Management of the menopause in Primary Care

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Aims

- Understand terminology
- Focus management on

- Improving quality of life
- Set realistic expectations
- Aid Women in making decisions for themselves

Menopause Attained when a year has elapsed since the last period.

Peri-menopause – phase when symptoms of the menopause appear and ends with the onset.

Premature ovarian insufficiency when menopause occurs at an age less than two standard deviations of the expected mean for the population.
Average age for menopause 51

Investigations

- In over 45 no need for tests

- Hormonal tests may be necessary in those under 40 and those between 40 -45 with changing periods and vasomotor symptoms

Advice and support

- Stages of menopause with common symptoms
- Lifestyle changes
- Benefits and risks of therapy
- Long term health implications

Common Symptoms

- Hot flushes, night sweats
- Changes in periods, length and frequency
- Aches and Pains along limbs
- Effects on mood
- Bladder and vaginal symptoms referred to as the Genito-Urinary symptoms of the menopause
- Sexual difficulties

Treatment modalities

- Hormone Replacement Therapy
- Other therapies
- Cognitive Behavioural Therapy

Hormone replacement therapy

In women with Uterus

Oestrogen and Progestogen as

- Sequential therapy
- Continuous combined therapy

In women without uterus

Oestrogen only

Other Therapies

- Tibolone
- TSEC
- Phytoestrogens
- SNRI and SSRI
- Gabapentin
- SERMS (Selective Estrogen Receptor Modulator) such as Raloxifene
- Bisphosphonates
- Strontium Ranelate
- Teriparatide
- Calcium and Vit D

Peri menopausal woman

HRT is not a contraceptive

Women about to undergo surgical/medical induced menopause

Inform about menopause

Discuss fertility

Hot Flushes and night sweats

- HRT is an effective treatment for hot flushes
- Tibolone is effective for alleviating the severity and reducing the frequency of hot flushes
- SSRI, SNRI, Clonidine – avoid as first choice

Non Hormonal treatment in managing Vasomotor symptoms

- Placebo – 30% relief
- Megestrol acetate - 85% benefit (20-80mg)

- Selective serotonin reuptake inhibitors SSRI

Paroxetine, Venlafaxine(SNRI), DesVenlafaxine. Upto 50%

- Clonidine alpha adrenergic agonist. Upto 30%

Side effects -dry mouth,dizziness, constipation and sedation

Non Hormonal management of VASOMOTOR Symptoms (cont)

- Phytoestrogens possible benefit but not enough evidence especially in the long term
- Gabapentin possibly beneficial in doses of 900 mg /day
- Oxybutynin

All are less effective compared to Oestrogen

Genito-urinary symptoms of the menopause

- Low dose topical estrogen (E1 or E3) is an effective treatment
- E2 (estradiol) therapy is also effective.
- DHEAS
- E2 ring
- Ospemiphine
- Laser

PSYCHOLOGICAL SYMPTOMS

Depression,

Mood changes,

Anxiety and Irritability,

Loss of libido,

Lack of energy and memory loss.

PSYCHOLOGICAL SYMPTOMS

- HRT helps in mood changes associated with menopause. Do not treat with anti-depressants if there is no history of depression.
- The addition of low doses of androgens to HRT provides relief in low libido, however always ensure a psychosexual evaluation prior to prescribing.

PSYCHOLOGICAL SYMPTOMS

- Tibolone is effective in providing relief from low libido in postmenopausal women
- Estrogen replacement therapy is not an effective treatment for loss of libido in postmenopausal women

Cognition

Insufficient or inconsistent evidence that HRT

1. Improves measures of cognition

2 Prevents or delays the onset of Alzheimer's disease

RISK OF BREAST CANCER

- Meta analysis of 51 observational studies show

Risk with HRT is 2.3% per year of use compared to late natural menopause where risk rises by 2.8% per year of delay

- Increased risk **decreases** on discontinuation

In **five years** risk is similar to one who has never been exposed

Absolute RISK OF BREAST CANCER

Breast cancer increased from 30 to 38 cases (did not appear in the first four years of use).

50-59 years – 5,

60-69 years – 8,

70-79 – 13/10000.

RISK OF ENDOMETRIAL CANCER

- **Unopposed estrogen therapy should not be used in women with a uterus because of an increased risk of endometrial cancer.**
- Sequential and long cycle HRT also increases risk of endometrial cancer especially when continued for more than five years. Minimal increase in risk.

RISK OF ENDOMETRIAL CANCER

Continuous combined regimens offer better protection of the endometrium than Sequential regimens – WHI (RR 0.83)

RISK OF OVARIAN CANCER

There is no conclusive evidence that <u>combined</u> regimens HRT either increases or decreases the risk of developing ovarian cancer.

