“Hot and Sweaty” When is it Menopause?

DR NICOLE AVARD

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- Acknowledgement of country
- Women – assigned female at birth (AFAB)

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Overview

- What is Menopause and do you diagnose it?
- What are the common symptoms?
- Why does it matter?
- How to approach the consultation
- What other preventative impacts do we need to think about?
- Approach to treatment

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Your Turn

- Menopause is….
- One day in the life of a women
- 12 months after the cessation of her Menstrual cycle
- Unless it is surgical menopause or iatrogenic
- Perimenopause – 4-7 years prior to the cessation of the period
- Hysterectomy/ablation

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What are the common symptoms ?

- Physical
- Psychological
- Those not spoken about

- Average age 51
- Under 40 – Premature Ovarian Insufficiency
- 40-45- early menopause /POI - a note on stress

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Physical

- Changes on Menstrual Cycle – Investigation of irregular PV bleeding
- Sleep disturbance
- Hot flushing
- Weight gain
- Dry skin, eyes, formication
- Hair loss
- Bloating

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Psychological

- Low mood/depression-high divorce and suicide rates
- Irritability
- Rage
- Anxiety
- Brain fog and difficulty concentrating

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Those not spoken about

- Vaginal dryness (Vulval conditions lichen sclerosis, psoriasis, dermatitis)
- Urinary frequency
- Urinary tract infections
- Painful intercourse
- Low libido

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Why does it matter?

- 100 % women
- 20% no symptoms
- 60% mild to moderate symptoms
- 20% severe
- 1 million women
- 25% less likely to take on leadership roles or reduce hours
- 40% more sick leave
- 10% leave the workforce
- $112 billion dollars

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Approach to the consultation

- **History – Physical**

Menstrual cycle, IMB, PCB

Heavy Menstrual bleeding

Hot flushing

Pre -menstrual symptoms eg breast tenderness, migraine,

Dysmenorrhoea

Sleep

Changes in weight

Dry skin and hair/hair loss , dry eyes

Bloating – take care with ovarian cancer

Joint pain

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Approach to the consultation cont…

- **Psychosocial**

Description of mood esp depression (Meno-D)

Anxiety (DASS-21)

Irritability and rage

Emotional lability

Impact on work

Impact on family and other relationships

Smoking

Alcohol intake

Dietary intake and exercise

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Approach to the consultation cont…

Those not spoken about…

Urinary symptoms- frequency, recurrent UTI’s

Vaginal dryness or irritation

Urgency and stress incontinence

Low libido

Painful intercourse

Intimacy , pleasure

NEXT PRACTICE
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Preventative Health

- Peri Menopause and Menopause is the gateway to increased of chronic disease including Cardiovascular events, Osteoporosis, Breast cancer and Dementia
- Family History
- CST
- Mammogram
- Bone density if indicated

www.garvan.org.au/research/bone-fracture-risk-calculator

- CV risk assessment

www.cvdcheck.org.au

- Sleep apnoea screen (STOPBANG)
- CONTRACEPTION- 2 years after the last cycle if under 50 and 1 year after the last cycle if > 50.

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Screening for women with low bone density

CONVENTIONAL RISK FACTORS FOR OSTEOPOROSIS AND FRACTURE

- Previous fracture
- Glucocorticoid therapy
- Parental history of hip fracture
- Low body weight
- Current smoker
- Excessive alcohol consumption
- Rheumatoid Arthritis
- Secondary causes (e.g. POI, medicines)

RELEVANCE IN YOUNGER WOMEN

- Presence of risk factors increases the chance of
  - low peak bone mass
  - premenopausal bone loss

Kanis JA, et al. Osteoporos Int. 2005 Jun;16(6):581-9. Chew CK and Clarke BL. Maturitas. 2018 May;111:61-68. Weaver C, et al. Osteoporosis international. 2016;27:1281-1386. Waugh EJ, et al; Perimenopause BMD Guidelines Subcommittee of Osteoporosis Canada. Osteoporos Int. 2009 Jan;20(1):1-21. Crandall CJ, et al. JAMA Intern Med. 2023 May 22:e231253.

Examination

- Height weight blood pressure
- Breast examination
- Abdominal examination
- PV- Labial and vulval changes, allodynia , cystocele, rectocele, Spec examantion
- CST if applicable with PV palpation

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Diagnosis

- CLINICALLY
- FSH when ? < 40, 40-45 with irregular cycle possibly, Ablation, hysterectomy
- >25 6 weeks apart
- TSH and Iron studies
- Lipids and fasting BSL +/- HBA1c or OGTT (PCOS)
- Pelvic U/S – diagnosis of IMB or menorrhagia , consideration for ovarian cancer

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What do we do ….

