A CLINICIAN'S VIEW

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RUDYARD Kipling has a verse in "The Elephant Child" in his "Just So Stories" which, for the clinician, is a piece of good advice,

"I keep six honest serving men
They taught me all I knew,
Their names are What and Why and When
And How and Where and Who."

For the clinician these six honest serving men will tell him all he needs to know about the menopause. First we must ask

WHAT ARE THE SYMPTOMS?

THE MENOPAUSE is a normal physiological event occurring in every woman's life span and therefore it should not be accompanied by any pathological symptoms. However, there is one symptom that few women avoid, even though they may only experience it intermittently and very occasionally, and that symptom is the hot flush. This presents itself in two forms, one visible, and the other non-visible. It is a sensation of heat rising throughout the body from the waist and gradually spreading up to the neck and face. It only lasts for a few minutes. Occasionally it is accompanied by a visible flushing and indeed beads of sweat may appear. When sweating of the scalp occurs it plays havoc with the hair style. Other women will have the same sensation but without any visible signs and so bystanders will be quite unaware of what is going on. When flushes occur at night they are apt to be accompanied by profuse sweating, so that the woman awakes suddenly and flings off the bedclothes, much to the annoyance of her husband, and sometimes she has to change into a dry nightdress. Flushes may occur only once daily with several days interval before the next one; at the other extreme they may occur twenty to forty times daily without any relief. Flushes are liable to occur during the paramenstruum, at times of missed menstruation and on stopping a cyclical course of oestrogens. Following ovariectomy, flushes are frequent.

Changes in the vagina may give rise to dryness, soreness and itching. This in turn may cause the frequency and pain on micturition and nocturnal micturition that is too often misdiagnosed as "cystitis". It also causes pain on penetration in coitus, leading to a loss of libido. On examination the vagina is pale and dry and the cervix firm and shrunken. These findings are a marked contrast to those seen in early pregnancy when the vagina is moist, red and hot and the cervix is soft and swollen. Women who miss menstruation for the first time at the menopause are often frightened that they have become pregnant. They can readily be reassured by a vaginal examination.

Oestrogen deficiency at this time may lead to thinning and increased porosity of the bones. Initially this presents as vague, fleeting joint pains, especially in the hands, feet and back, but other joints may be affected. If bone pathology is present, there is a rise in urinary and blood calcium and also in alkaline phosphatase. Later there may be an increased incidence of fractures, especially of the wrist and neck of the femur. During the sixties there may be crushed fractures of the vertebrae but by then, although oestrogen therapy may halt the osteoporosis, it will not repair the damage which has already occurred.

There may be a decrease in epidermal thickness, leading to wrinkles, especially of the face. The hair turning grey is hastened by oestrogen deficiency and darker hair may regrow once oestrogen therapy is instituted. One of my patients, an attractive socialite of forty-eight years had beautiful white hair, always well coiffured. After three months treatment she refused a repeat prescription for oestrogens because she felt it caused grey hairs to grow instead of white. She opted for non-hormonal therapy for her flushes.

There is also a group of non-specific psychological symptoms, commonly blamed on the menopause, but these are not directly related to hormonal imbalance and do not necessarily improve with the institution of hormone replacement therapy. On the other hand, the feeling of general well-being induced by oestrogens and the removal of specific symptoms already mentioned may improve the patient so much that further treatment is unnecessary. These symptoms include depression, irritability, anxiety, loss of energy, headaches, fainting, vertigo, palpitations, absent mindedness and loss of memory for recent events. In the presence of specific menopausal symptoms oestrogen therapy is indicated before resorting to expensive and addictable tranquillizers or anti-depressant drugs for these psychological symptoms.

Some women note an increase in their usual premenstrual symptoms, such as headaches, tension, depression and asthma, at the time of declining menstruation and at missed menstruation, and these symptoms may increase in severity when treated with oestrogen. They respond well to progesterone given by suppository or pessary: a few of these cases may be relieved with oral progestogens such as norethisterone.

During the forties and fifties there may be deterioration of focusing ability leading to difficulty in reading small print and threading a needle. These are the years when many who had previously boasted of good eyesight find it necessary to wear spectacles, and especially bifocals, but these changes are not due to the hormonal changes of the menopause and occur equally in males at the same age.

WHY DO THESE SYMPTOMS OCCUR?

THE SIMPLE answer is because of an alteration in the normal hormone levels, with a decrease in oestrogen and a rise in gonadotrophins. With the end of the reproductive era the uterus, ovaries and breasts

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diminish and become redundant. During the reproductive years most of the oestrogen required by the body is produced by the ovary, but with the cessation of ovarian function at the menopause the body is not left totally void of oestrogen because a small amount continues to be synthesized in the fat, liver and other peripheral tissues, from the oestrogen precursors in the adrenals. However, although there is decreased oestrogen from the ovaries there is no compensating increase in the size of the adrenals.

Coinciding with the failure of ovarian function there is an increased output of the gonadotrophin hormones (follicle stimulating hormone and luteinising hormone), from the pituitary in an attempt to stimulate the refractory ovaries. It would appear that the menopausal symptoms related to the flushes, the vagina, skin and bones are due to both a fall in the level of circulating oestrogens and a rise in the levels of follicle stimulating hormone and luteinising hormone.

