

MENOPAUSE AND THE WORKING BOOMER

An entire generation is approaching a big change. These women will demand more on-the-job openness about the fact than prevails now. ■ *by Faye Rice*

DURING AN ANNUAL industry gathering, the regional manager of a communications giant began to feel warm. The air conditioner must be on the blink, she thought. But then she realized that everyone else in the room—all men in suits—seemed comfortable with the temperature. Suddenly the heat surging through her body became as intense as that of a big-block V-8 idling in New York City's gridlock traffic. "The hair on the back of my neck was soaking wet," the woman, then 43, recalls. She frantically searched her briefcase for a wad of tissues to dab the perspira-

tion and then made a discreet exit to the powder room, where she splashed cold water on her face. As she later learned, this was her first encounter with menopause.

Baby-boomers are about to face just such a physiological change. Indeed, although 51 is the average age for the cessation of menstrual periods, many of their generation already have experienced the first symptoms—late periods, hot flashes, mood swings, and the like—which can come upon a woman as early as her late 30s. By the year 2000, the number of baby-boomers

going through this passage will be increasing at the rate of some two million a year as they embark on a process that can last five years or more.

You'd think that corporate America and the medical profession would see these statistics and try to find ways to recognize and handle the enormous physical and emotional turmoil that this change of life can cause among working women. Instead, it's still tough to find a doctor who can diagnose the symptoms of menopause, and medical research on the subject can at best be described as in-

The 1,500 members of the Red Hot Mamas, a Connecticut support group, include daughters, husbands—and nuns.



complete, causing confusion, even anguish, about appropriate and safe treatments. Only a handful of companies—AT&T, Eaton Corp., and Met Life among them—have formally addressed the impact that menopause can have on their employees.

Says Shirley Krohn, 56, a midlevel manager at an international engineering firm: “Companies are looking at glass ceilings and many other issues affecting women. But it is menopause that could have a drastic impact on a person’s performance.” Krohn blames the debilitating effects of the condition for derailing her own fast-track career and now intercedes as an unofficial menopause counselor at her job when she suspects that co-workers may be headed for the same kind of trouble.

Outside the workplace, however, the movement to break the silence and quash centuries-old taboos about menopause has been

building like a symphonic crescendo. What keeps the music rising is a craving for knowledge about a subject long underresearched and constantly misdiagnosed. More doctors are opening practices devoted exclusively to women over 40, but even so, confirms a 1992

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report by the congressional Office of Technology Assessment, “medical science has yet to provide systematic, objective information about the biological and medical implications” of menopause.

In response, women across the U.S. have formed support groups to fight ignorance by trading information on various treatments. Among the most important: the frequently prescribed artificial hormones that replenish lost estrogen levels—but may also cause cancer. Women and, yes, some men are also turning out in record numbers for lectures and workshops on menopause, usually sponsored by hospitals or clinics. Marie Lugano, 52, quit her management job at a Wall Street firm and established the American Menopause Foundation in New York City. “We need 75% more information about menopause than we have now,” she says. “So I became an advocate to make sure it is constantly addressed.”

As more boomers face midlife, the movement grows in size and character. Witness the Red Hot Mamas, a 1,500-member support group that started in Ridgefield, Connecticut, three years ago and now has chapters in five other Connecticut towns and in Poughkeepsie, New York. Says Karen GIBLIN, 43, who founded the group after undergoing surgical menopause, or the removal of the hormone-producing ovaries: “Some of the baby-boomers bring their husbands and teenage daughters, so the whole family will be better educated.” The chapters attend lectures, which are videotaped and stocked by local libraries. In fact, some boomer members of the group aren’t yet menopausal, says GIBLIN. “They don’t want to wait for a crisis.” They also get some good news. Example: Although hot flashes and mood swings may temporarily suppress sexual desire, menopause does not permanently damage a woman’s libido.

