NEWSLETTER

OF THE ASSOCIATION OF FORMER PAHO/WHO STAFF MEMBERS

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AFSM GUADALAJARA (MEXICO) MEMBERS AND SPOUSES

Back Row (left to right): Antonio Godoy, Teófilo Partida, Guillermo Gosset, Juan Roberto Unda, and Luis Jorge Uribe.

Front Row (left to right): Georgina de Godoy, Irma de Partida, Nady de Gosset, and Rosalina de Uribe.

INSIDE THE NEWSLETTER

PAHO ELECTS A NEW DIRECTOR

The second term of Sir George Alleyne as Director of the Pan American Health Organization will come to an end on 31 January 2003. As you will recall, Sir George has made known that he will not be a candidate for reelection. Member States will elect the new Director during the Pan American Sanitary Conference, to be held at the Headquarters building from 23 to 27 September 2002.

If tradition holds, the election will be held after coffee break on the morning of Wednesday, 25 September, and the new director will take office on 1 February 2003.

Since the last Conference, a constitutional change has been made that will enter in force as of the opening of this Conference. It changes the period of office of the Director to five years (from four years) and stipulates that the person cannot be reelected more than once (i.e., a maximum of 10 years in office).

The name of the person elected as Director of the Pan American Sanitary Bureau will be communicated to the Executive Board of the World Health Organization so it can appoint the person elected as Regional Director of WHO for the Americas.

The election procedure is described in Rule 56 of the Rules of Procedure of the Conference. It states: "The Conference shall elect the Director by secret ballot, in conformity with Article 21, paragraph A, of the Constitution. Before voting is begun, Members and Associate Members that wish to do so may nominate any person they deem suitable for the post, but no official list of candidates shall be drawn up, no eligibility requirements shall be established, and votes may be cast for a person whether nominated or not." To be elected, a candidate must receive a majority, which in the case of the election of the Director (Rule 47) is "...any number of votes greater than half the number of the Members of the Organization."

There are 38 Member and Participating Governments of the Pan American Health Organization ("Members"), thus a "majority" is any number of votes greater than 19, that is, 20 or more. (Puerto Rico, as an Associate Member, has the right to voice and to nominate, but does not have the right to vote.)

The new Director will be elected for a five-year term that begins on 1 February 2003 and ends on 31 January 2008.

At this time the number of announced candidates for the office of Director has dropped to two: Dr. Mirta Roses (Argentina, presently the PAHO Assistant Director) and Dr. Jaime Sepulveda (Mexico, presently Director of the Mexican National Institute of Health). Dr. Juan Antonio Casas (Costa Rica, currently director of the Division of Health and Human Development, PAHO) recently withdrew his candidacy.

CENTENNIAL REUNION

The long-anticipated centennial reunion, to be held from 30 November to 4 December in Washington DC, has been met with great enthusiasm. Many of you have indicated that you will be participating, and excitement is building! It is still not too late to join in, and we are attaching to the Newsletter another copy of the registration form, with instructions for its return. Also attached is the first draft of the program of sessions for the reunion. We look forward to a great gathering of former PAHO/WHO staff members from all over the Hemisphere!

STAFF HEALTH INSURANCE FUND: GOOD NEWS ABOUT PREVENTIVE CARE COVERAGE

Effective 1 July 2002, some preventive care procedures for both active and retired staff are eligible for 100% coverage.

In the United States, the procedures are eligible only if rendered by a "preferred provider." A preferred provider is any doctor or institution that participates with CareFirst, BlueCross BlueShield (BCBS). To know which doctors or hospitals in your area are preferred providers you can access the BCBS website at www.carefirst.com. Click on the icon "Find a doctor" and enter the information you want. Please be aware that PAHO's insurance is an Indemnity Plan, whenever asked that question on the web. You can also request a directory of preferred providers in the Washington DC

metropolitan area by contacting BCBS at: 202-479-1734 or 1-800-424-7474, ext. 1734.

Outside the United States, the procedures are eligible only if rendered by a doctor, hospital, or medical center that provides the services at a minimum of a 5% discount. Usually, the medical institutions that have contracts with field offices provide such a discount, but not in every case. Such discount must be stated on the receipt presented with the medical claim.

