Menopause Update: a multidisciplinary approach

Learning objectives:
• Outline a systematic approach to assessment, investigation and management of menopause symptoms.
• To explain and recommend appropriate menopause management options to women with different clinical presentations & indications.
• Recognise the key psychological symptomatology related to menopause and recommend appropriate management options
• To increase knowledge of evidence based complementary and alternative medicine therapies in managing menopause.

Case study A – Part 1
Jenny, a 48 year old woman presents to the GP with hot flushes, irregular period, sleep disturbance, sore breasts & mood changes & weight gain.
• She is worried about long term risks and does not want HRT.
• She wants to see a naturopath/ is interested in natural therapies.
• She is concerned about pregnancy and wants to know when she can stop using condoms.

Case study A - Part 2
Jenny reached menopause at 50 & she’s now 52. Her symptoms have worsened over the last 4 years and she’s finding them unbearable.
• She has been seeing a naturopath on and off, who has prescribed Black Cohosh as Femular
• The naturopath has now referred Jenny to the GP as she wants to discuss using HRT
• Jenny has a family history (first cousins) of breast cancer & prostate cancer, type 2 diabetes (grandparents) and thyroid disease
• Her BMI is 27.

Case study B
Ana is 36 years old and presents with 2° amenorrhoea for 6 months following ceasing the pill. She is trying to get pregnant and is keen to know what’s going on.

Case study C
45 year old was Lina diagnosed with L breast cancer with +ve node, ER +ve, PR +ve, HER2 –ve. Treatment: WLE lymph node excision, chemotherapy & radiotherapy.
• She had her final menstrual period after her first dose of chemo
  • onset of severe flushing & sweating, sleeplessness, joint pains, & vaginal dryness.
• Concerns about: body image, weight gain, irritable mood & loss of libido.
• Intercourse is painful-she is concerned about her relationship as her partner feels he has been patient during treatment and now feels he should have her attention.
A GP's approach to menopause

Dr Deidre Bentley MBBS
Jean Hailes General Practitioner

Your consultation

- Assessing the whole woman
- Communication
- History
- Referral

Assessing the whole woman

- Menopause presentation is opportunity to address all health - “well woman check”
- Assess risk factors
- Address modifiable issues
- Screening tests/tools

Communication

- Listen, ask, listen
- Impact on quality of life
- “understanding, sympathetic, attentive, tolerant and patient”
- Time

History

- Systems review, including gynaecological history
- Past history
- Family history
- Lifestyle factors
- Social history
- Mental health assessment

Gynaecological history

- Menstrual history - cycle length, amount
- Associated symptoms – pain
- PCB/IMB
- Contraception
- Pap smears
- Pregnancies/deliveries
### Menopausal symptoms
- Vasomotor
- Psychological
- Musculoskeletal
- Urogenital

### Vasomotor symptoms
- Hot flushes
- Night sweats
- Palpitations
- Dizziness
- Migraine

### Psychological symptoms
- Irritability
- Anxiety
- Tearfulness
- Decreased concentration
- Poor short term memory
- Insomnia
- Fatigue

### Musculoskeletal symptoms
- Aches /muscle pain
- Joint pain

### Urogenital Symptoms
- Dyspareunia
- Vaginal dryness “like sandpaper”
- Urgency or frequency
- Incontinence: stress or urge – won’t tell if not asked
- Dysuria
- Nocturia
- Prolapse – lump/bulge/dragging
- Bowels

### Sexual history
- Still sexual active ?
- Libido
- Libido of partner ? Mismatch
- ? new partner
- STI risk
Sleep history
- Insomnia - adequate quality and quantity
- Hot flushes, night sweats
- Sleep apnoea
- Partner snoring

Other symptoms/history
- Diminished sense of well being
- Skin - dryness, itch, insects crawling over skin
- Hair thinning/loss
- Body shape changes
  - Weight gain
  - Thigh and abdominal fat
- Change in breast size & shape
- Loss of muscle mass
- Osteoporosis
  - Decrease height
  - Fractures
- Recurrent urinary tract infections

General history
- Medications
- Allergies
- Immunisations
- Mammograms
- Colonoscopy
- Bone Scan

Past history
- Heart disease or blood clots
- Asthma or COAD
- Cancer
- Diabetes or thyroid disease
- Previous fracture
- Bowel disease
- Breast disease
- Surgical Procedures/ Hospital admissions
- Mood disorders - PMS, PND

Family history
- Cardiovascular disease
- Osteoporosis
- Cancer - especially bowel, breast, ovarian
- Diabetes
- Clotting problems
- Strokes
- Dementia
- Mental Health e.g. depression
- Addiction behaviours (alcohol)