THE MAMAS proudly sport their red T-shirts as they walk together through their hometown streets. Another clue that the formerly unspoken subject is emerging from the closet: Some of the Mamas are nuns of varying ages who wear the group’s red T-shirts under their habits. “They take the information they learn back to their congregations,” says GIBLIN.

Menopause affects every woman differently. For some the experience is as smooth as a spin in a \$60,000 luxury sedan, with none of the physical and emotional signs of the midlife estrogen wind-down. For others





it can be as churning as a ride on a roller coaster at Disney World.

A senior partner at a major law firm counts herself lucky. In her case, menopause signaled its approach soon after she turned 50 with irregular periods and sudden sparks of heat through her body. She was experiencing perimenopause, the transitional period between regular menstrual flow and none at all. She considered the flashes mild and decided not to look for treatment. But within six months, the lawyer recalls, "my face started turning bright red when I had a flash—sometimes while I was in the middle of negotiating a deal. I knew then that it could be interfering with my ability to appear neutral in business meetings." That persuaded her to seek medical help, consulting a female doctor whom she found through a friend who happened to be a nurse. The doctor prescribed hormones. These, taken either orally or via a patch, substitute for the nat-

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ural decline of estrogen, thus relieving symptoms.

Some 10% to 15% of women, however, have a considerably tougher experience. For them, menopause is totally disruptive both on and off the job. "It hit me like a Mack truck," says Shirley Krohn, the manager at the engineering firm, who like many women

uses automotive metaphors to describe her early encounters with menopause. "I suddenly began crying in the middle of meetings for no apparent reason," says Krohn, who was then 48. "I had to go to my office and close the door because I often came close to being hysterical. It was like being 9 years old, when you cry so hard that you can't catch your breath. Around the same time, I began having problems handling stress. I didn't have a clue it was menopause because I had none of the well-known symptoms." Krohn became so distressed she took a seven-month leave from her job. "I was embarrassed to stay at work," she explains, "because I felt colleagues viewed me as being emotional, which always destroys one's credibility in corporate America."

Both Krohn and the corporate lawyer were fortunate in that each found a doctor relatively quickly who properly diagnosed them and helped develop strategies to manage their menopause.

MANY MORE women tell of long, circuitous searches for medical help. Often the results seem downright scandalous. At 38, for example, a CPA with a regional accounting firm began to experience alarming mood swings and violent reactions to changes in temperature. She often stepped out of the chill of her air-conditioned office into the heat, only to lose her lunch. This, in turn, led to a series of visits to various doctors—all male—provided by her HMO. In each case, she asked whether she might be suffering from menopause, a self-diagnosis they all rejected because of her age. Instead, a gastroenterologist not only said she had colitis but also suggested she was mentally disturbed. He sent her to a psychiatrist. The psychiatrist prescribed tranquilizers and sent her to another internist. He said she had a minor intestinal problem.

So it went for four years, during which she consulted no fewer than ten doctors. Not one of them bothered to check her hormone levels. The fact that these were plunging would have revealed that her self-diagnosis was on target. It was a female psychologist who finally convinced the now self-doubting CPA that she was "a perfectly logical person." As a result, she went to the library, learned the classic symptoms of menopause, and recited them to one of the doctors she had previously visited. "He just gave me a prescription for hormones without any questions or tests,"