Procedures eligible for the 100% provision are:

- mammography with a medical prescription;
- gynecological check-up once every three years, including PAP smear test;
- PSA (prostate-specific antigen) exam;
- consultation with a dietitian for obesity cases (BMI (body mass index) greater than or equal to 30 only) with a doctor's prescription;
- colonoscopy each ten years as from age 50;
- general medical check-up once a year for retired staff, spouse/surviving spouse.

Should you have any questions about these provisions you can contact the Staff Health Insurance Unit in Washington, DC, by phone 202 -974-3751 or by e-mail (falqueza@paho.org).

UN JOINT STAFF PENSION FUND REPORT

Extracted from a statement by Mr. Bernard Cocheme, CEO of the Fund, to AFICS, and published in its June 2002 Newsletter

Continued volatility in the financial markets

The significant drop in the value of the Fund's assets experienced over the period March 2000 to March 2001 has not been reversed. Although the drop was significant, at least the situation has now stabilized. More specifically, the value of the Fund's assets, which at its historic peak had stood at $US 26.3 billion on 27 March 2000, dropped to $21.9 billion as of 31 March 2001 - and stands at almost exactly the same value today. On this note, I should first reiterate that the investment strategy of the Fund is geared towards the long-term and that any assessment of its performance should be based on an analysis of the returns, not over one or two years, but over extended periods such as the last 5, 10 or even 20 years. It is this long-term view that the Fund's actuaries take into account in carrying out their biennial valuations of the Fund. You will recall that the last two actuarial valuations, carried out as at December 1997 and December 1999, revealed surpluses of 0.36% and 4.25% of pensionable remuneration, respectively. To put this in another context, I would note that at the Board session in 2000, the Consulting Actuary had provided a sensitivity analysis that concluded the Fund could bear a temporary loss of 30-40% of the market value of its financial assets without detriment to its long-term viability.

Actuarial situation of the Fund

While we cannot predict the results of the valuation being completed based on the data as of 31 December 2001, it may be expected that, based on early estimates carried out by the Consulting Actuary, the surplus has decreased but not disappeared. Such a favorable outcome would be primarily attributable to the fact that the Fund's actuarial valuations are carried out based on average asset values, rather than on current market values, with the year-to-year drop in the value of the assets therefore having less of an impact on the valuation results. As was done for the early estimates, the final results that are to be presented to the Board next July are going to take into account the effects of an increase in liabilities and a decrease in the value of the Fund's assets.

On the liability side, I would recall that the Board recommended and the General Assembly approved two benefit enhancements in 2000, namely (a) to lower the interest rate for lump-sum commutations from 6.5 to 6.0%; and (b) to lower the threshold for implementing cost-of-living adjustments of pensions from 3% to 2%. Also on the liability side, the actuarial assumptions have been modified to account for the effects of longer life expectancies and the increased incidence of participants opting for early retirement.

Growth in the Fund's operations

On another closely related point, I would now like to turn to the significant growth the Fund has experienced with respect to its operational activities, especially since the last valuation as at 31 December 1999. Although the final figures have not yet been certified, I would note that as of 31 December 2001 the total active participant count had reached 80,082, representing an increase of 16.2% over the number recorded on 31 December 1999. In addition, the total number of benefits being paid has increased to 49,416 as of 31 December 2001, representing a 7.0% increase over the same two-year period. The total value of all benefit payments during the two-year period amounted to $2.1 billion, representing a 4.8% increase over the prior two-year period.

I would note that this relatively low increase in the dollar amount of payments was due to the overall strengthening of the US dollar vis-à-vis the other currencies in which the Fund makes its payments. A final and critical point that I would like to stress in respect to the growth in our operations is that, during the biennium 2000-2001, the Fund's staff processed over 24,000 new entrants and nearly 13,000 separations. I believe that while this fact alone clearly illustrates the magnitude of our operations, it also serves to highlight the challenges the Fund has been facing. In fact, after considering that the Fund is now serving over 130,000 participants and beneficiaries working and residing worldwide, I believe it is safe to assume that such challenges will continue to grow, not only in numbers, but also in their implications. On an informational note, the Fund has a new website: http//www.unjspf.org.

GOOD NEWS FROM THE CREDIT UNION!

Retirees can now borrow from the Credit Union on equal terms with active staff. This means that they can now borrow up to 35% of their total income, which includes their UN Pension and any other income they might have, such as Social Security or income from investments. Up to this year, retirees could only borrow up to 30% of their UN pension, with a ceiling of $10,000. Now they are equal citizens! All PAHO/WHO Credit Union loans are subject to Credit Committee approval.

