AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

OCTOBER 2016

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HRT INCREASES RISK OF BREAST CANCER

In 2002 and 2003 reports from the Women's Health Initiative trial and the Million Women Study revealed that the use of hormone replacement therapy (HRT) increased the risk of stroke, venous thromboembolism, and breast, ovarian and endometrial cancers. Following the publication of results of these studies and the international media headlines it generated, the use of HRT dropped dramatically worldwide.

While HRT continued to be prescribed to provide relief from menopausal symptoms including hot flushes, night sweats, insomnia, mood swings, and tiredness, many women were not advised by GPs and specialists of the results of these studies and the risks associated with the use of both forms of HRT.

Within a few years both the pharma-ceutical industry, dismayed at the rapid drop in sales of these drugs, and the health professionals who had jumped on the bandwagon and set up menopause clinics peddling HRT to women, began to fight back. Among other strategies they began casting doubt on the findings of both of these studies at conferences and in the media. Downplaying the risks associated with use of HRT has continued up till the present day. (2)

British Journal of Cancer

In August 2016 a British study published in the *British Journal of Cancer* revealed that women who use the commonly used form of HRT, a combination of oestrogen and progestogen, are nearly three times more likely to develop breast cancer than those who do not use it. (1) The study monitored 39,000 women for six years. During that time 775 – nearly 2% – developed breast cancer and women using combined HRT were 2.7 times more likely to develop the disease during the treatment period than women who had never used HRT.

Anthony Swerdlow, professor of epidemiology at the Institute of Cancer Research in London, said "What we found is that the risks with combined HRT are larger than most of the literature would suggest."

Oestrogen-only HRT

Most women take combined HRT because taking oestrogen alone increases the risk of endometrial cancer. Taking the combined form of HRT is known to minimise this risk. Using oestrogen by itself is usually recommended only for women who have had a hysterectomy.

The latest research found no increase in risk in women using oestrogen-only HRT and a year or two after women stopped taking combined HRT, there was not a significantly increased risk of breast cancer. This confirms the findings of previous studies.

Researchers believe the lack of follow-up information on the use of HRT and menopausal status affected the accuracy of other studies. For example, the failure to account for women who had stopped using HRT during the research period could lead to the risk being underestimated.

The authors of the *BJC* paper stated:
"In conclusion, our results show that risk of breast cancer increases with duration of use of combined MHT [menopausal hormone therapy] for

more than 15 years, and relative risks in most of the published literature are likely to be substantially under-estimated because of lack of updating MHT status through follow-up in cohort studies and inclusion of women with inferred menopausal age in cohort or case-control analyses. These results provide further information to allow women to make informed decisions about the potential risks and benefits of MHT use." (1)

The response to the *BJC* paper from the health professionals was entirely predictable. Dr Heather Currie, a spokesperson for the Royal College of Obstetricians and Gynaecologists, and Chair of the British Menopause Society, said "Women need clear, evidence-based information to break through the conflicts of opinion and confusion about the menopause."

It can be argued that much of the confusion has been caused by those with vested interests in the menopause industry.

"For many women, any change in breast-cancer risk is outweighed by the benefit on their quality of life, bearing in mind there are many other factors that increase the risk of breast cancer, for example lifestyle factors," Dr Currie said.

This, too, can be seen as an attempt by health professionals to deflect attention from the results of the recent research. In this instance it adds to the confusion by pointing the finger at women's lifestyle thus blaming women.

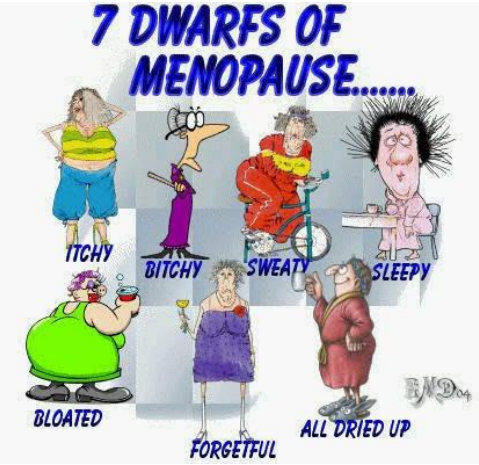
The response from the Medicine and Healthcare Products Regulatory Agency (MHRA), which monitors the safety of medicines, was also lukewarm and vague. It said it would evaluate the study and provide updated information to prescribers and users of HRT *if necessary* [italics added].

An MHRA spokesperson said "Medicine safety and effectiveness is of paramount importance and under constant review. Our priority is to ensure that the benefits of medication outweigh the risks. Current product information on all forms of HRT carries strong warnings on breast cancer, including that the risk increases with duration of use."

Medsafe, New Zealand's medicines and medical devices safety authority, reported on the Women's Health Initiative study results in 2002 (3), and featured an update in 2003 (4), but if their website is anything to go by they have ignored the issue since then.