Lifestyle factors
- Cigarettes
- Alcohol - 2 drinks/day with 2 alcohol free days/week
- Diet - Assess quantity AND quality
- Exercise
- Vitamin D / Sun exposure
- Caffeine - tea, coffee, soft drinks
- Other drug use
Social history

• Profession
  – work, financial concerns
• Partner
  – relationship
• Progeny
  – children
• Parents
  – ageing parents
• Personal
  – friends, hobbies & pleasures, time out

Mental health assessment

• Mood
  – anxiety, depression
• Stresses
  – isolation or overburdened
• Relationship issues
• Self esteem
• Body image

Symptoms may also be

• Depression
• Anaemia
• Fibromyalgia
• Thyroid dysfunction
• Cushings
• Bowel cancer
• Ovarian cancer

Examination

- General appearance
- Weight & height = BMI
- Abdominal circumference
  - At risk >80cm
  - High risk >88cm
- BP
- Pulse
- Pulses
- Skin
- Vulvar area
- Speculum or bimanual vaginal examination
  - ASK PERMISSION
- Legs, Joints, Spine
- Pelvic floor
- Thyroid
- Abdominal palpation
- Heart / lungs
- Legs, Joints, Spine
- Pelvic floor
- Thyroid
- Abdominal palpation
- Heart / lungs

Investigations

• FBE, Ferritin
• U&E, LFT, TSH
• Fasting Lipids
• Fasting glucose
• Clotting studies
• Calcium, Vitamin D
• B12, Folate
• Hormones?
  - FSH – early menopause
  - AMH – not useful
• Ca 125?
• Pap smear
• Mammogram
• FOBT
• MSU
• STI screen

Further investigations if clinically indicated

• DEXA scan
• Pelvic ultrasound
• Urodynamic studies/bladder diary
• Colonoscopy (screening history 3-5 yearly)
• Spirometry? ECG?
• Other medical tests – e.g. inflammatory markers for Rheumatoid arthritis
Referral?
- Beyond your scope of practice/expertise
- When what you have done doesn’t work
- When you don’t have the time

Menopause management: a gynaecologist’s approach
Dr Elizabeth Farrell AM
MBBS, Hon LLD, FRANZCOG, FRCOG
Jean Hailes Gynaecologist

Definitions
- Menopause: the final menstrual period
- Postmenopause: 12 months after the final menstrual period and onwards
- Perimenopause: from the onset of irregular periods
- Early menopause: final menstrual period between 40-45 years of age - 8%
- Premature menopause: Final menstrual period prior to 40 years of age – 1%

Geographical variation in age at menopause

<table>
<thead>
<tr>
<th>Region or country</th>
<th>Mean age at menopause (95% CI)</th>
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<tbody>
<tr>
<td>Africa</td>
<td>48.4</td>
</tr>
<tr>
<td>Asia</td>
<td>48.8</td>
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<tr>
<td>Australia</td>
<td>51.3</td>
</tr>
<tr>
<td>Europe</td>
<td>50.5</td>
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<tr>
<td>Latin America</td>
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<td>47.4</td>
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<tr>
<td>United States</td>
<td>49.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>48.8</td>
</tr>
</tbody>
</table>

Danielle AJM Schoenaker et. al., Int. J. Epidemiol. 43, 1542–1562 (2014).

Life after Menopause

Table 4: Australia: Expectation of Life at Age 50, 1901-1910, 1970-72, 1981 and 2011
Source: ABS

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
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<tr>
<td>1901-1910</td>
<td>21.2</td>
<td>23.7</td>
</tr>
<tr>
<td>1970-1972</td>
<td>23.2</td>
<td>28.3</td>
</tr>
<tr>
<td>1981</td>
<td>25.2</td>
<td>30.8</td>
</tr>
<tr>
<td>2011</td>
<td>32.0</td>
<td>35.6</td>
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</table>

Hugo G APMRC Adelaide

Endocrinology
- Complexity of the perimenopause: constant change/“chaos”
- FSH Ovulation within ±2 cycle

(Burger et al. Recent Prog Horm Res. 2010;67:267-76)
Symptoms across the transition

Perimenopause symptoms
- Mood changes
- Sore breasts
- Bloating
- Headaches/migraines
- Periods: irregular in flow & pattern & symptoms

Menopause symptoms
- Hot flushes
- Night sweats
- Sleep disturbance
- Faintness
- Joint pain
- Irregularities
- Unusual symptoms

80% some symptoms
80% have symptoms
80% have symptoms for < 5 years

Diagnosing Menopause

Do not
- Check FSH, LH, oestradiol or testosterone levels in a woman with symptoms at the normal age for menopause (over 45 years) because these results are unlikely to change your management.
- The indications for intervention are clinical

Do
- Take a good history of menopausal symptoms, preferably using a standardised symptom measurement system
  - Record personal medical history and risk factors for breast cancer thromboembolic disease and osteoporosis
  - Take a menstrual history

Because you will offer help to the woman with symptoms and these factors will influence what treatments you advise!