- Patient education – Australian Menopause Society Patient Information

www.menopause.org.au/hp/information-sheets

- Lifestyle measures and risk reduction measures
- MHT
- Non hormonal therapies

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Lifestyle and Allied Interventions

<u>Find the choice point</u>

- Smoking cessation
- ETOH reduction
- Diet- reduce refine CHO, increase protein, serving sizes, caloric need, calcium intake (dairy products, fish with bones, sesame seeds)
- Hot flushing- reduce caffeine, light cotton clothing, reduce spices, layers
- Movement- cardio and weight bearing , morning exercise
- Sleep hygiene- phones and screen, layers , room temperature , mediation
- Stress management - time in nature, box breathing, psychological intervention
- CBT and MBSR
- Pelvic Floor physiotherapy

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What about MHT???

Far and away the most effective way to assist with symptom reduction

- Women's Health Initiative
- If started before age 60 reduction in cardiovascular events and bone protection
- Improved all cause mortality and reduced fracture risk
- Breast cancer risk 1:1000 - 14:1000 depending on age. Population risk 1:8

https://www.petermac.org/iprevent

- Increased risk VTE 2:1000 depending on delivery
- Recent Dementia study taken with care

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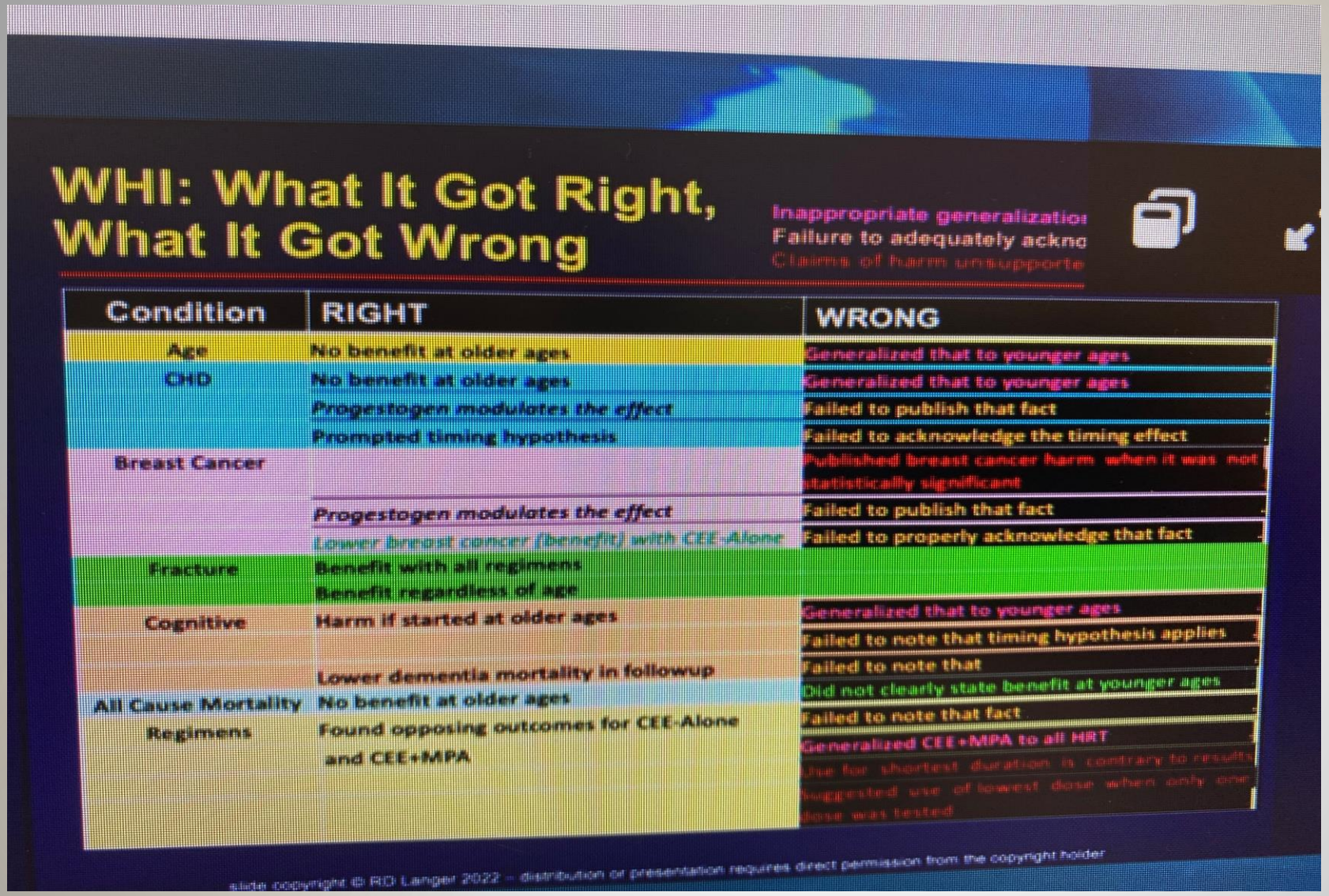
WHI: What It Got Right, What It Got Wrong
Inappropriate generalizatio
Failure to adequately ackno
Claims of harm unsupporte
Condition
RIGHT
WRONG
Age
No benefit at older ages
Generalized that to younger ages
CHD
No benefit at older ages
Generalized that to younger ages
Progestogen modulates the effect
Failed to publish that fact
Prompted timing hypothesis
Failed to acknowledge the timing effect
Breast Cancer
Published breast cancer harm when it was not statistically significant
Progestogen modulates the effect
Failed to publish that fact
Lower breast cancer (benefit) with CEE-Alone
Failed to properly acknowledge that fact
Fracture
Benefit with all regimens
Benefit regardless of age
Cognitive
Harm if started at older ages
Generalized that to younger ages
Failed to note that timing hypothesis applies
Lower dementia mortality in followup
Failed to note that
All Cause Mortality
No benefit at older ages
Did not clearly state benefit at younger ages
Regimens
Found opposing outcomes for CEE-Alone and CEE+MPA
Failed to note that fact
Generalized CEE+MPA to all HRT
Use for shortest duration is contrary to results
Suggested use of lowest dose when only one dose was tested
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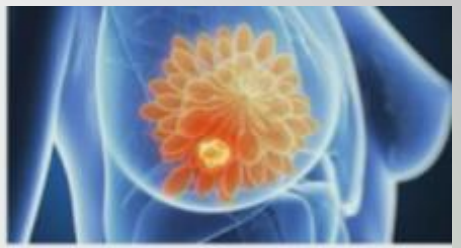
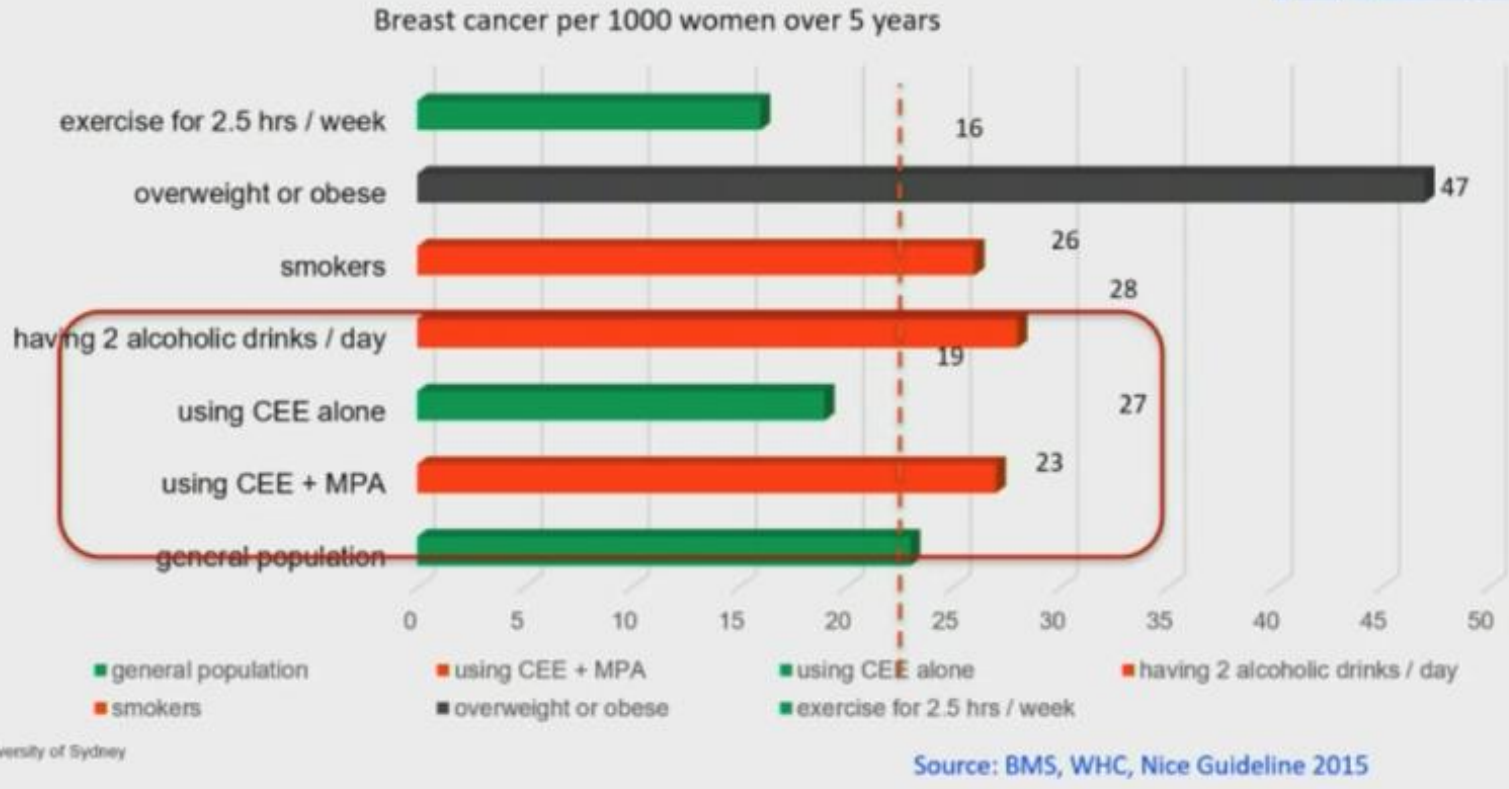
What about MHT???

