monday morning they'd get calls from people all over America that had watched the show reporting those symptoms. So that whole mass distribution communication process got involved.

KM: It's very important and the journalistic community has a burden to actually read the research and make sure what they're giving to the public is actually true.

BN: But what they tend to do is not read it and go to "experts" and ask for a sound bite. And actually my understanding is that that's what happened in St. Louis. When this new study broke in JAMA, and LA times broke it, and it hit the internet everyone was going, "oh my gosh, maybe replacement of hormone therapy isn't such a bad thing."

KM: This was a retraction of the WHI study.

BN: Maybe we should go and look at that or reconsider that and then the news media went to the research hospitals in St. Louis and asked a male physician and said, "What do you think about this?"

KM: And he said “Oh that retraction is all bunk.” He didn’t give us any reason. He didn’t read it.

BN: Based on not reading the article. And not doing the research. But he didn’t just say it’s all bunk. He said women don’t need it. Women, who have those issues, don’t need it.

KM: Well, he’s not a woman, he has no idea how much we need that or not. Most of my patients wouldn’t be living a real life if they didn’t have their hormones.

BN: So we have the issues with the way the research was done originally, the way the media covers the issues, the way doctors absorb and reflect the communication back to their patients. And then you have some recommendations that when women go and see their doctor or when people go and see their doctor complaining of symptoms, complaining of issues there are certain, (three or four), criteria that you say people ought to look at when the conversation isn’t real clear for them. Can you run through what those points are?

KM: Well, some of those things have to do with making sure you ask the question the doctor can answer. And if he can’t answer it and says ‘you don’t need to know about that’ or dismisses you, you probably need to find another doctor. Or pursue the question a little bit more safely. Are you talking about all the estrogen questions or are you talking about any question?

BN: I’m just talking in general. If I go see the doctor and the doctor is dismissive of my concerns and the doctor tries to placate me and say “oh well that happens when you get old” or “that happens sometimes and you just have to learn to deal with that.” You know I have a tendency to think doctors know what they’re talking about so I’ll just go away and suffer.

KM: Right, it’s a wastebasket term for doctors. It means ‘I don’t have enough time to explain this to you and I don’t have a good answer for this so you need to get out of my exam room’.

BN: We did a podcast a couple weeks back on the process for making good medical decisions. And one of the things that you said at that point was that you should ask yourself and you should ask your doctor. “If I don’t take a particular medicine or do a particular intervention what happens? What happens if I don’t act or don’t move any differently than I have acted and moved? And if I do this intervention what happens? What are the costs or benefit ratios for doing it and not doing it?”

KM: The risk of either doing it or not doing it.

BN: And in looking at the estrogen research the two pieces, the two ends of that, I think one of the things that really shouts out is look for global generalizations of a generic type of drug as opposed to a specific drug or a specific intervention. And the

other is, ask your doctor to slow down and talk to you. Ask them if they have done the research, if they've actually read the study.

KM: If they've actually read the study. It's very important that they read the study. And that was my problem with advising my patients when the WHI study came out. All of a sudden I'm flooded with phone calls and no information. And that's because I wasn't given the whole study. I actually read the whole study and realized that it had been done poorly.

BN: In specific to the practice that you have and the hormone replacement therapy that you do, one of the points that you constantly make when you talk to your patients is if you don't do this then what other kinds of issues might you have or what other kinds of medicines might you be taking? Because one of the tradeoffs is if this works for you, you can come off of this medicine, that medicine, the other medicine. So when you calculate cost benefit ratio, those things need to be considered as well.

KM: Right, so it's cost, but it's more risk. The answer to the "if you don't take hormones" question is you increase your risk of Alzheimer's, you increase your risk of heart disease. If you take estrogen or estrogen in particular forms, it doesn't increase your risk for heart disease, it decreases it. All of that and you don't have depression, you don't have anxiety. In general if you've had depression/anxiety enter your life after 40 it fixes that. You can get off all those medicines.

BN: Insomnia.

KM: It helps Insomnia and that's amazing. That's one of our subjects we're going to be talking about.

BN: So depression, anxiety, insomnia.

KM: It prevents Alzheimer's, and heart disease, it actually prevents muscle shrinkage, and decreases your risk of possibly being in a nursing home and being cared for as you're older. You maintain your muscles and your bones. No osteoporosis medicine.

BN: It isn't a panacea and it doesn't guarantee those things. But statistically there are reductions of risk and there are improvements for most of the patients that have had hormone replacement therapy.

KM: That's right. And if you don't take it increases your risk. In the end it's really important to ask what happens if I don't? What happens if I do? Almost with every treatment. Especially in hormone replacement therapy.

BN: Basically what we're saying is look at the information that's out there. Take the time to talk to your doctor. Make sure that you get your questions answered. But also talk to yourself about the cost benefit ratio. If I do this, if I don't do this, what are the trade offs? And, if you have specific questions about this or any of the other podcasts

that we have done please email those questions to us at [podcasts@biobalancehealth.com](mailto:podcasts@biobalancehealth.com). And also if you have time I'd like you to go out and look at my blog which is [brettnewcomb.com](http://brettnewcomb.com) where I talk about what I believe about good therapy and how to get and do good therapy.

KM: And if you'd like to know more about BioBalance Health or Bio-identical hormones visit our website [biobalancehealth.com](http://biobalancehealth.com) or call 314-993-0963.