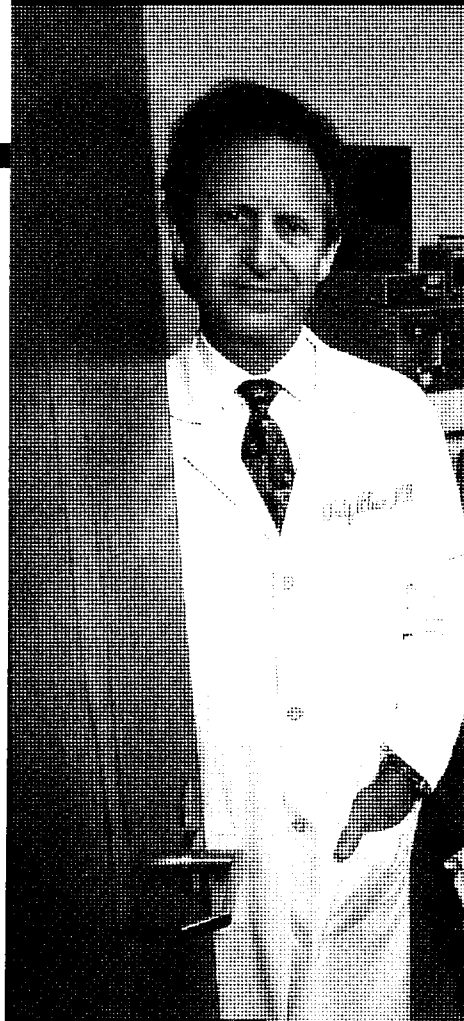
REPORTER ASSOCIATE Jane Furth

says the CPA. She believes that she would be "much further up the corporate ladder" if she had been diagnosed earlier. Instead, "I lost my confidence because doctors told me I was crazy." Sadly, her story is not that unusual.

Why do so many doctors blunder? As the Office of Technology Assessment report notes, the medical community has essentially neglected menopause, as they have many other women's health issues. The few doctors who have specialized in the subject are just as condemning of their profession as patients who have suffered from this neglect. Says Dr. Wulf Utian, a pioneer in menopausal medicine who is director of obstetrics and gynecology at University Hospitals of Cleveland: "The majority of practicing doctors in the U.S. have never been taught anything about menopause." Utian has focused on menopause since his medical school days in his native South Africa, and five years ago founded the North American Menopause Society in Cleveland. The organization helps educate doctors and other health care providers about the subject. "It was a one-liner in most U.S. textbooks when I came here in 1970," says Utian, who gave a speech that year at an international conference on obstetrics and gynecology. Most seats in the room were empty, and the few who attended asked why he chose an "insignificant" subject.

Dr. Robert Barbieri, a professor of obstetrics and gynecology at Harvard Medical School, acknowledges that apathy prevailed until recent years: "Many people who finished training before 1980 did not have much exposure to menopause," he admits. Since then, however, the study of menopause has been a fundamental part of Harvard's curriculum, Barbieri says. Other medical schools have now developed courses on the subject.

S O HERE'S the challenge for menopausal women: Find a doctor who attended medical school during the 1980s. Or, even trickier, one who was educated before then but has diligently researched menopause and kept up to date with the latest studies. One hopes that same doctor explores other, potentially lethal parts of the midlife passage such as cardiovascular disease, osteoporosis, and breast cancer. Incidences of all three increase dramatically after menopause. The quest for such a physician is as difficult as finding a pollution-free neighborhood next door to a toxic dump, and helps account for the corporate powder room network and support group meetings, both of them intelligence-gathering systems.



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Dr. Utian, 55, a graduate of South Africa's University of Witwatersrand (medical school class of '62), clearly fits that profile. So, too, does Dr. Morris Notelovitz, 59, of Gainesville, Florida, as it happens a graduate of the same school. Not for these two the all-too-common 15-minute visit and cursory pill pushing. Rather, their patients can receive comprehensive, coordinated care under one roof, a one-stop-shopping approach to medical service that includes the latest in diagnostic machines.

Both Notelovitz and Utian emphasize wellness and the prevention of illness. Among other things, they closely monitor the diet and exercise regimes of their patients, insisting that they take an active part

in their own health care. No two patients are treated exactly alike. Says Notelovitz, author of the book *Menopause and Midlife Health*: "The medical community has consistently underestimated the variety of women and the variety of their needs. If we treat them generically, we will undertreat some and overtreat others."