WHY BE SCARED OF THE MENOPAUSE?

UNFORTUNATELY EVEN today there are women who dread the end of their reproductive years and are frightened by its inevitability. Any individual woman's attitude to the menopause is dependent upon the age at which she is questioned, it is conditioned by her family background in her earlier adult life, her parity, sexual experiences and social status. Those who have fulfilled and enjoyed their childbearing roles are happy to see an end to possible pregnancies. However, the single and nulliparous women often cling tenaciously to the impossible dream of a child of their own one day, and their last menstruation represents the death of that dream. If menstruation has proved troublesome with mood swings, premenstrual tension, bloatedness, pain or heavy loss then its cessation will be welcomed with relief, whilst those who have been plagued by hypochromic anaemia frequently find renewed zest and energy in the post menopausal years. Not all women appreciate that there need be no decrease in the sex urge following the menopause and, indeed for many, sexual enjoyment is increased once the fear of pregnancy and the monthly mood swings are removed. More than one woman has experienced her first orgasm after the menopause. A few Catholics, who have been educated to regard intercourse solely for the procreation of children, may find it difficult to adjust to coitus purely for pleasure, and women who have never experienced sexual enjoyment may use the menopause as an excuse for abstaining.

WHEN TO EXPECT THE MENOPAUSE?

TO BE precise, the term "menopause" means "the last menstruation", although in this symposium it has been used more loosely to cover the years before and after the last menstruation, during which the hormonal changes are occurring. The actual time of the last menstruation occurs between the ages of forty-five and fifty-five years, a few experience an early premature menopause at or before forty years of age. For the last twenty-five years women in my practice have been encouraged to keep menstrual records of the dates and duration of each menstruation. This gives valuable information and helps to pinpoint when the earliest menopausal changes are occurring. Women with least symptoms tend to be those whose chart shows a gradual shortening in the duration of loss, from perhaps six or seven days to three or four, then over the following year the duration may gradually reduce further until it lasts only one or two days and the loss becomes scanty. Once the duration has decreased there tends to be missed menstruations, with intervals of one, two or more months. The intervals are haphazard, sometimes intervals of six or nine months and then, perhaps, several coming regularly once more. The last menstruation after an interval of twelve months is nowadays considered to be the menopause, although earlier it used to be an interval of two years. If there is any bleeding after this interval then it is considered to be pathological and needs investigation.

Another pattern frequently seen at the end of the reproductive era is that of a sudden missed menstruation without any marked reduction in menstrual duration or less. When women suddenly miss one menstruation their mind immediately considers the possibility of pregnancy, and reassurance is sought on this point. Again the incidence of missed menstruation is haphazard, with intervals of one to six months, but it is usually a regular irregularity and women usually know when menstruation has been missed as the build-up of menstrual tension and molima decreases.

Occasionally menstruation ends suddenly without any preceding reduction in duration or loss, and never returns. This is apt to occur if a stressful event has coincided, such as a child's wedding, moving house or changing employment. It is this type of ending of menstruation which is most likely to be accompanied by acute menopausal symptoms and possibly depression.

HOW TO RECOGNIZE THE MENOPAUSE?

THOSE WHO have been keeping menstrual records over the years usually experience little difficulty in recognizing the menopause. And even those who consult for menopausal symptoms can very usefully be given a menstrual chart on which to record accurately the ending of their reproductive years. Menopausal symptoms tend to become noticeable during the last twelve months of menstruating life.

Single estimations of oestrogens and gonadetrophic hormones are of little value as the diurnal variations are too great. Serial estimations have their uses, but are excessively expensive and better left for research workers. For the clinician help may be obtained from the karyopycnotic index (K I) of the vaginal smear. This can easily be performed in the surgery or, if asked for, is available when a routine cervical smear is examined by the cytologist. It has its limitations, and is only of value when progesterone is absent, namely in the first half of the menstrual cycle or at times of amenorrhoea. It is a measure of how much oestrogen is present, and depends upon the number of cells with dark nuclei. When progesterone is present the K I will always be low.

If osteoporosis has occurred there will be decrease in height, due to thinning of the vertebrae and discs. In one of normal proportions her height is equal to the span of her outstretched arms, measured from fingertips to fingertips. After the menopause when a decrease in height occurs it is useful to compare height with the armspan, and if there is a difference of more than an inch this suggests that oestrogen therapy should be undertaken.

In many cases the therapeutic test is still the favourite. The woman is given a month's course of oestrogen and if on her return she reports an improvement in symptoms a further course is given. Admittedly there is frequently a placebo effect in giving the tablets, but if that is still maintained two or three months later then it suggests it is the hormone which is beneficial.

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WHERE TO GO FOR TREATMENT?