Breast Cancer risk in UK women aged 50-59:





The University of Sydney

Source: BMS, WHC, Nice Guideline 2015

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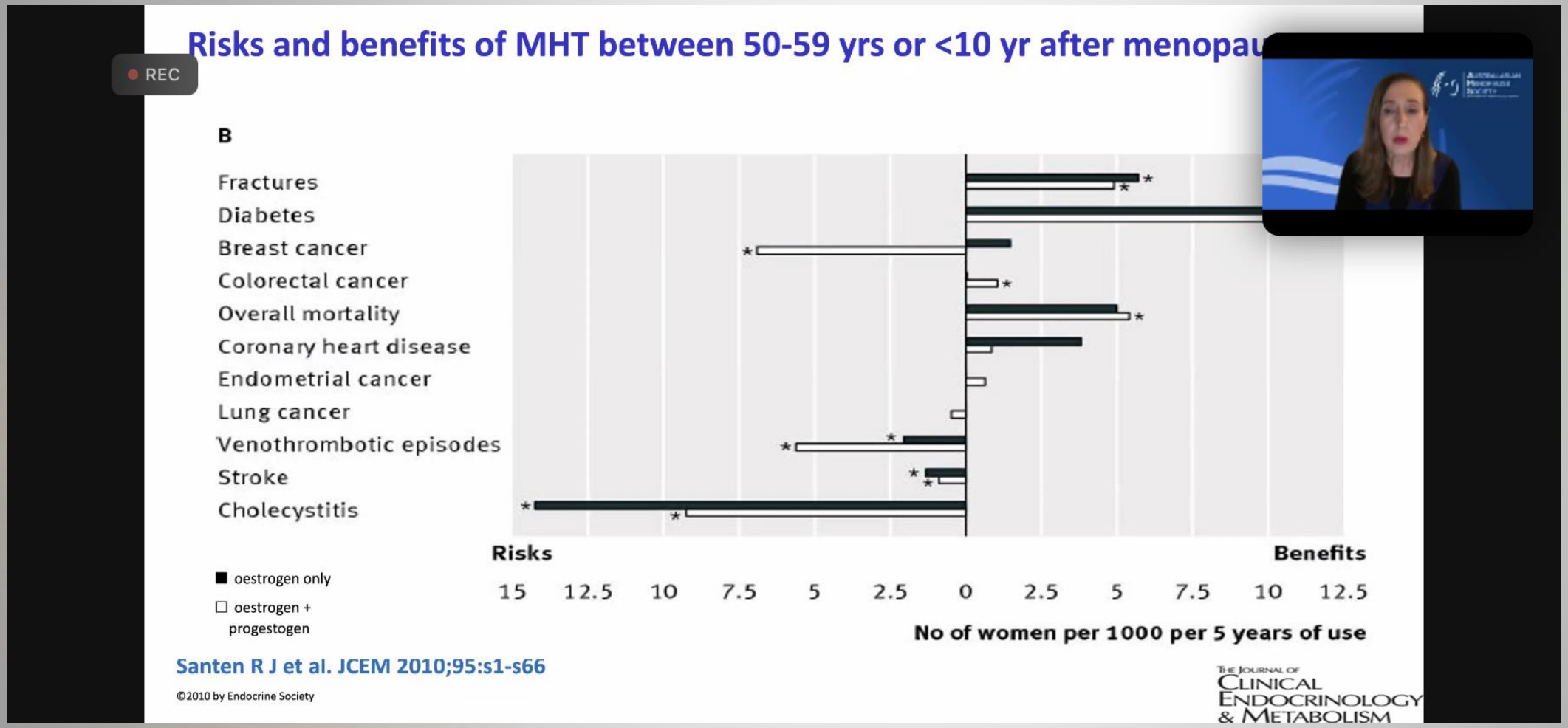
What about MHT???



