The GP and the Menopausal patient

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Fertility & Gynaecology

ECIPA HEALTHCARE SYMPOSIUM

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There are probably few challenges as great, and rewards as many, as to manage the Menopausal woman

It is probably unwise, and even dangerous, for low-risk women to be managed by specialists
Dr Archie Cochrane

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What is the purpose of Menopausal Health care?

Purpose: Screening and early detection of disease if present.

Identifying risk factors for increased morbidity and mortality

Suggest timely intervention, lifestyle modification

Diagnose and offer treatment options

The consultation

Monday AM: 07:30

Mrs Smart is a 56 year old patient, requesting an annual examination as a new patient to your practice. She offers the following information:

History: Sister has breast Ca

Uses Equine Conjugated estrogen 0.625 daily for the past two years.

Previously a smoker

Main complaint: Recurrent UTI's, dyspareunia, mild urinary incontinence. Sleep disturbance, hot flashes

Your response: History taking

Clinical Examination

Summary of history and clinical examination

History

- Medical: HT on Rx. Weight loss 3 kg
- Surgical: Cholecystectomy, Appendisectomy, L4/L5 Fusion
- Allergies: Nil
- Family Hx: Sister (44) Breast Ca. Mother (79) Ovarian Ca
- Menopause: 50
- Obstetric Hx: P2 G2. NVD x 2
- Divorced, SA +
- Pap smear: 5 years ago (Some abn cells..?).
- PMB: Intermittent
- Bladder Fx: N
- Bowel Fx: IBS

Examination

- BMI 19
- Bp= 165/92. P= 96, VES
- Thyroid: Normal
- Skin: Naevi, ? Basal Cell changes Face
- Breast Exam: Non specific, dense
- Abdominal: No organomegaly
- Gynaecological: V+V: Atrophic. Cx: N, no apical prolapse. Ant and post walls intact. Uterus normal size
- Legs: Varicose veins

Problem list

let's talk menopause!

Symptoms Checklist

Over the past 3 months have you experienced any of the symptoms below?

Symptoms	Never	Sometimes	Often
Anxiety: Overly worried or tense, feeling stressed out, panicky, overwhelmed	○	○	○
Brain Fog: Difficulty focusing, forgetful, poor word retrieval, easily distracted, feeling out of it	○	○	○
Depression: Feeling low or hopeless; loss of interest in things once enjoyed; easily fatigued; increased mood swings; small tasks take great energy; feeling overwhelmed	○	○	○
Fatigue: Low energy, tire easily	○	○	○
Headaches and/or Migraines: Head pain, often intense or throbbing, sometimes to the point of debilitation; nausea; light and/or noise sensitivity	○	○	○
Heart Palpitations: Racing, skipping, or fluttering heartbeat	○	○	○
Hot Flashes / Night Sweats: Intense spreading heat, usually across the chest, neck, or face; excessive sweating; racing heart	○	○	○
Incontinence: Urinary leaks when laughing or coughing, loss of bladder control	○	○	○
Irritability: Unusually impatient, easily frustrated	○	○	○
Joint Pain: Soreness, heat, or swelling knees, ankles, fingers, elbows or jaw; feeli	○	○	○
Low Libido: Diminished sex drive, difficulty fe	○	○	○
Painful Sex: Vaginal dryness or tightness; burning ir vulva before, during, or after intercourse	○	○	○
Period Changes: Lighter or heavier blood flow, shorter or longer cycles, entirely skipped cycles	○	○	○
Skin and/or Hair Changes: Dry, itchy, skin; thinning or coursening hair; new facial hair; appearance of dark spots	○	○	○
Sleep Issues: Difficulty falling or remaining asleep; tossing, turning, or fitful sleep	○	○	○
Urinary Tract Infections (UTIs): Bacterial infection with symptoms that include frequent urination, burning, change in the color or odor or urine, pain in the pelvic region, fever, and/or nausea	○	○	○
Weight Gain: Increased weight, especially around abdomen and thighs; feeling bloated; no longer able to easily drop "those few extra pounds"	○	○	○

LetsTalkMenopause.org hello@LetsTalkMenopause.org @LetsTalkMenopause Let's Talk Menopause is a registered 501c3