O NCE a menopausal woman finds a concerned doctor and gets a complete work-up, she must decide on her treatment, if any. One of the most popular—and controversial—is the drug estrogen. Without doubt, estrogen replenishes the body's declining supply of the hormone while reducing or eliminating discomforting signs of menopause. This treatment also slows the progression of the bone-thinning disease osteoporosis, which causes more than one million debilitating fractures each year and affects 20 million women, most of them postmenopausal. As if those were not benefits enough, dozens of epidemiologic studies suggest that low doses of estrogen cut the risk of coronary disease by half.

But estrogen may also be a killer. Indeed, the risk explains why fewer than 25% of the 26 million women between the ages of 45 and 64 choose to take the hormone. Many of them remember the big estrogen scare of the 1970s. A best-selling book promoted it as a wonder drug that transformed middle-aged women into dazzling and sexy young things. But then scientists found the drug escalated the risk of uterine cancer by as much as tenfold, and also linked it to gall bladder disease. Even before the 1970s, in fact, estrogen therapy had been criticized as dangerous. Beginning in the 1940s, pregnant women used one of the first synthetic estrogens, called DES, to prevent miscarriage. By the late 1960s, the drug had been linked to vaginal cancer among the daughters of those women.

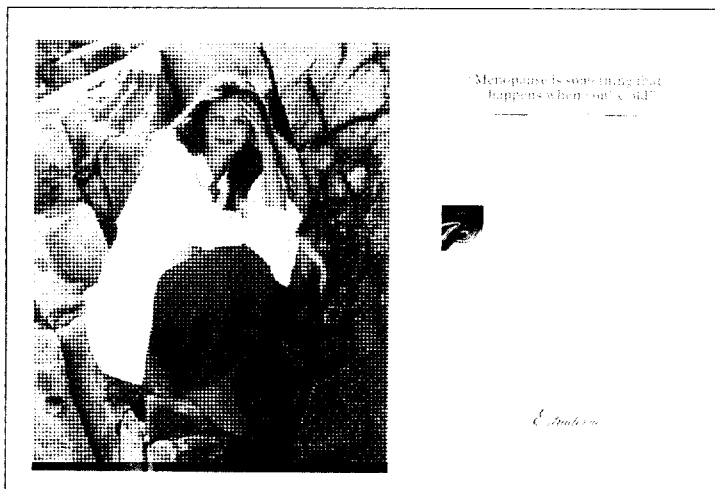
Estrogen sales plummeted after the 1970s revelations but rallied again during the 1980s as doctors routinely prescribed it in conjunction with progestin, a synthetic form of progesterone, a female hormone found to effectively reduce the risk of uterine cancer caused by estrogen. Today, Wyeth-Ayerst Laboratories' estrogen, Premarin, derived from the urine of pregnant mares, is the most commonly prescribed drug in the U.S., with sales of some \$700 million. Most of the Premarin sales are to women who also take progestin in the two-pill strategy. Progestin has its own problems. It can cause bloating,

weight gain, and heavy, unpredictable bleeding.

That estrogen in any mix or form survives seems mystifying. As Gayle Sand writes in her witty book, *Is It Hot in Here or Is It Me?*, "If estrogen were prescribed for men instead of women and the drug had this same history, it would have been exposed on *60 Minutes*, discussed by the McLaughlin Group, [and] debated in the House ..." She herself uses an estrogen-progestin combination.

Potentially even more worrisome, researchers still know little about the long-term consequences of combining estrogen and progestin. One big question: Does progestin negate estrogen's effectiveness against heart disease? Another quandary for many women is whether combining the two drugs increases the risk of breast cancer.