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Contraindications to MHT

- Undiagnosed vaginal bleeding
- Active Cardiovascular disease
- Active or past history of hormone sensitive cancer
- Previous VTE – liase with haematologist
- Intolerance or patient preference

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How to deliver MHT

- Tablets
- Patches
- Gels
- Vaginal pessaries
- Patient preference and cost
- **Cyclical** = Oestrogen given continuously with Progesterone 14 days of 28. Can induce a withdrawal bleed. Usually how it is delivered within 12 months of the cycle ceasing
- **Continuous**= Oestrogen and progesterone continuously. Usually after 12 months of amenorrhoea.
- Progesterone **MUST** be given in adequate doses to all women with a uterus using oestrogen (aside vaginal delivery) to protect against endometrial cancer

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How to deliver MHT

- Oestrogen
- Oestradiol tablets 1-3mg
- Oestrodiol Gel 75mcg/pump 1-3 pumps
- Oestradiol patch 50mcg-100mcg
- Oestradiol pessaries for GSM symptoms 10 mcg
- Progesterone
- MPA 2.5-10mg
- Norestherione 1.25-2.5 mg
- Dydrogesterone (anti And Anti Min) 5-10mg
- Drosperinone 1-2 mg
- Micronsied Progesterone 100-200mg
- LARC as a progesterone options
- Mirena

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AMS Guide to Equivalent MHT/HRT Doses

AUSTRALIA ONLY

This Information Sheet has been developed as a guideline only to approximately equivalent doses of the different TGA registered MHT/HRT products available in Australia in August 2022. Hormone Replacement Therapy (HRT) is now referred to as Menopausal Hormone Therapy (MHT). The intention of this sheet is to help physicians change their patients to higher or lower approximate doses of MHT if needing to tailor therapy, or remain within the same approximate dose if needing to change brands of MHT. Private/non-PBS script products are marked with an*

CYCLIC MENOPAUSAL HORMONE THERAPY (MHT)

Use continuous oestrogen and cyclic progestogen combinations at peri-menopause or if less than 12 months amenorrhoea

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Femoston	tablet	1mg oestradiol/10mg dydrogesterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle
MEDIUM DOSE		
Trisequens*	tablet	1 and 2mg oestradiol/1mg norethisterone
Femoston	tablet	2mg oestradiol/10mg dydrogesterone
Estalis sequi 50/140)	transdermal patch	50mcg oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis sequi 50/250 (same oestrogen, more progestogen than Estalis sequi 50/140)	transdermal patch	50mcg oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle

https://www.menopause.org.au/hp/information-sheets/ams-guide-to-mht-hrt-doses

NEXT PRACTICE
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Choice of progestogen for endometrial protection

Progestogen	"LOW DOSE" 1 pump of E2 gel 25ug patch 1mg E2 tablet CE 0.3mg	"MEDIUM DOSE" 2 pumps of E2 gel 50ug patch 2mg E2 tablet CE 0.625	"HIGH DOSE" 3 pumps of E2 gel 75ug patch
Mic. progesterone Sequential 14 days	200mg daily	200 mg daily	**300mg daily**
Mic. Progesterone continuous	100mg daily	100 mg daily	200mg daily
Dydrogesterone sequential 14 days	10mg daily	10 mg daily	20mg daily
Dydrogesterone continuous	5mg daily	10 mg daily	20 mg daily
MPA continuous	2.5 – 5mg daily	5 mg daily	10mg daily
NETA continuous	0.5mg daily	1mg daily	2mg daily

Mueck A and Romer T . Horm Mol Biol Clin Invest. 2018;37(2). Doi10.1515

Non hormonal options

- CBT and MBSR especially for sleep
- Hypnotherapy
- SSRI/SNRI eg fluoxetine (not with Tamoxifen), Venlafaxine
- Clonidine
- Gabapentin
- Weight Management- peptides
- New medications coming soon