References

1. www.nature.com/bjc/journal/v115/n5/pdf/bjc2016231a.pdf
2. www.theguardian.com/society/2015/nov/07/scientists-fear-pr-campaign-underplays-hrt-cancer-risks
3. http://www.medsafe.govt.nz/profs/PUarticles/HRTreview.htm
4. http://www.medsafe.govt.nz/profs/PUarticles/HRT2003.htm



Alcohol Regulations Review Needed

Co-convenor of the Federation of Women's Health Councils, Barbara Holland reports:

A stated intent of the Sale and Supply of Alcohol Act 2012 (the Act) is to minimise alcohol-related harm. It's a laudable aim. It was intended that responsible business and communities would work together to achieve a fair balance of freedom to trade and individual choice to legally purchase alcohol, with regulatory controls in place to minimise harm.

Intended & unintended outcomes

The introduction of supermarket sales of two of our favourite legal drugs in New Zealand, wine (1989) and beer (1999), has spread trading options across a wider field. It has also led to a flood of cheap alcohol that can be purchased alongside the daily groceries. This has had a normalising effect on buying patterns.

Liberalisation of social attitudes has led changes in gender drinking patterns and the age of debut drinking is getting younger. But there are particular risks for the unborn child associated with women drinking. Fetal Alcohol Spectrum Disorder (FASD) has lifelong impacts. Why don't we require compulsory signage warning about this displayed in alcohol outlets as a preventive measure?

Marketing and promotion of alcohol products now occurs on an unprecedented scale; branding and sponsorship of elite activities and public spaces infiltrates our living room space via TV, online and social media. We don't allow this for the sale of other carcinogenic or neurotoxic products.

Distortion of the messaging and evidence by the alcohol industry around related harms continues unabated. Self-responsibility is emphasised whilst collective responsibility efforts get sidelined. Economic benefits to the country are constantly talked up but the enormous costs reaching into the billions of dollars are downplayed.

Out of balance

The objectives of the Act are still relevant. Many of the in-built powers and mechanisms for balancing community voice and the free market sound fine but are ineffective in practice.

Default trading hours are too liberal for supporting community wellbeing, especially in smaller urban and/or country areas. Opportunities for local voice through creation of Local Alcohol Policies are being deliberately thwarted nationwide by the alcohol industry with appeals through the courts and threats to do the same held against others who simply can't afford the legal process. This obstructs the role citizens can play in shaping the social environment and wellbeing of their local neighbour-hood. After all, they are the ones who pick up the tab of alcohol-related harm.

District Licensing Committees are too often a weak step in the chain – community pleas to restrict trading are seldom applied. Expert clinician and researcher voices are often denigrated and personal attacks in the media are intended to silence.

Where is the action arising from the Government-initiated 2014 recommendations of the Ministerial Forum on Alcohol Advertising and Sponsorship?

Whose interests are being served?
The way the Act is working in practice favours industry interests – without strong checks in place it simply facilitates the sale and supply of alcohol. Lodging notifications of alcohol licence applications on district council websites may be efficient and cost effective for the applicant but it removes the matters of availability and accessibility from the public radar. It also lessens the likelihood of timely and allowable public objections.

The NZ Law Commission Report (2010) strongly recommended the need for regulation to curb the growing harm. (1) The report supported internationally recognized evidence-based solutions based on regulatory controls on marketing, pricing, accessibility, and age of purchase. Lowering the drink-driving levels and increased treatment funding for heavy drinkers was also promoted.

Bottle to grave losses
Easton et al have produced a 2013 data snapshot. (2) Their estimate of economic losses to the country is between $49 million to $200 million from Fetal Alcohol Spectrum Disorder (FASD) alone. This measure calculates lost production and decreased participation in the workforce due to morbidity and premature mortality. It doesn't take into account other health and social costs of having FASD or having a child with FASD. Government has allocated $12 million in this year's budget to expand an alcohol and other drug support programme for pregnant women. It's merely a drop in the ice-bucket.

No calculations have been produced to date for productivity losses across the general adult population from injuries, sickness, or disrupted work performance related to alcohol use. Then we need to add the mainstream agency and social services costs to health, education, justice, etc. And let's not forget the silenced and unmeasured individual/whānau burdens.

What needs to change?
Alcohol consumption is a modifiable risk factor.

Local Councils must be able to adopt a community-supported Local Alcohol Policy without legal contest from the alcohol industry for each one.

Central government must strengthen population based measures through more effective regulation. Reforms needed include: an end to alcohol advertising and sponsorship, an end to ultra-cheap alcohol for sale; reduced trading hours; raising the purchase age; and further lowering of the adult drink-driving limit.