You are reminded to advise the Credit Union if you should change your address. This information is not automatically conveyed to the Credit Union when you notify PAHO. The Credit Union address is:

PAHO/WHO Federal Credit Union
2112-F Street NW, Suite 201
Washington DC 20037

Tels: 202-974-3453, 1-866-724-6328
Fax: 202-659-4513
E-mail: fcu@paho.org

The lobby hours of the Credit Union are 8:00 am to 2:00 pm, Monday to Friday.

PAHO STAFF AWARDS, 2002

The annual awards ceremony to recognize staff retiring in the calendar year, staff completing 5, 10, 15, 20, 25, 30 and 35 years of service to PAHO, and recipients of the various annual awards was held at the Headquarters Building in June. The following staff, managers, units/teams received special recognition:

Director's Award

Diane Arnold
Peter Carrasco
Lily Jourdan Hidalgo
Celia Josa de Leon

Outstanding Manager

Fitzroy Henry
Ana Kaul
Ana Cristina Reis Nogueira
Gina Tambini Gomez

Outstanding Unit/Team

General Services (AGS)
BIREME
Country Office - Ecuador
Public Information (DPI)
Special Program of Health Analysis (SHA)

Outstanding Support Staff

Alma Erazo
Rickey Harpster
Cecilia Jibaja
Marta O'Brien-Goldie

We congratulate all the Awardees!

NEW OR SOON-TO-BE RETIREES

The following Headquarters staff retiring in calendar year 2002 were recognized at the PAHO Awards Ceremony in June:

Julio Roberto Barreda ('73)
Tom Becker ('74)
Ligia Blanco ('77)
Gladys Bohlmann ('72)
Heidy Buttari ('80)
Alfonso Chang-Lay ('81)
Ciro de Quadros ('70)
Claude De Ville de Goyet ('77)
Bruce Loc Eckersley ('96)
Biliosa Mangosin Evangelista ('75)
Marjorie León ('75)
Richard Marks ('73)
Gustavo Mora ('77)
René Noda ('75)
Carlos Oliva ('77)
Paulo Cezar Pinto ('93)
Elisabeth Sipkov Pineros ('65)
Nina Toro ('85)

IN MEMORIAM

Dr. Ruth Rice Puffer of McMinnville OR passed away on 2 September 2002 at age 95. Daughter of J. Adams and E. Hope Rice Puffer, she graduated from Hudson High School in Hudson MA in 1925 and from Smith College in 1929. She did graduate work at Johns Hopkins School of Hygiene in 1937-1938 and at Harvard School of Public Health in 1942-1943 and received the degree of Doctor of Public Health from Harvard University in 1943.

In 1970, she received an honorary degree of Doctor of Science from Smith College. In 1970, she also received the Centennial Award for Outstanding and Dedicated Service in the Field of Public Health presented by the Tennessee Health Public Service. She received the Abraham Horwitz Award for Inter-American Health in 1978. She was one of eleven distinguished individuals selected, in 2002, to receive honor as a Public Health Hero of the Americas, which is to be conferred in recognition of the 100th anniversary of the Pan American Health Organization.

After college, she worked at the Harvard School of Public Health in Boston MA; in 1933, she became Director of Statistical Service of the Tennessee Department of Public Health in Nashville TN; and in 1953 she was appointed chief of health statistics of the Pan American Health Organization in Washington DC. She semi-retired in 1970, continuing to work as a health consultant in Washington DC and in the Americas, India and Indonesia. She was the author of several books and papers on public health, some resulting from large inter-American research programs for which she was responsible.

She moved to Corvallis OR in 1982 and continued to serve as a consultant. In 1991 she moved to McMinnville OR. She was active in the American Public Health Association, serving several offices including vice-president. She was also a fellow of the American Statistical Association. She was preceded in death by a sister, Marjorie Field, and a brother, Stanwood Puffer. She is survived by a sister, Evelyn Knowlton, of Medford NJ and a nephew, Richard Field, of Corvallis OR. A private graveside service was held in Berlin MA. In lieu of flowers, memorial contributions may be made to the Ruth Rice Puffer Endowment Fund, Johns Hopkins University, School of Public Health, 615 N Wolfe St, Baltimore MD 21205-2179.