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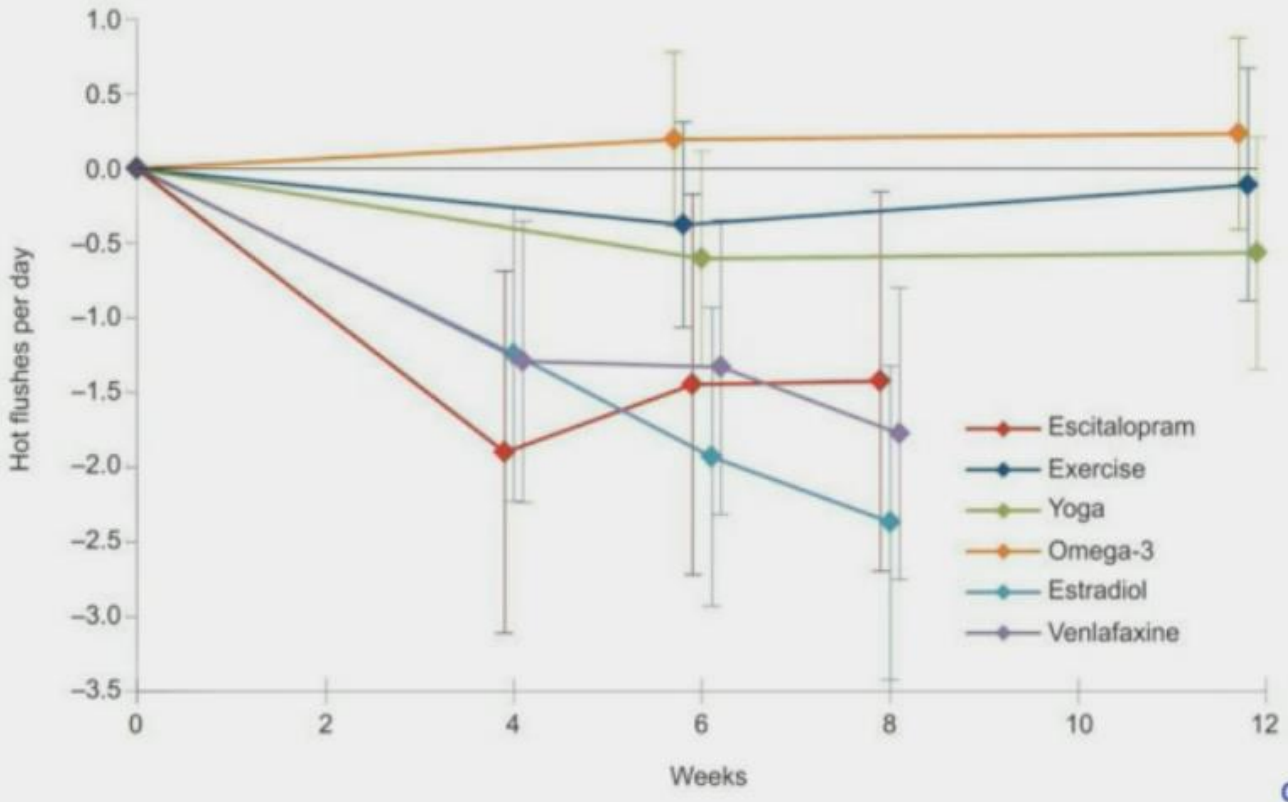
VMS - antidepressants vs. other strategies



Pooled analysis from three RCTs including 899 peri- and postmenopausal women with ≥14 bothersome VMS's a week.