ON THE ONE HAND, the estrogen used these days is dispensed in far smaller doses than hitherto. Even so, studies of the newer variety and its relationship to breast cancer are still contradictory and confusing. Admits Karen Steinberg, chief of the molecular biology branch at the U.S. government's Center for Environmental Health: "We just don't know for sure." Her recent quantitative analysis of 16 studies indicates that estrogen increases the risk of breast cancer by 30%. Compared with the 300% increased risk of uterine cancer, this 30% is "relatively small" in epidemiology studies, Steinberg says. Moreover, it could reflect certain research biases. For example, the women studied tended to be upscale and have healthy lifestyles. A salient point indeed, since nearly all the women who have participated in studies on menopause thus far have been well-heeled, well-educated, and white. On the other hand, the group tends to drink, if only socially, and alcohol may have a bigger role in bringing on breast cancer than previously thought. Says Dr. Trudy Bush, an epidemiologist at the University of Maryland who specializes in menopause: "Many studies suggest that of the women who take estrogen, the ones who drink"—we're talking about two glasses of wine a day here—"have a higher risk of developing breast cancer than those who don't. No one wants to hear it because they don't want to give up drink-



This ad reflects how drugmakers are targeting younger women.

ing." Alcohol's effect on estrogen is one more mystery dividing the medical profession. Says Cleveland's Dr. Utian: "On the left you have the hormone evangelists who say that every woman should take them, and on the right you have those who say it's poison. The truth is somewhere in the middle."

Come 2007, that elusive middle may finally be clearer. That's when the results of a 15-year, \$628 million clinical survey of 163,000 postmenopausal women, ages 50 to 79, will be announced. Sponsored by the National Institutes of Health, the survey will examine the causes and possible

prevention of heart disease, cancer, and osteoporosis.

The survey includes a study on how hormone replacement is affecting 25,000 of these women. This is a welcome change from previous studies. These have been observational, tracking women who have already decided to take hormones, a relatively homogeneous lot. The NIH is recruiting a diverse group of women from various ethnic and economic backgrounds who are not taking hormones. One-third will receive estrogen, one-third an estrogen-progestin combo, and one-third placebos. Experts say this is a more precise methodology, which will result in fewer biases than in previous studies.

In the meantime, women must make tradeoffs with their health, like football team owners swapping players to build a better team: Harlene Marshall, 49, owner and president of the boutique recording label Bainbridge Entertainment, has a history of heart disease on both sides of her family. Current research suggests that Marshall, who is perimenopausal, would benefit greatly from estrogen because it would reduce her risk of a heart attack by 50%. But she also has cystic breasts and has already had two benign tumors removed. For now Marshall has decided against estrogen treatment because existing studies indicate that it could increase her risk of breast cancer. To relieve the discomfort of sporadic heart palpitations, prolonged periods of PMS, and occasional eruptions of perspiration, she is sticking to a strict low-fat, no-caffeine diet, which includes Chinese herbs that she brews for tea, and a regimen of regular acupuncture sessions. She is also treating herself to an occasional break from the 60-hour-a-week stints she typically puts in at the office. *continued*

DID YOU KNOW . . .

- 1** For some women, the first signs of menopause appear in their late 30s.
- 2** Hot flashes may suppress sexual desire temporarily, but typically no acute change in libido occurs.
- 3** A common drug reduces many discomforts but also increases the risk of cancer.
- 4** The risk of heart disease, breast cancer, and osteoporosis increases dramatically after menopause.
- 5** Of women surveyed, 18% are lucky: They never had hot flashes.

Women who sail through perimenopause with no discomfort may still have to make a decision about taking estrogen simply because it remains the best way to fight off osteoporosis, a deterioration that can reduce bone mass by as much as 50%. One such person in this dilemma is a real estate executive in her late 40s. On the advice of Morris Notelovitz, her doctor, she has been eating calcium-rich foods, taking calcium supplements, and exercising daily since becoming perimenopausal three years ago. Even so, her bone density has rapidly deteriorated by 3% a year, no big surprise to Notelovitz, since her mother has osteoporosis. Now she, her family, and her doctor must make a decision quickly about hormones, since estrogen is the only FDA-approved drug for the prevention of osteoporosis.