THE GENERAL practitioner is obviously the first to treat menopausal symptoms. Most are sympathetic to women who have symptoms, although those who are symptom free and wish to insure themselves against problematic years may not be so well received. The general practitioner who has cared for the woman for years, knows her and her family well and also her reaction to drugs and he can be relied upon to care for her regularly throughout the menopause. Some are referred to the nearest gynaecological clinic, where the emphasis is on more important pathology, such as the early recognition of malignancy, the alleviation of severe pain or infertility. There may be long waiting lists and the addition of hundreds of symptomless women to their outpatient clinics will not necessarily be appreciated.

Gradually more menopause clinics are being established where full investigations and regular examinations are instituted, and hormone replacement therapy is undertaken. The optimists hope that as more financial help becomes available within the National Health Service, more clinics will be established. With the establishment of free contraception now undertaken by general practitioners and hospitals perhaps the Family Planning Association may be able to start a new crusade by helping women over the menopausal years with the establishment of menopause clinics attached to their family planning clinics.

WHO NEEDS HELP?

THERE HAS always been a steady flow of women presenting to the general practitioner with menopausal symptoms and for the past quarter of a century or longer these women have been receiving the necessary oestrogen therapy. The high sounding and emotive term "Hormone Replacement Therapy" was not in vogue then, patients merely asked for "more tablets Doc.". However, in recent years as a result of the medical education by the media, there has been an increase in that group of women who regard all menopausal changes as pathological rather than physiological, and who seek, or rather demand, medical help to prevent senility, wrinkles, middle-age spread and the onset of the awkward years. I have known women not yet thirty-five years of age and free from symptoms anxious to start on oestrogens in order to take out, or should one say swallow, an insurance policy against future menopausal discomforts.

Another group who seek advice are those frightened of the unknown, usually women in whom sex instruction was absent or fragmentary. They recall seeing their mother having a depressive illness or attempting suicide at her menopause and are anxious to avoid this happening to them. Such women tend to be vague, and cannot understand the changes which are occurring within them. Their first night sweats are likely to be interpreted as the flu. They may be inarticulate using such phrases as "feeling queer", "definitely need a tonic" or "somehow I look different". These call for the full diagnostic skill of a physician, for at this age other disease may present in a similar way such as an incipient anaemia, malignancies or disturbances of the thyroid gland.

Yet others come with the "by-the-way syndrome", initially presenting some acceptable reason for a consultation such as a sore throat or cut finger and then just as they are leaving the door mentioning the occurrence of hot flushes, or the opposite can happen. Recently I met a patient whom I had known very well some years ago, but had not seen for the last ten years. She now has carcinoma of the breast, too large for surgery and is undergoing radiotherapy. Three months earlier she had noticed an indrawn nipple. She confessed to me she was too frightened to face up to reality and mention it directly, but on two occasions she had visited the health centre and seen different doctors complaining of "menopausal palpitations". Both had examined her chest, or rather as it seemed to the patient, her breasts, and as they had not commented on the lump she assumed it was of no significance.

Other women who need help are those who have had an artificial menopause while still in their thirties or early forties. No surgeon will easily undertake a radical operation on a young woman, but all too often there is no choice because of some gynaecological disease. The natural menopause is a gradual ending of reproductive life and takes several years to complete, with a very gradual slowing down of menstruation and ovulation, and a gradual decrease in the size of the uterus and breasts accompanying the hormonal changes. In a surgical castration the ovaries and possibly also the uterus are removed abruptly and in a matter of hours, the body has to readjust to a completely different hormonal state, within a few days hot flushes may be noticed by the woman. It is important to appreciate that following ovariectomy, hot flushes will occur before there is any demonstrable lowering of the oestrogen level or a rise in gonadotrophin levels. Where the underlying disease permits it, the surgeon will often insert an oestrogen implant at the time of operation to avert too abrupt a menopause. Usually, within two or three months of the operation, the menstrual controlling centre situated in the hypothalamus reasserts itself, and the woman becomes aware of the times when menstruation might have been expected. Although she no longer has any blood loss, there may be the other tell-tale symptoms, like tender swollen breasts, sensations of bloatedness, tension, depression, lethargy and irritability. Unless she has hormone replacement therapy early on she will inevitably develop menopausal changes in her vagina, skin and bones.

The general practitioner is the one who should be available and prepared to discuss with both the husband and the wife, the possible implications of a hysterectomy or ovariectomy before the operation is undertaken. They should appreciate the probability that hormones will be required, and observation for possible oestrogen deficiency should be continued until the time of the natural menopause. The husband should be alerted to the possibility of depression or excessive weight gain following either a hysterectomy and/or an ovariectomy, and he should appreciate that these are best treated sooner rather than later. Both should be reminded that the normal sexual function will be preserved and sexual enjoyment will not be interfered with, indeed it may even be enhanced. But reassurance is not enough. Regular hormonal monitoring is essential. In any Menopausal Clinic women who have had an artificial menopause should be considered first priority.

THE SIZE OF THE PROBLEM

THERE ARE in Britain today ten million women who would probably benefit from hormone replacement therapy. They need not wait for the universal establishment of Menopausal Clinics, for under the National Health Act it is the duty of the general practitioner to give "reasonable and necessary care" to those on his list. Who can deny that hormone replacement therapy for those with signs of oestrogen deficiency symptoms is "reasonable and necessary"?

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