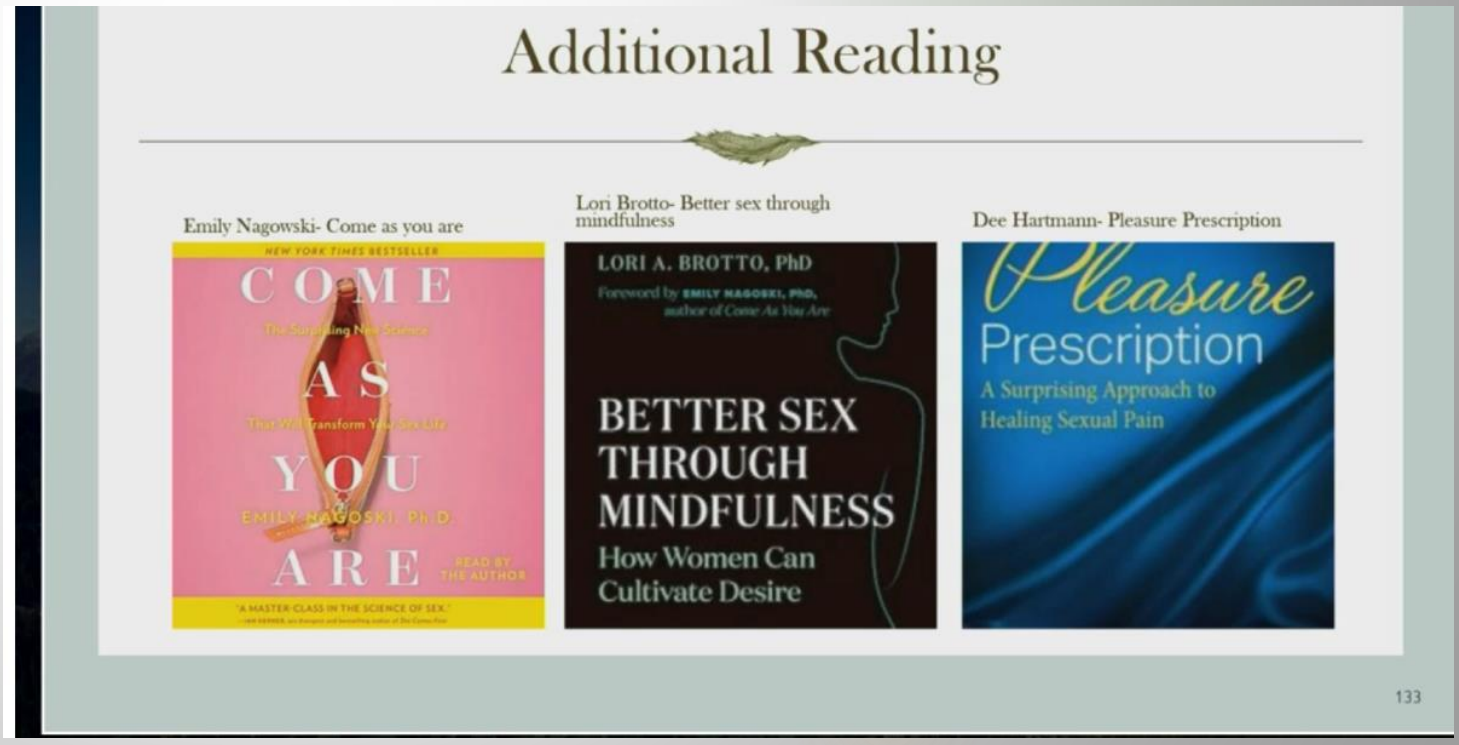
Interventions:

- escitalopram 10–20 mg/day
- non-aerobic yoga
- aerobic exercise
- 1.8 g/day omega-3 fatty acids
  0.5-mg/day oral 17-betaE2
- 75-mg/day venlafaxine XR