Washington Post, 5 Sept 2002

Other Staff, 2002

Name	*Date of Death*
Santos, Jorgevaldo Sales dos	January
De Los Rios, Severo	January
Kim, Yong Sung	January
Oliveira, Sebastiao Gomes	February
Fiedler, Elson	February
De Abreu, Iris Martins	April
Rodrigues, Bichat	April
Mascolo, Joseph	May
Villas Boas, Aldo	May
Patterson, Artie C.	June
Strittmatter, Gustavo	August

FINDING YOUR WAY AROUND THE NEWLY RENOVATED HEADQUARTERS BUILDING

Finding your way around in the newly renovated Headquarters Building can be a challenge! To help you find the office or service you are looking for, we are attaching to this newsletter a list of the floor locations of the various departments, programs, and services. A letter "V" in front of the room number indicates that it is in the Annex across Virginia Avenue, and a "W" indicates that it is located in the Watergate complex. In addition, we are attaching a list of the organizational codes in alphabetical order, with the corresponding telephone extensions. (Note: The main PAHO telephone number is: 202-974-3000, and each of the extensions listed must be preceded by the numerals 202-974- if dialed from outside the building.)

YOUR HEALTH MATTERS

by Jaime Ayalde, MD., MPH

Hormone Replacement Therapy and Women's Health

Recent health news has been dominated by the controversy over hormone replacement therapy, which in the US alone is used by 14 million menopausal and postmenopausal women. Not only have medical publications been preoccupied with the topic, but also the daily press and weekly magazines. For example, the TIME magazine issue of 22 July 2002 has an extensive article: "The truth about hormones. Hormone replacement therapy is riskier than advertised. What's a woman to do?"

The attention being given this subject is justified. About 40 years ago gynecologist Robert Wilson focused his attention on the female hormone estrogen, not only as a treatment for the symptoms of menopause, but also as a means of prolonging youthfulness and at the same time preventing coronary disease and osteoporosis. The problem was that these hormones promoted cell growth, and uncontrolled cell growth signifies cancer, or at least increased risk of cancer. Researchers found that the use of estrogen by women with the uterus intact was not risk-free, but that its use in combination with the hormone progestin could control this problem. This resulted in the introduction of Prempro, produced by the North American company Wyeth Pharmaceuticals. Prempro combines .625 mg/d of estrogen with 2.5 mg/d of medroxiprogesterone acetate.

The use of combination medications for hormone replacement therapy was the object of follow-up studies, but it was never subjected to strict protocols until late in the eighties and the beginning of the nineties when congresswomen and women activists succeeded in interesting the National Institutes of Health in the subject. This was the origin of the "Women's Health Initiative" study (WHI). The original contribution was published in the Journal of the American Medical Association (JAMA),[1] 17 July 2002, and can be accessed by internet, in abstract or in full text, at the following sites:

http://jama.ama-assn.org/issues/v288n3/abs/joc21036.html

http://jama.ama-assn.org/issues/v288n3/ffull/joc21036.html

The WHI, which began in 1991, was scheduled to run for 15 years. More than 160,000 post-menopausal women participated in the five major studies of the program, which was conducted under the auspices of the National Heart, Lung and Blood Institute together with other units of the US National Institutes of Health (NIH).

The goal of the study was to evaluate the health benefits and risks brought about by the use of the combination hormones used in the US. In this segment of the study, 16,608 women from 50 to 79 years of age, with the uterus intact at the beginning of the study, participated. They were registered in 40 clinics in the US. It was to be a randomized controlled primary prevention trial of the effects on coronary heart disease and cancer, the specific object of the study.

On 31 May 2002, the monitoring board charged with oversight and control of the statistical information and safety of the interventions recommended, after an average of 5.2 years in the study, that the program "estrogen plus progestin vs. placebo" be suspended because the risks outweighed the benefits. Originally it was to have continued for an average of 8.5 years.

The clinical information covers the results obtained up to 30 April 2002. Hazard ratios were estimated within nominal confidence intervals of 95%, finding, for example that the hazard ratio for

coronary heart disease was 1.29 (1.02-1.63), with 286 cases, and for breast cancer, 1.26 (1.00-1.59), with 290 cases. In absolute numbers, the increased risk per 10,000 persons/year that could be attributed to the use of estrogen plus progestin was 7 cardiovascular events; 8 strokes; 8 cases of pulmonary embolism; and 8 cases of invasive breast cancer. On the other hand, there were 6 fewer cases of colorectal cancer and 5 fewer cases of hip fracture.

