Menopause Update 2023

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Menopause: Definition

Menopause is a biological stage in a woman's life when menstruation ceases permanently due to the loss of ovarian follicular activity. It occurs with the final menstrual period and is usually diagnosed clinically after 12 months of amenorrhoea.

Perimenopause, also called the 'menopausal transition' or 'climacteric', is the period *before* the menopause when the endocrinological, biological, and clinical features of approaching menopause commence. It is characterized by irregular cycles of ovulation and menstruation and ends 12 months after the last menstrual period.

Diagnosis Menopause

- Diagnosis should be based on clinical symptoms if >45
  - Perimenopause – vasomotor Sx & irregular periods
  - Menopause – no period for 12m & not taking contraception
- Consider FSH if…
  - >45 years with atypical symptoms
  - 40-45 years with Sx and change in periods
  - <45 years and suspecting premature menopause
- Laboratory results
  - Consistently raised FSH >30IU/l. Repeat on 2 occasions at least 6 weeks apart
  - Raised LH
  - Low serum oestradiol.

Menopause - Clinical Features

- Clinical Features: (affects 2/3rd woman)
  - Menstrual irregularity
  - Vasomotor
  - Musculoskeletal
  - Psychological
  - Urogenital

Menopause – Clinical Features

Vasomotor.

- Hot flushes, night sweats, disturbed sleep patterns, insomnia, irritability, short term memory loss and concentration.

Sexual dysfunction.

- Multifactorial.
- Sexual desire disorders.
- Sexual arousal disorders.
- Orgasmic disorders.
- Sexual pain disorders like Dyspareunia, Vaginismus, genital pain.

Psychological symptoms.

- Depressed mood, anxiety, irritability, mood swings, lethargy and lack of energy.

Urinary symptoms.

Assessment of Menopause

- Assess symptoms and their severity
- Assess risk of cardiovascular disease – BP, past hx of IHD
- Assess risk of osteoporosis
- Discuss her expectations
- Consider investigation if any sudden change in menstrual pattern (IMB, post coital)

Premature Menopause

- Menopause <40 years (1%).
- Increased risk of osteoporosis and IHD
- Diagnosis – FSH >30 with raised LH and low oestrogen on two occasions 4-6 weeks apart
- Management
  - Should have hormonal treatment with HRT or combined hormonal contraceptive until age of natural menopause & 5-10 yrs after
  - HRT can benefit BP/ CVS risks, but both HRT and combined contraceptive offer bone protection.
  - HRT **not** a contraceptive

Menopause treatments - HRT

- Indications
  - Relief of vasomotor or other menopausal symptoms
  - Prevention of osteoporosis
  - Premature ovarian failure

- Contraindications
  - Pregnancy, undiagnosed abnormal PV bleeding
  - Breast disease or endometrial cancer
  - Active liver disease
  - Clotting risk and IHD – now more possible for some with Transdermal oestrogens

Menopause Treatments - HRT

- Various preparation available:
  - Different strengths.
  - Combined Oestrogen and progesterone or Oestrogen Only
  - Different routes of administration.

- “Sequential” Vs “continuous”

- Routes: oral, transdermal, subcutaneous, Vaginal.

- Can start HRT before amenorrhea begins.

HRT Medication

Latest studies suggest some reduced risks when using transdermal oestrogen with added progesterone cover

Progesterone can be given as oral micronized progesterone (utrogestan) or via a Mirena IUS device

Transdermal oestrogen can be given as a patch twice weekly or a daily dose of oestrogen gel or spray

HRT Medication

- **Prescribe the lowest effective dose of hormone replacement therapy (HRT) for the shortest time possible.**
- **Oestrogen dose for symptom control**
  - Older women may be less tolerant of oestrogen and need to start (and are usually maintained) on a lower dose (for example 1 mg of oral estradiol or 25–50 micrograms of transdermal estradiol).
  - Younger women may require higher doses (for example 2–4 mg of oral estradiol or 100 micrograms of transdermal estradiol) to remain symptom-free.
  - Tailor the dose to the symptoms, as the ingested or applied dose may not be well absorbed.
- **Progestogens for endometrial protection**
  - Micronized progesterone (Utrogestan)
  - IUS containing 52mg of Levonorgestrel – can be used for 5 years from time of insertion

HRT Medication

Transdermal HRT Options :

Oestrogen patch – 25, 50, 75, 100mcg preps available – apply continuously and replace twice weekly

.Oestrogen Gel – licensed for 1-4 pumps daily

Oestrogen Spray – Licensed for 1-3 sprays daily

Gel suggests to be applied below the waist to reduce breast cancer risk but ?evidence

All require additional progesterone cover if uterus still in place – consider double dose if going over licenced Oestrogen dose

HRT Medication

BMS EQUIVALENT GUIDE

Oestrogen: • Evorel 50 patches • Estradot 50 patches • Estraderm 50 patches • Femseven 50 mono patches

Or

an oestradiol gel preparation such as Oestrogel two pumps a day equivalent to the oestrogen dose in Evorel 50