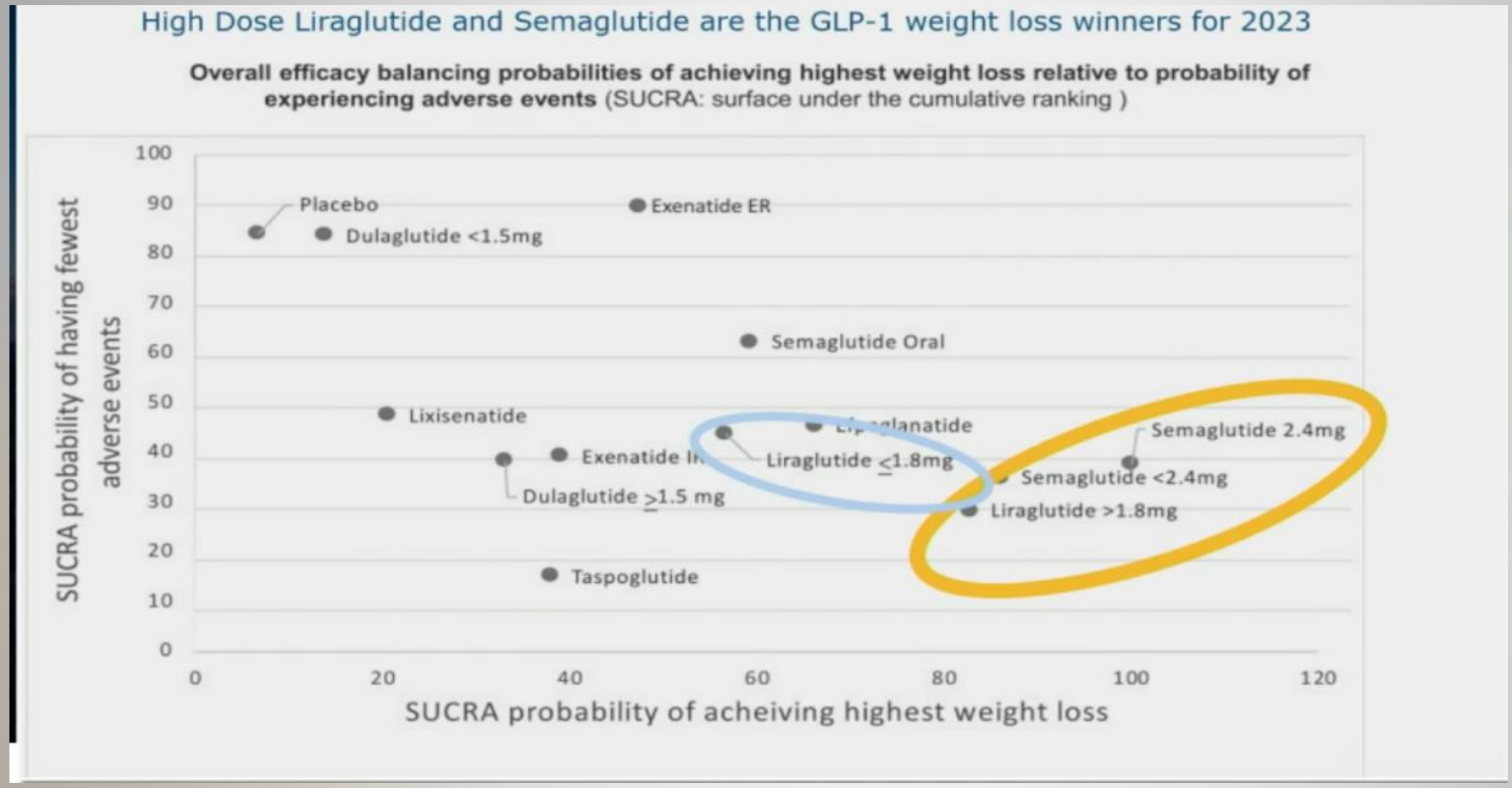
Guthie KA et l 2015; Obstet Gynecol

Genitourinary symptoms

- Topical oestradiol for vaginal dryness, recurrent UTI and urge incontinence
- Pelvic Floor Physiotherapist
- Pleasure toys and lubriucants
- Mindfulness



What about Ozempic?



Case Study Tracy 49 y.o female

- Presents with hot flushes, insomnia, low mood
- Cycle LMP was 4 months ago
- No dysmenhorroea , bleed 4 days, no HMB
- What next ?
- History
- Examination
- Ix
- Options for treatment

Case Study Leanne 53 y.o female

- Presents with bloating, hot flushing at night, increased agitation
- Cycle LMP was just over years ago
- What next ?

- History
- Examination
- Ix
- Options for treatment

Useful resources

- Jean Hailes Institute

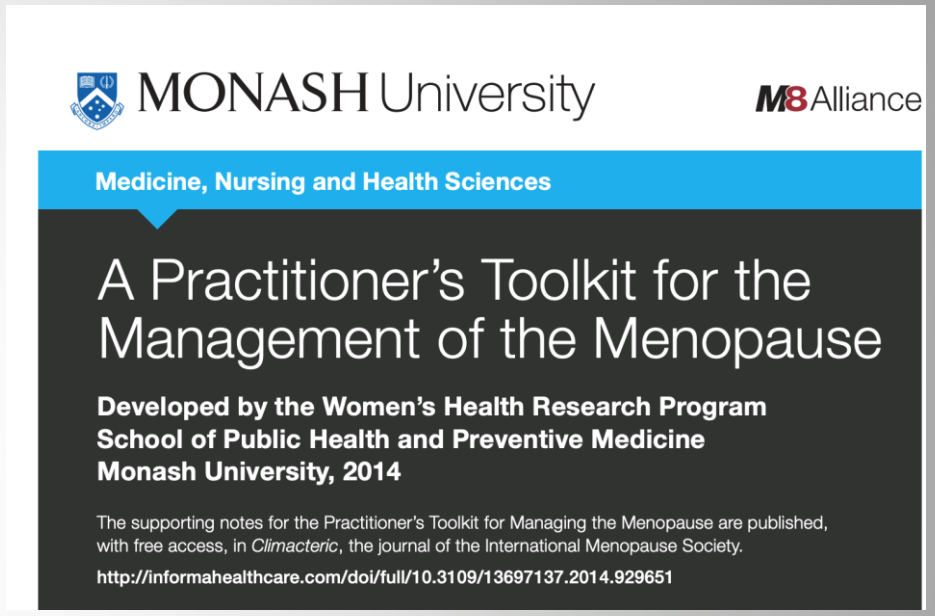
www.jeanhailes.org.au/health-a-z/menopause

- Australian Menopause Society –Patient Handouts

www.menopause.org.au/hp/information-sheets

- Australian Menopause Society Guide to Menopause

https://www.menopause.org.au/images/stories/documents/management-menopause-toolkit.pdf



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