NIH, through its WHI unit, highlights the fact that the findings refer to the whole population at risk. Therefore, women should not be unnecessarily alarmed, as the risk to the individual woman is slight. For example, each women in the study who took estrogen/progestin had an increased risk of breast cancer of 0.1% per year. The findings prompted the publishing of the following recommendations on the use of estrogen/progestin:

1) The therapy should not be continued or begun for the prevention of heart disease. Women should consult with their doctor on other methods of prevention, such as changes of lifestyle, and, if necessary, the use of medications to reduce cholesterol and lower blood pressure. Exercise and diet control are recommended.

2) In consultation with a doctor, alternative methods of preventing osteoporosis should be undertaken, taking into account the risk of HRT in relation to coronary heart disease, stroke and cancer. Prevention includes weight lifting, a diet rich in calcium and milk, and other foods rich in vitamin D, such as salmon.

3) Women should continue with their schedule of check-ups, mammograms, and breast self-examination.

4) With age, the blood vessels become less flexible, producing high blood pressure and the risk of stroke, and estrogen has a tendency to promote the formation of blood clots, thereby increasing this risk. Alternative control measures include control of blood pressure with medications and relaxation programs such as yoga.

5) Short-term effects were not part of the study but it is likely that women taking hormones to counter the symptoms of menopause have more benefits than risks.

It is worth recalling that a woman reaches menopause for one of three reasons: Age, surgery when the ovaries are removed, or chemotherapy to treat cancer. As a result of the WHI studies, it is recommended that women who have been taking estrogen/ progestin for a long period of time should cease taking them. If undesirable symptoms return, they should be treated with other means. For example, hot flashes and night sweats may respond to some natural remedies (black cohosh, soy, yam and other tubers). Dietetic soy seems to produce better results than isoflavone pills. Skin and vaginal dryness can benefit from the topical application of estrogen creams and the taking of vitamin E. Mood swings can be helped by relaxation exercises, psychological help, acupuncture, and in extreme cases, with antidepressants. Dr. Susan M. Love[2] recommends keeping a diary of the circumstances that trigger hot flashes, such as stressful situations, consumption of certain foods, condiments or spicy products, or caffeine, and consider behavior changes that improve the quality of life. Thirty minutes or more a day should be spent walking, swimming, dancing, etc.

The US Food and Drug Administration has established expert study groups to analyze in depth the conclusions of the WHI study and present their findings to the pharmaceutical industry, the medical community and users, with new directives to redefine who can take hormones in combination, the recommended doses, and for how long. It is hoped that their findings will be available by the fall of this year, or by winter at the latest. Meanwhile, it would seem prudent to suspend the use of hormone replacement therapy and, if necessary, recommence it only with a medical prescription and in line with the new guidelines.

For more information, consult the recommendations of the National Institutes of Health that are periodically updated on the internet: at http://www.nhlbi.nih.gov.

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[1] JAMA, Vol 288 No. 3, July 17, 1001 (JAMA-EXPRESS) Risks and Benefits of Estrogen Plus Progestin in Healthy Menopausal Women. Principal Resuls from the Women's Health Initiative Randomized Controlled Trial. Writing Group for the Women's Health Initiative Investigators.

[2] Dr. Susan Love's Breast Book, Perseus Printing, Third Edition (2000) Chapter 31 "Dealing with Menopausal Symptoms."

Terapia de Reemplazo Hormonal y Salud de la Mujer

Las noticias recientes sobre salud han estado dominadas por el tema de las hormonas de reemplazo que solamente en los Estados Unidos son usadas por 14 millones de mujeres en el período menopáusico y post-menopáusico. Pero no solo las publicaciones médicas se han ocupado de este asunto, sino también la prensa diaria y las revistas semanales. Por ejemplo, el TIME del 22 de julio 2002 presenta como artículo de fondo un ensayo sobre "La verdad acerca de las Hormonas ... La terapia de reemplazo de hormonas presenta riesgos mayores a los anunciados.... Qué debe hacer una mujer?".