Or

Sandrena 1mg sachet a day would be equivalent to the oestrogen in Evorel 50

Or oestradiol spray Lenzetto three sprays (40 mcgm) equivalent to the oestrogen dose in Evorel 50

HRT Medication

BMS EQUIVALENT GUIDE

Progestogen:

Micronised Progesterone: Utrogestan 100mg orally at night daily on continuous basis or 200mg at night for 14 days and then 14 days off

Or Provera 5mg orally daily on continuous basis or 10mg daily for 12/14 days

Or Norethisterone 5mg orally daily on continuous basis or 5mg daily for 12/14 days(1mg would be sufficient for use in a continuous combined regimen but not available in stand-alone preparations)

HRT - Counselling Points

- Irregular bleeding is common in first 3-6 months
  - (Bleeding > 6mnths after amenorrhoea requires investigation
- Importance of adherence with treatment
- Remind peri-menopausal women that HRT is not a contraceptive
- No evidence that HRT causes weight gain

HRT Follow up

- 1st visit after start of treatment in 3 months.
- Then after evaluation every 6-12 months
- BP monitoring every 6/12.
- Contraception:
  - Continue contraception for 2 years after last period if women <50years.
  - One year contraception after last period if >50 years.
  - Until 55 Yrs if period history unknown
  - Mirena IUS only contraception that can be used as progesterone arm of HRT

Expect side effects

Oestrogen related: fluid retention, bloating, breast tenderness. Nausea, headache, leg cramps, dyspepsia

Progesterone related: migraines, headache, fluid retention, depression, acne, mood swings.

Common to both: weight gain, poor cycle control and BTB

HRT Risks (over 5 years)

- Breast cancer
  - Background risk is 15/1000. 2-6/1000 extra cases in women on HRT
- Venous thromboembolism
  - Background risk is 5/1000. 2 extra cases over 5 yrs. Risk neutralised if using transdermal oestrogen
- Cardiovascular disease
  - No increased risks in those with no pre-existing CVS disease

HRT Risks (in perspective)

Breast cancer risks :

- <>2-3 units alcohol per day increases risk by 1.5x
- Post menopausal obesity increases risk by 1.6x
- First pregnancy >30 years increases risk by 1.9x
- 5 years of HRT increases risk by 1.35x

Stopping HRT

- **Explain that:**
  - **For vasomotor symptoms,** most women require 2–5 years of HRT, but some women may need longer. This judgement should be made on a case-by-case basis with regular attempts to reduce or discontinue treatment. Symptoms may recur for a short time after stopping HRT due to oestrogen withdrawal
  - **Topical (vaginal) oestrogen** may be required long term. Regular attempts (at least annually) to stop treatment are usually made. Symptoms may recur once treatment has stopped.
  - **Women with premature menopause** usually take HRT up to the average age of the natural menopause (51 years), after which the need for HRT should be reassessed. Some women will still be symptomatic.

Stopping HRT

- **Offer women who wish to stop HRT a choice of gradually reducing or immediately stopping treatment.** Explain that:
  - Gradually reducing or immediately stopping HRT makes no difference to their symptoms in the longer term.
  - Gradually reducing HRT may limit recurrence of symptoms in the short term.
  - Symptoms of urogenital atrophy often come back when treatment with vaginal oestrogen is stopped. Consider using vaginal HRT longer term to control these symptoms

Menopause – Other treatment options

- Lifestyle Modifications – Diet, exercise, stop smoking
- Alternative Therapies – Isoflavines (red clover) and Black Cohosh, acupuncture, reflexology
- Hot flushes - Progestogens, clonidine, SSRI, Gabapentin, propranolol.
- Vaginal atrophy - Lubricants, moisturizers (Replens, sylk)
- Osteoporosis - Bisphosphonates, Alendronate, SERMs like raloxifene
- Mood changes - SSRI’s

Management of Co Morbidities

- **For menopausal women with, or at high risk of, breast cancer:**
  - Provide information on non-hormonal and non-pharmacological treatments
  - Offer referral to a healthcare professional with expertise in menopause.
- **For women at increased risk of venous thromboembolism (VTE):**
  - Consider prescribing transdermal hormone replacement therapy (HRT) rather than oral HRT as less risk
- **For women with cardiovascular risk factors (for example hypertension):**
  - HRT can be considered; however, cardiovascular risk factors should be managed and BP should be well controlled
- **For woman with type 2 diabetes:**
  - Consider HRT after taking comorbidities into account and seeking specialist advice if needed.
  - Advise that HRT is not associated with an adverse effect on blood glucose control.
- **For women with hypothyroidism:**
  - Monitor their thyroid function regularly to ensure that thyroid hormone levels remain in the acceptable range.

Useful websites

www.thebms.org.uk

www.menopausematters.co.uk

www.mapofmedicine.com

- Information on support groups, such as:Menopause Matters (www.menopausematters.co.uk) — provides information on the menopause, menopausal symptoms, and treatment options.
- The Daisy Network (www.daisynetwork.org.uk) — a nationwide support group for women who have suffered a premature menopause.

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