Osteoporosis

After 35 yrs 1% bone mass lost every year

Osteoporosis Risk Factors

- **Premature menopause**
- **Family history**
- **Steroids for 6 months**
- **Amenorrhoea for 6mths or more - BMI or exercise**
- **Liver, Thyroid or Renal Disorder**
- **Alcohol intake**
- **GnRH analogues>6 mths**

Osteoporosis

Bone loss resumes on stopping therapy

Turnover resumes after 3-6mths of therapy

- **Bisphosphonates comparable to therapy with E2**

With treatment risk of Spinal fracture reduces from 6.2 to 3.2%

Osteoporosis

- **Calcitonin SC or intranasal less effective**

- **Raloxifene SERM slightly less effective than E2 Grade A efficacy in the spine not hip**

  No effect on endometrium

Osteoporosis

- **Forsteo(Teriparatide)- Parathyroid hormone extract helps new bone formation through Increasing osteoblastic activity**

  18 months injectable SC
- **Strontium ranelate – dual action**
- **Denosumab - receptor activator of nuclear factor kappa B ligand (RANKL) inhibitor. Slows bone loss and increases bone strength.**

HRT and Osteoporosis

The silent killer

- HRT and Bisphosphonates has positive effects on bone density in postmenopausal women whether or not they have osteoporosis

HRT and Osteoporosis

- **Maintaining HRT use decreases the risk of fractures in women after Surgical menopause Early postmenopausal women and in women with Established osteoporosis**
- **Effect is less for women >60yrs**

Osteoporosis

- **Selective Estrogen Receptor Modulators (SERMs) may be useful in the prevention of vertebral fractures in women who cannot use HRT or bisphosphonates.**

HRT and cardiac risk

- **In under 60's HRT does not increase the risk of CVD. Less so when E2 only preparations are used. *NICE***

HRT and cardiac risk

- **HRT is contraindicated for secondary prevention of further coronary disease because of lack of documented efficacy and a possible early excess mortality.**

VTE

Increases risk **two** fold with highest risk in first year of use.

Baseline risk is 1 in 10,000 per year and mortality is 1 – 2%.

Advancing age and **obesity** increase risk. Absolute rate increase is 1.5 VTE events per 10,000 women.

Women's Health Initiative (WHI) study

- This randomized controlled trial examined the risks and benefits of long-term combined HRT use in 16,608 asymptomatic postmenopausal women compared to the placebo group

- The trial was halted prematurely, after 5. 2 years of an 8-year study, due to an increased risk of invasive breast cancer.

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The Women's Health Initiative (WHI) Study

The other arm of the WHI trial on estrogen use continued and showed no increased risk of breast cancer

The Women's Health Initiative (WHI) Study

The key findings after five years / 10,000 women per year

- Breast cancer increased from 32 to 38 cases (did not appear in the first four years of use).

The Women's Health Initiative (WHI) Study

- Coronary heart disease increased from 30 to 37 cases (appeared in first year of use) 7/10000 person risk (absolute risk)

- Stroke increased from 21 to 29 cases

  greatest during the first 2 years 8/10000 person absolute risk

The Women's Health Initiative (WHI) Study

- Blood Clots: increased from 16 to 34 cases
- Absolute risk is small 16-23 cases excess /10000 women per year
- Women on HRT have twice the risk of VTE compared with non users
- Greater in the first year OR 4.6(2.5-8.4)