At long last, the pharmaceutical companies seem to be waking up to the fact that this woman and millions like her constitute a huge new market that will grow dramatically beyond its current \$1-billion-a-year size, particularly if it offers a wider choice of drugs. Women also want a bigger choice of so-called delivery systems, meaning pills, patches, and the like. Some of these are already on the near horizon. In 1995, Wyeth-Ayerst, a subsidiary of American Home Products, expects to market a pill that combines progestin and estrogen. The company is also racing competitor Ciba-Geigy to sell a patch in the U.S. that delivers both drugs. Bristol-Myers

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Squibb is testing a topical gel for estrogen. Further out, these drugs, singly or in a duo, will also be available in such forms as implants and IUDs.

Such delivery systems will still carry the same estrogen that has been on the market for over 50 years. This leads epidemiologist Dr. Trudy Bush to wonder why drug companies have not developed “different classes of hormones with fewer side effects, as they

have for hypertensive drugs.” Replies Dr. Robert Levy, president of Wyeth-Ayerst Research: “Until the tools we now call molecular biology came along, we didn’t even know which questions to ask.” Now armed with the tools, Wyeth-Ayerst and its competitors are trying to isolate the good aspects of estrogen that lower the risk of heart disease and osteoporosis. Meanwhile, several companies, including Merck, are working on hormone-free drugs for osteoporosis.

For many women, health food stores provide an alternative to synthetics. Shelves brim with plants and foods containing natural estrogen, such as ginseng, soybeans, and papaya, centuries-old remedies for reducing menopausal distress. But it is difficult to quantify the amount of the hormone they deliver. WomanKind, a health clinic in Long Beach, California, is asking pharmacists and scientists to help calculate the actual quantities of estrogen in different plants. Dr. Mary Jane Minkin, an associate clinical professor at Yale medical school who has a private practice in New Haven, orders a “natural” progestin from a pharmacist, which she says is mostly made from yams, for her many patients who get unpleasant side effects from synthetic progestin.

WOMEN baby-boomers won’t settle just for new medicines and treatments, of course. They will be looking for big changes at work. Although many women—and men affected indirectly—are no longer content to suffer in silence, most are not completely liberated from old taboos, especially at the office. One fiftysomething mid-level executive at a major consumer products company run by male boomers worries about the “double whammy” of being a woman and menopausal: “The stigma of aging is the hardest part of menopause in the workplace.” Whether it is the aging factor, the fear that women have of appearing weak, or a residue of the old taboo, the fact is, most workplace discussions about menopause are still fairly clandestine. Says Harlene Marshall, the record company exec: “Most of my friends at major corporations are loath to discuss menopause openly at work. They think it will be bad for them politically.”

You can see why women might think that. A male boss at AT&T laughed at a woman subordinate when she mentioned an upcoming “lunch and learn” seminar that the company was offering on menopause. She went but never told him. AT&T began offering

such classes two years ago after an increasing number of employees went to company nurses Loren Spann and Susan Anastario. Says Anastario: “Many of the women didn’t even know what was happening to them and why.” The company has these lunch sessions twice a year for its New York and New Jersey employees, and plans to take them nationwide. About 30 women—no men so

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far—show up for each seminar. Additional sessions are available on request.

Eaton helps its Cleveland employees by keeping them informed about menopause-related seminars and support groups around the city. Many attend sessions that Dr. Utian runs at the University Hospitals of Cleveland. Says Barbara Jackson, Eaton’s administrator of human resources: “Some of our male employees pick up fliers to take home to their wives because Dr. Utian is such a well-known figure.”

Met Life’s corporate wellness and fitness services department has sponsored a series of health education campaigns for all employees since 1991, several focusing on menopause. Guest speakers have included Fredi Kronenberg, an associate professor at Columbia University who specializes in women’s health and menopause. Employees can also view videos on menopause.

Trend watcher and psychologist Ross Goldstein of the San Francisco firm Generation Insights notes that a few forthright baby-boomers are already willing to buck tradition and talk openly in the office about menopause. “The changes that baby-boomers will force companies to make regarding menopause will resemble a lot of other things that women and other groups have imposed on the corporate culture in the last two decades,” says Goldstein. “Those did not come without resistance.” But then, progress never does. **F**