La atención que se da a este tema está plenamente justificada. Hace aproximadamente 40 años el ginecólogo Robert Wilson enfocó su atención en la hormona femenina, estrógeno, no sólo como tratamiento de los síntomas de la menopausia sino como un medio de prolongar la juventud y de paso prevenir la enfermedad coronaria y la osteoporosis. El problema era que estas hormonas promueven el crecimiento celular... y un crecimiento incontrolado significa cáncer o al menos aumento del riesgo de cáncer. Los investigadores encontraron que el uso del estrógeno en mujeres con útero intacto no era seguro pero que el uso de otra hormona, la progesterona, en combinación con el estrógeno podía controlar ese problema. De allí surgió el medicamento combinado, siendo el Prempro, producido por los laboratorios Wyeth, el más popular en Norte América. El Prempro contiene 0,625 mg de estrógeno conjugado y 2,5 mg de acetato de medroxiprogesterona.

El uso de los medicamentos combinados para la terapia de reemplazo hormonal fue objeto de seguimiento mediante observaciones pero no estuvieron sujetos a estrictos protocolos, hasta finales de los años 80 y principios de los 90 cuando mujeres congresistas y grupos de mujeres activistas lograron que los Institutos Nacionales de Salud se ocuparan seriamente del tema. De allí surgió el estudio llamado en inglés, "The Women's Health Initiative" o WHI. La contribución original fue publicada en el Journal of the American Medical Association (JAMA),[1] July 17, 2002 que se puede acceder a través del internet, en abstracto o en texto completo, en su sitio:

http://jama.ama-assn.org/issues/v288n3/abs/joc21036.html

http://jama.ama-assn.org/issues/v288n3/ffull/joc21036.html

El WHI se programó para 15 años y se inició en 1991. En total participaron más de 161.000 mujeres post-menopáusicas en las distintas fases del programa auspiciado por el Instituto Nacional del Corazón, Pulmones y Sangre (NHLNI en inglés) en colaboración con otras unidades de los Institutos Nacionales de Salud de los Estados Unidos.

El objetivo del estudio fue el de evaluar los beneficios y riesgos para la salud derivados del uso de las hormonas combinadas utilizadas en los EEUU. En este componente del estudio participaron 16.608 mujeres de 50 a 79 años de edad, con la matriz intacta al inicio del reclutamiento y que fueron registradas en 40 centros clínicos de los EEUU. Se trataba de un estudio aleatorio controlado de la prevención primaria de las afecciones motivo del estudio, principalmente la enfermedad coronaria y el cáncer.

El 31 de Mayo de este año (2002) la junta encargada de la vigilancia y control de la información estadística y de la seguridad de las intervenciones después de un promedio de 5,2 años de seguimiento recomendó interrumpir la administración de "estrógeno más progesterona VS placebo" porque los riesgos excedían los beneficios. Originalmente el seguimiento estaba programado para un período promedio de 8,5 años.

La información clínica cubre los resultados obtenidos hasta el 30 de abril de 2002. Se estimaron los riesgos dentro de un intervalo de confianza nominal de 95% encontrándose, por ejemplo, que la tasa de riesgo (*hazard ratio*) de enfermedad coronaria era de 1,29 (1,02-1,63) con 286 casos y de cáncer del seno 1,26 (1,00-1,59) con 290 casos. En números absolutos el exceso de riesgo por 10.000 personas-año atribuibles al uso de estrógeno más progesterona fue de 7 más eventos cardiovasculares; 8 ataques cerebrales más (*strokes*); 8 casos de exceso de embolismo pulmonar; y 8 casos más de cáncer invasivo del seno. Por otra parte hubo 6 casos menos de cáncer colo-rectal y 5 casos menos de fracturas de cadera.

Los Institutos Nacionales de Salud a través de su unidad WHI destacan que el aumento del riesgo aplica a la población total. Las mujeres no deben alarmarse innecesariamente pues el riesgo para una mujer individual es pequeño. Por ejemplo, cada mujer en el estudio que tomó el estrógeno más progesterona tuvo un aumento del riesgo de contraer cáncer del seno menor que una décima de un punto porcentual, por año.

Los datos encontrados respaldan las siguientes recomendaciones sobre el uso de estrógeno más progesterona:

1) La terapia no debe continuarse ni iniciarse para prevenir enfermedades del corazón. Las mujeres deben consultar con sus médicos sobre otros métodos de prevención, cambios en estilo de vida y si es necesario el uso de medicamentos para reducir el colesterol y bajar la presión arterial. Se recomienda ir al gimnasio y vigilar la dieta.