Factors influencing menopausal symptoms

Socioeconomic/education
Psychological issues
Cancer treatments
Other health issues
Menopausal symptoms
Age
Ethnicity and culture
Cause of menopause
Climate
Lifestyle
Attitude to menopause/ageing

Management

Depends on menopause experience
- May be:
  - Simple practical measures
  - Prescriptive therapy appropriate to the symptoms/her risk factors/her preference
  - Non-prescriptive therapy
  - OCPs, naturopathic, herbal
  - Psychological counselling or therapy

Hormone Replacement Therapy (Menopause Hormone Therapy)

The appropriate time to initiate HRT is at the onset of symptoms, i.e., near the menopause.
- HRT should be part of an overall strategy including:
  - Lifestyle e.g. diet & exercise
  - Smoking cessation
  - Safe alcohol consumption to maintain health of peri and post menopausal women
- The option of HRT is an individual decision with consideration of:
  - Quality of life and health priorities
  - Personal risk factors e.g. age, time since menopause
  - Risk of various thromboembolism, stroke, ischaemic heart disease and breast cancer

CAM use in Australia for Menopause

Safety & Efficacy

Ms Sandra Villella
Jean Hailes Naturopath & Herbalist
Prevalence of use of CAM and CAM visits for Australian women for menopausal women aged 40-65 years
• 13.22%, CAM use for vasomotor symptoms (VMS) – Phytoestrogens, evening primrose oil, ginseng.
• 8.33% (168/2017) consulted CAM practitioner for VMS – (2.68% consulted a naturopath)
– (2.78% to chiropractor, 1.98% to acupuncturists)
• Where are women sourcing information on CAM
– Research findings suggests self prescribing
– Choices may not be appropriate
– Ideally seek advice from naturopath/herbalist

Efficacy of CAM
• Commonly criticised for insufficient evidence OR not evidence –based.
• Some specific CAMs have evidence supported in the scientific literature.
  – Quality & quantity of sound research varies
• Levels of evidence
  – Compare RCT to traditional/historical use
  – WHO guidelines for assessment of traditional medicines for efficacy
• “Product”- quality & efficacy
  – Remefemin®, Femular®

CAM Safety
• Separate ‘product’ from ‘practices’
• Considered safer than pharmaceuticals
• Relatively few adverse events given widespread use & availability
  – Probably under-reported
• Predictable reactions owing to pharmacological effects. E.g John’s Wort
• Reactions & reactions not predicted by pharmacology (Allergic or idiosyncratic reactions) E.G Black Cohosh & the rare liver damage cases
• Belief: “natural” = safe and harmless
  – Ideally professionally prescribed rather than self prescribe

Concerns to medical practitioners about CAM
• Possible delayed or missed diagnosis & treatment
• CAM users ceasing medical therapy - subsequent loss of benefit of that therapy
• Collaborative relationship between well trained CAM practitioners and medical practitioners
• Unregistered profession

Consider the context of a woman’s life
“Psychological, social and cultural aspects of the menopause as well as lifestyle factors play major roles in the menopausal transition.”
(Utian WH, NAMS)
Negative mood significantly predicted by:

• Personality
• Genetics
• Prior negative mood
• Health status
• Lifestyle
• Body image
• The domino effect
• Partnership status
• Crisis & high stress
• Role satisfaction

What about hormones?

• Negative mood scores (depression or anxiety) not related to natural menopause transition, FSH, E2, inhibin
• Negative mood more likely in perimenopause, surgical menopause & premature menopause
• Oestrogen may improve mild depressed mood, but not clinical depression
• More negative attitude to menopause - more symptoms – chicken or the egg?

What to do?

• Assess:
  • Prior experience of depression and/or anxiety?
  • Role of other health issues, eg DM, arthritis
  • Lifestyle, including physical activity, alcohol, sleep
  • Overall quality of life, the domino effect
  • Stress and critical events
  • Relationship status and satisfaction
  • Support networks
  • Role satisfaction
  • Mental health and potential role of psychotherapy
  • Australian Psychological Society
    www.psychology.org.au

What’s important

“What women’s experience of the menopausal transition appears complex, potentially involving a range of factors and influences in their lives, and is by no means overwhelmingly negative.”

(Mishra & Kuh, 2006, p.23)