The Women's Health Initiative (WHI) Study

The benefits were

- **A reduction in colorectal cancer from 16 to 10 cases**

  The reduced risk of colorectal cancer emerged after 3 years

- **Hip fracture (reduced from 15 to 10)**

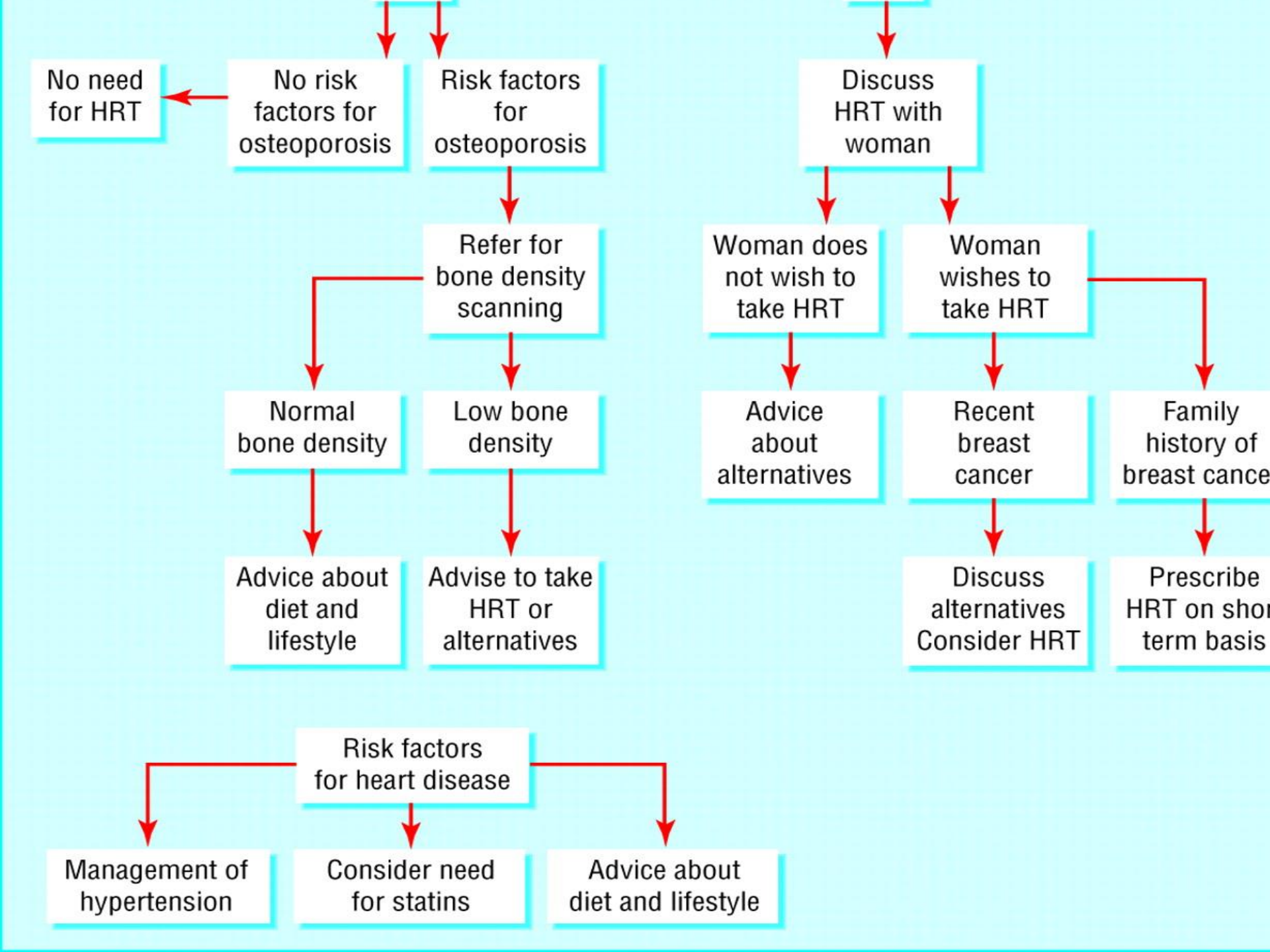
The results of the WHI study confirm what is already known about the long-term risks of HRT, including breast cancer and venous thromboembolism.

HRT has not been proven to be beneficial in primary and secondary prevention of coronary heart disease.

BMS and RCOG continues to recommend that decisions regarding HRT therapy must be made between the woman and her physician on an individual basis.

HRT is the most effective treatment of menopausal symptoms .

- For patients with osteoporosis, other preventive therapies such as bisphosphonates and SERM are available. However, for women at risk of osteoporosis who also have vasomotor menopausal symptoms, HRT can be of benefit .


No need for HRT
No risk factors for osteoporosis
Risk factors for osteoporosis
Refer for bone density scanning
Normal bone density
Low bone density
Advice about diet and lifestyle
Advise to take HRT or alternatives
Discuss HRT with woman
Woman does not wish to take HRT
Woman wishes to take HRT
Advice about alternatives
Recent breast cancer
Family history of breast cance
Discuss alternatives Consider HRT
Prescribe HRT on shor term basis
Risk factors for heart disease
Management of hypertension
Consider need for statins
Advice about diet and lifestyle

Conclusion

- Individualised therapy
- Contraindicated in women with clinical evidence of Heart disease
- Overall risk benefit balance in women without symptoms is not favourable
- Women in premature menopause should be encouraged to take HRT
- Avoid rigid cut off’s in duration of therapy, maintain surveillance, allow patients to weigh risks against benefits and make an informed choice