

LETTER TO THE EDITOR

Dear Ms. McTaggart,

As a physician who has been a proponent and prescriber of bio-identical hormone replacement for over a decade, I reviewed WDDTY's May 2006 Viewpoint and Special Report on the cancer risks of 'natural' progesterone with great concern and dismay. My concern stems from the fact that both your opinion voiced in your Viewpoint, as well as the data presented by Dr. Ellen Grant in the Special Report, grossly misrepresent the medical research and clinical data supporting the health benefits of maintaining optimal hormonal equilibrium via safe and effective bio-identical progesterone or progestogens (not to be confused with synthetic progestins) replacement. My dismay stems from the fact that, by erroneously characterizing progesterone as carcinogenic and overlooking the wealth of data implicating estrogen as the main sex hormone initiating and promoting breast cancer, this issue of WDDTY provides false information to both physicians and female healthcare consumers. The end result of reading and buying into your false premises? ***More women at risk for breast cancer***, not less.

Rather than offer you a point-by-point rebuttal of the misinformation you published in your May issue, I believe it would be more productive for me to provide you with the scientific rationale supporting my counter-position. Let me begin by stating that John R. Lee, M.D. was both my friend and a respected colleague. While you were correct in stating that Dr. Lee identified estrogen dominance as a health concern and that environmental estrogens could negatively contribute to estrogen dominance, you failed to identify Dr. Lee's most critical premise.

It was Dr. Lee's position that the condition of estrogen dominance results from a shift in hormone production, particularly the decrease in progesterone production that occurs naturally with age. With regard to the relationship between sex hormones and breast cancer, Dr. Lee's books established a clear link between estrogen dominance and breast cancer. Moreover, along with Dr. David Zava, Dr. Lee compiled compelling medical evidence citing the cancer-protective effects of re-establishing hormonal equilibrium – and therein eliminating the underlying condition of estrogen dominance – via bio-identical progesterone therapy.

For years now, the clinical and medical evidence supporting Dr. Lee's original premise has continued to mount. In 1988, Goings and colleagues published a seminal study in the *American Journal of Pathology* which profiled the proliferative and secretory activity in the human breast during menstrual cycles. Of great significance was their finding that, when mitosis (cell proliferation) was correlated to breast tissue concentrations of estradiol or progesterone, the lowest mitotic index was observed in the tissue samples with the highest concentration of progesterone; the highest mitotic index was found in those tissues with the greatest estradiol concentrations.

The British textbook *Estrogens and Progestogens in Clinical Practice* includes an excellent chapter on the use of estrogens and progestogens in women with breast cancer. I would urge

you to obtain a copy of this text and review its contents. In the meantime, the following is a direct quote from that chapter:

At the cellular level, continuous exposure to progestogen reduces breast cell E2 content and promotes pathways leading to the depletion of intracellular E2 levels. **Continuous large doses of progestogen have been shown to be as effective as tamoxifen when given to women with advanced breast cancer.** Clarke and Sutherland and Musgrove and colleagues have performed a series of elegant experiments with progestogen on human breast cancer cells *in vitro*. They have shown that progestogen does not directly stimulate resting breast cells to proliferate. Instead, cells that are already entering the S phase are hurried through the cell cycle only to have their growth arrested in early G1 phase. Thus a modest increase in mitotic activity is seen over the first 24 hours, followed by a profound and continued inhibition of breast cell mitotic activity as long as the progestogen is given.

Now, let me conclude by addressing the fallacy of what you stated was “a simple and sobering truth: taking extra sexual hormones at any point in your life is likely to give you cancer.” If this is true, Ms. McTaggart, then why is bio-identical progesterone routinely prescribed for pregnant women who are at risk for prematurely terminating their pregnancy? Perhaps it would be prudent to withdraw such your statement as a gross over-generalization.

Perhaps we can agree on one point: there is no need for *extra* sexual hormones. While too much bio-identical progesterone’s greatest side effect may be drowsiness rather than cancer, the bio-chemical goal of bio-identical hormone replacement is to replace *just enough* of the hormone whose production has sloughed off. I feel strongly that any type of bio-identical hormone replacement is a serious endeavor and one only to be undertaken by informed physicians working with knowledgeable and skilled compounding pharmacists.

Bio-identical hormone replacement should always begin with an analysis of an individual’s hormone levels in order to identify areas of hormonal deficits of disequilibrium. Both saliva and serum testing are viable means to obtain an individual’s hormonal profile. Once a patient has been prescribed bio-identical hormone replacement, they should continue to be followed by their physician to insure that hormone levels remain in physiologic range.

Finally, Ms. McTaggart, over the last twelve years I have literally treated tens of thousands of patients with BHRT. None of these patients has ever been diagnosed with breast or uterine cancer. My clinical experience is my own testimony to the scientific validity of the research previously cited. Clearly more unbiased research is needed and I would hope that we would both eagerly anticipate its output.

Sincerely,
[C.W. Randolph, Jr., M.D., R.Ph.](#)

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