References

1. Alcohol In Our Lives: Curbing The Harm A Report on the Review of the Regulatory Framework for the Sale and Supply of Liquor. NZLC 114. A (2010)
2. Brian Easton et al. "Productivity losses associated with Fetal Alcohol Spectrum Disorder in New Zealand". NZMJ 19 August 2016. Vol 129 No 1440

CONSULTATION ON NCSP CLINICAL GUIDELINES

At the end of September the National Screening Unit (NSU) released a consultation document "*Updated Guidelines for Cervical Screening in New Zealand.*" (1) Clinical Director of the NSU, Dr Jane O'Hallahan, said "The clinical guidelines provide high-level direction to clinicians caring for women on the cervical screening pathway, and are being updated to align with the move to human papilloma virus (HPV) primary testing in December 2018." (2)

The draft guidelines have been produced with the assistance of the Cancer Council of Australia's Cervical Screening Guidelines Working Party, and are based on the Australian guidelines which were developed as part of the planning Australia has undertaken as it prepares to move to HPV primary screening.

While Dr O'Hallahan refers to the fact that New Zealand's cervical screening programme is recognised as one of the most successful in the world, what she omits to mention is that New Zealand moved to the semi-automated and more sophisticated LBC (liquid based cytology) in 2008, while Australia's cervical screening programme is still based on the Pap smear test. New Zealand's cervical screening programme is based on 3-yearly LBC smear tests, while Australia's is largely based on 2-yearly Pap smear tests. (3)

These important differences are why New Zealand cannot and should not compare the results achieved by our cervical screening programme with Australia's cervical screening programme.

The guidelines were released the day after the Ministry of Health announced that it would be raising the age at which women begin having cervical smear test from 20 to 25. The change will take place in 2018 as part of the switch to primary HPV testing.

The Ministry said there was now a strong body of evidence that screening women between the ages of 20 and 24 did more harm than good. The main reason for this was because the HPV types which caused more than 90% of cervical cancers were common in younger age groups and typically cleared up on their own, Dr O'Hallahan said.

"The screening of the younger age group raised the stress and anxiety associated with additional tests, treatments and unnecessary colposcopy," she said. (4)

Submissions on the draft clinical guidelines are due by 28 October.

References

1. www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/cervical-screening-guidelines/updated
2. www.nsu.govt.nz/news/clinical-guidelines-national-cervical-screening-programme-out-consultation
3. http://www.cancer.org.au/about-cancer/early-detection/screening-programs/cervical-cancer-screening.html
4. http://www.radionz.co.nz/news/national/313325/cervical-screening-age-to-be-raised

Sexual and Reproductive Health and Rights

The Abortion Providers Group Aotearoa NZ, Family Planning NZ, and the NZ Sexual Health Society are organising a conference in

Te Papa, Wellington

10 - 11 November 2016

The theme of the conference is improving access and advancing equity.

Keynote speakers include:

- Dr David Grimes, Clinical Professor in the Department of Obstetrics and Gynaecology at the University of North Carolina School of Medicine
- Professor Jane Hocking, head of the Sexual Health Unit at the Melbourne
- Jon O'Brien, president of Catholics for Choice

http://www.familyplanning.org.nz/news/2016/keynote-speakers-announced

Cost: $440

Places are limited and due to high demand it will be necessary to register immediately in order to go on the waiting list

For more information is available at: http://nzfvc.org.nz/events/sexual-and-reproductive-health-and-rights-conference-aotearoa-new-zealand-2016-wellington-10

AWHC GENERAL MEETING October 2016

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- Submissions due
- Cartwright Forum follow-up actions
- Ethics committee meeting
- AWHC strategic plan

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for October/November 2016:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata DHB Board meeting opens to the general public at 12.45pm on Wednesday 2 October 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 12 October 2016.

Auckland DHB (Website address: www.adhb.govt.nz)
The Auckland DHB Board meeting opens to the general public at 12.45pm on Wednesday 26 October 2016 and will be followed by the Hospital Advisory Committee meeting which starts at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Hospital Advisory Committee meeting will be held at 9am on Wednesday 19 October 2016 at Ko Awatea and will be followed by the Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 9 November 2016 at 19 Lambie Drive, Manukau.

ETHICS COMMITTEE meetings – dates for the four MOH ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

The National Screening Unit is hosting two sessions on the science behind the plan to introduce HPV testing as the primary screening test in the National Cervical Screening Programme in New Zealand.

5.30 – 7.30pm Thursday 13 October 2016 School of Medicine, Christchurch

12 noon – 3.30pm Friday 14 October 2016 Auckland City Hospital, Auckland.

Register at:
https://www.eventbrite.co.nz/e/screening-with-hpv-testing-for-cervical-cancer-prevention-christchurch-tickets-27763809301

https://www.eventbrite.co.nz/e/screening-with-hpv-testing-for-cervical-cancer-prevention-auckland-tickets-27763844406