2) Para prevenir la osteoporosis, en consulta con el médico se deben aplicar métodos alternativos. La prevención incluye el levantamiento de pesas, una dieta rica en calcio, leche y otros alimentos que contienen vitamina D como el salmón.

3) Las mujeres deben mantener su calendario de exámenes, mamografía y auto-examen del seno.

4) Recordar que con la edad los vasos sanguíneos se hacen menos flexibles lo cual conlleva el aumento de la presión arterial con el riesgo de provocar ataques cerebrales (strokes). El estrógeno tiene tendencia a promover la formación de coágulos aumentando este riesgo. Las medidas alternativas incluyen el control de la presión arterial con medicamentos y programas de relajación, como el yoga.

5) Los efectos a corto plazo no fueron motivo del estudio pero se puede decir que las mujeres que tomaron las hormonas de reemplazo para contrarrestar los síntomas de la menopausia obtuvieron más beneficios que riesgos.

Conviene recordar aquí que una mujer puede llegar a la menopausia por una de tres razones: simplemente por la edad, por cirugía cuando se remueven los ovarios o por la aplicación de quimioterapia contra el cáncer. Como resultado de los estudios de la Iniciativa de Salud de la Mujer se recomienda que las mujeres que han estado tomando la combinación de estrógeno más progesterona por un largo período deben parar el uso de esas hormonas. Pueden presentarse algunos síntomas indeseables que deben tratarse con otras medidas. Por ejemplo los episodios de "rubor y calor" (*hot flashes*) y sudores nocturnos pueden ceder ante remedios naturales (*black cohosh*, soya, ñame y otros tubérculos). Aparentemente la soya dietética da mejores resultados que las píldoras de *isoflavone*. La piel y la vagina secas pueden beneficiarse de cremas con estrógeno de uso tópico y vitamina E tomada vía oral. Los cambios emocionales pueden beneficiarse de ejercicios de relajación, apoyo psicológico, acupuntura y medicamentos anti-depresivos en casos extremos. La Dra. Susan M. Love[2] recomienda llevar un diario de las circunstancias que disparan los episodios de calor y rubor, tales como ambiente, situaciones estresantes, consumo de ciertos alimentos, condimentos o especies "picantes", cafeína y así poder adoptar modificaciones de conducta que mejoren la calidad de vida. Incluir en el programa diario ejercicios como caminar, nadar o bailar durante 30 minutos o más.

La Administración de Drogas y Alimentos de los EEUU (FDA por su sigla en inglés) ha organizado grupos de expertos con el objeto de estudiar a fondo las conclusiones del estudio (WHI) y presentar a la industria farmacéutica, a la comunidad médica y a las usuarias nuevas directivas destinadas a redefinir "quienes pueden tomar las hormonas combinadas, las dosis recomendadas y por cuanto tiempo". Se espera que estas decisiones se conozcan en el otoño de este año o a más tardar en el invierno. Mientras tanto, se estima que es apropiado suspender el uso de las hormonas de reemplazo y si se requiere su uso reiniciarlo solamente mediante prescripción médica dentro de los nuevos parámetros que serán establecidos.

Para mayor información se recomienda consultar las recomendaciones de los Institutos Nacionales de Salud, que son actualizadas periódicamente en el *internet*:: http://www.nhlbi.nih.gov

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[1] JAMA, Vol 288 No. 3, July 17, 1001 (JAMA-EXPRESS), Risks and Benefits of Estrogen Plus Progestin in Healthy Menopausal Women. Principal Resuls from the Women's Health Initiative Randomized Controlled Trial. Writing Group for the Women's Health Initiative Investigators.

[2] Dr. Susan Love's Breast Book, Perseus Printing, Third Edition (2000) Chapter 31 "Dealing with Menopausal Symptoms."

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AFSM would like to know about the needs of its members. We might not be able to solve all your problems, but we have many experts and resources that could be utilized. We might either help in some way or refer you to the right source.

We would also like to have your input to the Newsletter, either in the form of articles for publication or in comments on the content: What kinds of articles do you like? Are there some that should be eliminated? Are we missing something that should be included?

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