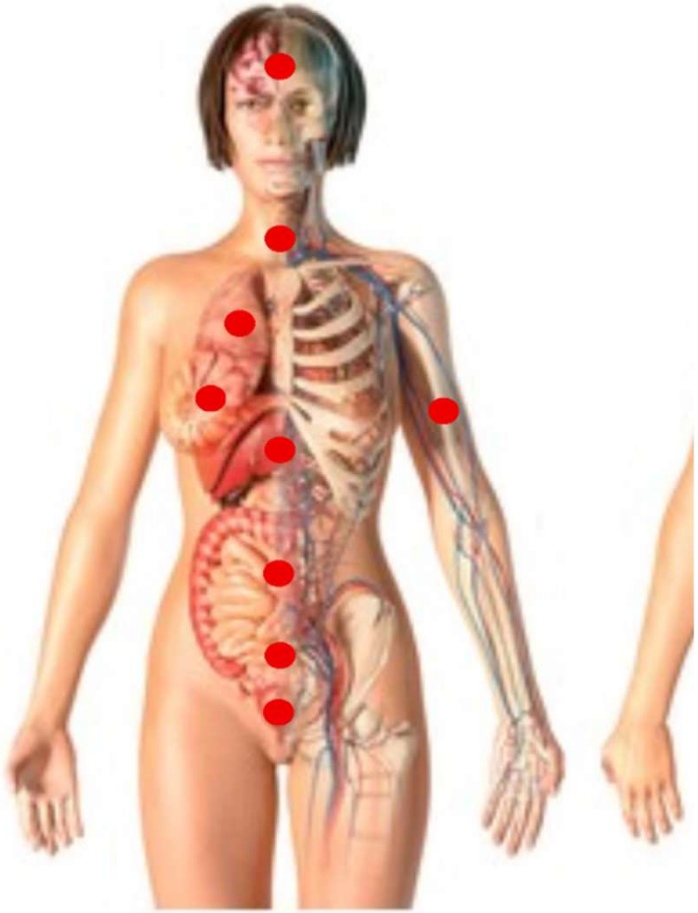
- Caucasian
- Low BMI
- Previous smoking Hx
- Breast and Ovarian Ca Family HX
- Unopposed E2 use , PMB
- Skin abn
- HT
- ? Hyperthyroidism
- Pap smear overdue.
- Varicose Veins

- No Colonoscopy/ FIT
- No DXA
- ? Genetic mutation familial Ca
- Pap smear-new partner
- CXR
- Bladder urine cytology
- Other risk factors evaluation CVD : Glucose/Lipids
- Menopausal Sx despite Rx

Special investigations

Immediate Actions

Systematic approach



- Exclude Graves' disease
- DXA, CXR
- Breast MRI
- Arrange colonoscopy
- Urine Cytology
- Metabolic markers
- Skin Biopsy

- Stop Premarin
- Arrange US, then Pipelle, HPV PCR
- Bp Follow up
- Discuss genetic screening
- Arrange follow up, arrange referral


Future Management
and follow up

Menopausal Hormone Therapy

Climacteric

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Menopause and MHT in 2024: addressing the key controversies – an International Menopause Society White Paper

Nick Panay, Seng Bin Ang, Rebecca Cheshire, Steven R. Goldstein, Pauline Maki, Rossella E. Nappi & on behalf of the International Menopause Society Board

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Historical perspectives on menopause and its treatment

- Menopause and MHT continue to be topics of considerable controversy and debate to the detriment of many women and society as a whole.
- Although the mean age of natural menopause is often quoted in some regions such as Europe at 51 years, meta-analyses of global data indicate that the mean age at natural menopause is actually 48.8 years

- In many women 50% of life is now spent in a postmenopausal state, and given that we generally have an aging population globally it is expected that by 2025 more than one billion women globally will be in a perimenopausal or postmenopausal age group.
- In the Middle Ages it was thought that the disorderly uterus rose or descended and committed actions difficult to endure, leading to faintness of the heart, tightness of the chest, breathlessness, hiccups and troublesome accidents.
- In her publication *Hot Flushes, Cold Science i*n 2010, Louise Foxcroft stated that current attitudes to menopause have been reached through the filter of thousands of years of rampant chauvinism, collusion, trial, error and secrecy

Impact of the major MHT studies

- The initial reports from the **Women's Health initiative (WHI)** study in the USA in 2002 and the **Million women Study (MWS)** in the UK in 2003 resulted in a significant decline in the use of MHT (by 80%) due to concerns about the reported risks of cardiovascular events and breast cancer.
- Although the absolute risks of MHT on health outcomes in the WHI were rare to very rare by common standards, the data were alarmingly presented as percentage changes rather than absolute numbers by the media, and the risks were said to apply across all age groups. the fall in prescribing, especially in primary care, resulted in many women 'suffering in silence' and seeking other solutions for their symptoms.

Rationale for menopause management

There is also now good evidence that women predisposed to severe VMS also have a higher incidence of cardiovascular disease

The 5Ws of prescribing MHT

Who is MHT for?

What types and doses of MHT?

When should MHT be started and stopped?

Why is MHT important?

Where can MHT be accessed?

WHO IS MHT FOR ?

MHT is conventionally indicated for women with natural and surgical menopause who are experiencing distressing vasomotor and/or vulvovaginal symptoms.

Should women without symptoms be prescribed MHT?

