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EDITORIAL

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Records show that for thousands of years medical texts have referred to loss of fertility and cessation of menstruation [1].

Life expectancy in those times rendered such knowledge somewhat irrelevant to women and doctors, and this remained so until life expectancy increased. In the late nineteenth century, physicians embarked upon a range of so-called 'treatments' for 'menopause', a term first coined in 1821 to describe permanent cessation of menses [2]. Treatments included hysterectomy, confinement to asylums, belladonna, opium, vaginal injections of lead and pulverized cow ovaries.

Perhaps they thought cessation of menses was a disease?

Exactly who these 'treatments' were meant to benefit is a moot point but at least the pulverized cow ovaries suggested some early knowledge of an association between sex hormones and cessation of menstruation.

The discovery of 'an ovarian hormone' by Allen and Doisy in 1923 [3], followed by identification of the structure of estrone by Butenandt shortly after [4], allowed scientists to establish a link between the end of menstruation and changes in sex hormone production in the ovary. Thus, it followed that, if loss of sex hormones was the cause of symptoms of the menopause, replacing those hormones would be a 'cure'.

What facilitated treatment of menopause for the masses was the discovery that a group of estrogens could be extracted from the urine of pregnant mares. First isolated in the 1930s at the University of Toronto, this collection of conjugated estrogens came to be known as Premarin and became available as a pharmaceutical product in Canada in 1941 and the USA in 1942.

So began the first wave of menopause marketing. The Internet, let alone social media, was yet to arrive. Television was in its infancy and news of this breakthrough treatment reached doctors via pharma company representatives and reached women via advertisements in newspapers and magazines.

Conjugated estrogens were marketed not only as a 'cure' for menopause (by now considered a disease) but also as a fountain of youth. Advertising was often framed in a manner which today would be considered sexist and inappropriate. Husbands (the only people who had 'partners' in the 1940s were law firms) were targeted too. Advertisements suggested, to husbands, that if their wives took Premarin they would be 'pleasant to live with again'. In 1966 Robert Wilson wrote his famous book, *Feminine Forever*, in which he described menopause as a serious painful and often crippling disease for which estrogens were the cure [5].

Thus, we embarked upon the first era of mass use of estrogen replacement therapy, a movement which continued to gain pace until 1975 when observational data linked unopposed estrogens to an increased risk of endometrial cancer. Sales nose-dived until progestogens were added to correct this problem. New benefits for what was now called hormone replacement therapy (HRT) were found in prevention of bone loss and osteoporosis-related fracture.

The medicalization of the menopause combined with societal mores and assumptions caused many women in midlife to feel useless, unattractive and ill [6]. They developed negative attitudes toward menopause and aging, and consequently welcomed any interventions which might correct these fears.

The International Menopause Society (IMS) [1], founded in 1978, has always been committed to the study of all aspects of the climacteric. Scientific meetings have been convened regularly and research into the effects of menopause on postmenopausal life has increased exponentially.

Prominent amongst that research were numerous observational studies examining the consequences of menopause both short and long term. These studies found that approximately 80% of menopausal women experienced menopausal symptoms but that only approximately 30% suffered severely enough to seek medical help. Most of these data came from studies of middle-class women in western countries.

Research from other parts of the world has followed but, still today, most data on menopause and its consequences are derived from western populations.

Other observational studies examined long-term consequences of menopause, finding that women's bone and cardiovascular health declined after menopause and that HRT was a helpful intervention. In 1988, the US Food and Drug Administration (FDA) approved HRT as a preventative treatment for osteoporosis.

Prompted in part by the positive findings from observational studies, in 1991 the largest ever randomized clinical trial on the role of HRT in the prevention of disease was commenced. It was called the Women's Health Initiative (WHI).

Details of the WHI trials have been reported extensively elsewhere [7]. Suffice to say that the original results were not what was expected and caused widespread alarm amongst women and their doctors when released in 2002. By now, the Internet had arrived. Medical journals of course

still existed but, despite this, the original WHI data were given to the media first and the medical profession later.

As we all know, the damage done by the original misinterpretation of WHI data and particularly the assertion that the results applied to all women regardless of age and underlying health was profound.

Despite more positive subsequent reviews of WHI data by the WHI investigators [8] and dissenting views by some amongst their number [9], the damage was done. Use of HRT plummeted, and women remained scared.

Twenty-one years later, recommendations and guidelines from national and international societies consistently agree on the core principles for the management of midlife women's health and menopause [10].

First and foremost, menopausal hormone therapy (MHT) is not for every woman.

Not every woman will experience bothersome menopausal symptoms and, in the absence of other medical conditions, MHT is not recommended for asymptomatic women.

MHT is an appropriate treatment for the relief of troublesome menopausal symptoms and will reduce the risk of postmenopausal osteoporosis and fracture.

Estrogen replacement therapy may be beneficial for cardiovascular health in postmenopausal women, but is currently not recommended for primary prevention of cardiovascular health.

MHT use brings with it some small risks. Oral MHT is associated with an increased risk of thrombosis and some forms of MHT, particularly those combining an estrogen with a synthetic progestogen, are associated with a small increase in the risk of breast cancer detection with long-term use. These risks must be balanced against benefits for each woman before commencing MHT.

Unfortunately, the persisting legacy of WHI is a widespread fear of MHT amongst women and health-care professionals completely disproportional to the evidence.

Recent research has once again demonstrated a very limited knowledge of menopause amongst women, particularly those younger than age 40 years [11].

One of the challenges of the twenty-first century is to overcome this lack of knowledge and the many misconceptions, and to provide our colleagues and women with evidence-based guidelines to improve the overall health of women in midlife and beyond.

Major societies, including the IMS, regularly convene menopause congresses, webinars, lecture series, continuing education programs and newsletters. Many of us travel far and wide speaking about the menopause to interested groups of women and doctors. Largely, we are preaching to the converted.

It was not until 2005 that social media became the cultural institution it is today with massive reach never imagined. Social media are ubiquitous and have become the primary method of distributing information and advice. Unfortunately, information and advice proffered on social media is often unfiltered, rarely assessed for truth and often provided by people with little or any knowledge of what they are advocating.

In the past few years there has also been a significant increase in discussion of menopause on social media. There can be no doubt that this will facilitate the spread of information about menopause to many more women than ever before but, for reasons already noted, will that cause more harm than good?

Celebrities have now joined the throng of commentators. Most, if not all, are well meaning and have shared their experiences (usually horrible) bravely with the rest of the planet.

Their advice to women to seek help and to advocate for better access to information and care is to be applauded. Perhaps the suggestion that all menopausal experiences are terrible is not as helpful.

Health-care practitioners have also used social media to promote their services and to advocate for more widespread treatment of menopause. No doubt their intentions are well meaning, and no one could deny that the menopause and menopausal women have a long history of being ignored, if not neglected.

The advocacy by commentators, celebrities and health workers on social media is, however, a two-edged sword. Their work to increase awareness and to lobby government for greater attention to midlife women's health in national health planning is commendable and can only benefit women.

On the other hand, over-enthusiastic endorsement of treatments, particularly unproven treatments, for menopause and its consequences is unwise. Any advice on best practice management of menopause should be based on evidence-based national and international guidelines and not on anecdote.

The second age of marketing the menopause has arrived. We must avoid exaggeration and the mistakes of over-treatment and mistreatment seen in the mid twentieth century and take this opportunity to further improve women's health through mid-life and beyond with appropriate use of MHT and other proven interventions.

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