The research findings regarding the impact of MHT on cognition and dementia are considerably less reliable and require further research

• Should medically high-risk women be prescribed MHT?

- the benefits of treating bothersome symptoms on a woman's quality of life must be weighed against the potential risks associated with MHT.
- MHT is conventionally contraindicated in women with hormone receptor-positive breast cancer and endometrial cancer.
- in women with a past history of VTE, MHT may be considered if it had been provoked by certain circumstances, for example major surgery or prolonged immobility

WHAT TYPES AND DOSES OF MHT ?

- patient preference;
- uterine presence or absence;
- contraceptive needs;
- symptom type and severity;
- comorbidities

Is the type of estrogen important?

- There are four types of estrogens which occur naturally in human beings; estrone, estradiol, estriol and estetrol.
- The recent move toward use of transdermal estradiol (patches/gels/sprays) is supported by evidence from observational and case-controlled studies of reduced risk of VTE.
- if there are no particular risk factors (e.g. obesity, history of VTE) there is little reason why oral estrogen could not be prescribed.

Are the types of progestogen important?

- There is now considerable evidence that micronized progesterone and biologically similar progestogens (e.g. dydrogesterone) appear to have metabolic and possibly breast advantages over androgenic progestogens.
- In women with a past history of premenstrual syndrome (PMS)/premenstrual dysphoric disorder (PMDD) who often have progestogen intolerance . In these patients it may also be necessary to reduce the dose and duration of micronized progesterone, for example, 7–10 days per month at 100 mg (rather 200 mg) in sequential MHT regimens.

Are the doses of estrogen and progestogen important?

- Higher doses of **estrogen** are also typically required in women with premature ovarian insufficiency (POI) and early menopause in order to achieve full symptom relief and optimal bone mineralization.
- the rationale supporting the principle of using lower doses of MHt to achieve adequate benefits is the lower likelihood of adverse estrogen effects (e.g. breast tenderness, bloating, bleeding problems), including a lower risk of VTE with oral estrogen, and of stroke, even with transdermal estrogen.
- Supraphysiological levels of estrogen also confer a risk of a sudden decrease in treatment effectiveness 'tachyphylaxis', due to estrogen receptor insensitivity.

- It is important to reiterate that the dose of **progestogen** used provides adequate endometrial protection according to standard guidelines.
- the levonorgestrel intrauterine device is another way of providing effective endometrial protection as well as contraception

Monitoring of MHT doses

- The prescribing principle here is that we should ‘first treat the patient, not the result’. As such, if a patient with menopause at the usual age is using MHT purely for symptom relief, and they achieve full relief of their symptoms without any adverse effects, then it is unnecessary to routinely check their hormone levels.

Why are women still turning to compounded bioidentical MHT in some countries?

- The revised global consensus statement on MHT states that ‘the use of custom-compounded hormone therapy is not recommended because of lack of regulation, rigorous safety and efficacy testing, batch standardization, and purity measures’

Has the prescribing of testosterone in women become overzealous?

- Although there is evidence for the safety and efficacy of testosterone used alone in menopause, it is generally recommended that conventional MHT is commenced before testosterone is considered for persistent HSDD symptoms to ensure that women are well estrogenized, especially vaginally, before their libido is enhanced.

When should MHT be started and stopped?

Should MHT be started before the menopause?

- Starting up to 10 years or more before the final menstrual period, perimenopause is a frequently neglected and poorly managed phase of a woman's life course.
- Prescribing MHT in the perimenopause can be difficult because the fluctuations in hormone levels can result in episodes of estrogen deficiency rapidly followed by episodes of estrogen excess.
- MHt remains an option for these women if they are symptomatic, recognizing that MHt is off-label in this phase of life.

Should MHT be initiated in older women well past the menopause transition?

- Most society recommendations advise caution when it comes to prescribing MHT de novo in women 60 years of age or older.

When should MHT be stopped?

- MHT should be used at the lowest dose for the shortest duration needed to relieve symptoms, because MHT may increase the risk of some cancers, VTE and stroke, and because the risks increase the longer MHT is used.
- However, there is now universal agreement amongst national and international menopause societies that arbitrary limits should not be placed on the duration of use of MHT

- The IMS governing principles on MHT state ‘there are no reasons to place mandatory limitations on the duration of MHT’.
- ‘*whether or not to continue therapy should be decided at the discretion of the well-informed woman and her HCP, dependent upon the specific goals and an objective estimation of ongoing individual benefits and risks*’

Why is MHT important?

- Menopause per se does not require treatment but the distressing symptoms and conditions that can be associated with it do warrant treatment. the current indication for use of MHT is treatment of VMS and VVA/GSM.
- it is estimated that 80% of women experience VMS, 25% of women will suffer with severe VMS and the median duration of symptoms is 8–10 years

Mrs Smart

08: 20

Thank you for your attendance