



# Menopause forum

## A case discussion on midlife issues



The authors of our theme articles this month discuss their approach to the assessment and management of a woman presenting with issues relating to menopause and midlife.

### Helen's story

Helen is 45 years of age. She has a partner, two teenage children, is a nonsmoker and is not taking any medication. She presents with hot flushes and premenstrual tension, and has regular menstrual cycles.

In your assessment it is important to undertake:

- a thorough history including past medical and family history of osteoporosis, heart disease, breast cancer and thrombosis
- a social history – consider family, work, substance abuse
- a preventive health screen – check breasts and blood pressure and ensure all routine examinations are up-to-date, ie: Pap test, mammogram, lipid levels

### Education

Explain to Helen that she is going through the 'menopausal transition'. Hormones begin to change after the age of 35 years and fluctuating hormones can lead to symptoms similar to those she is experiencing. However, she still needs contraception even if her periods become irregular.

After a routine history was taken, Helen reveals that she has a family history of osteoporosis and distant breast cancer. Breast examination is normal.

Helen has various management options for her symptoms. Discussing them thoroughly with her will assist Helen in making an informed decision. Helen's options include:

- diet and lifestyle – discuss the benefits of a balanced diet and regular exercise for general wellbeing. With Helen's family history of osteoporosis, adequate calcium intake and weight bearing exercise is particularly important (see the article by Alice Murkies page 895 this issue)
- low dose combined oral contraceptive pill (OCP) – a 20 µg ethynyl oestradiol OCP is an option if the woman is not a smoker and has a low cardiovascular disease risk profile. It provides contraception and relieves menopausal symptoms
- hormone therapy (HT) – discussion needs to include the risks and benefits of HT (see the article by Helena Teede page 875 this issue) and remember it is not a contraceptive. Low dose HT is less potent and a lower dose than the contraceptive pill, but this option is more suitable for women once oligomenorrhoea.

After discussion of the above options Helen says she has a friend on 'livial' and asks: 'Why can't I go on tibolone?'

It was explained that tibolone is best not used until a woman is truly postmenopausal, however, this option can be considered in the future.

Helen says she had heard about 'troches' and wants to know if they are the same as bio-identicals, and are they more natural than conventional HT.

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## Bioidenticals

Information abounds on ‘hormone imbalance’ and dealing with menopause ‘naturally’. Many women are turning away from approved and regulated pharmaceutical postmenopausal HT and using hormonal lozenges or troches which are absorbed through the buccal mucosa. These are called ‘bio-identical’ or ‘natural’ hormones, however, these hormones are still manufactured in a pharmacy rather than a factory, but are usually the same or similar hormones as prescription HT.

Pharmacists making the lozenges are not required to adhere to codes of conduct of the professional pharmaceutical body – Medicines Australia – therefore there is limited quality control or assurance process and no formal regulation. There is limited preclinical, and no significant clinical research into dosage, safety and efficacy. The hormone formulations made in a pharmacy are often very expensive.

The oestrogen present in many pharmaceutical HTs is estradiol, the oestrogen that occurs naturally in humans. It is currently misleading to claim that these troches have advantages over Therapeutic Goods Administration approved pharmaceutical therapies. Oestrogen compounds may be combined with testosterone or DHEA or each prescribed alone. Of note, DHEA is not approved for use in Australia.

Currently there is no quality clinical published data for the safety, doses, and effectiveness of bio-identical hormones, and although symptomatic benefits are likely, their use cannot be recommended until there is sound pharmacokinetic, efficacy and safety data.

**Helen decides that it would be best to try and adapt her lifestyle and diet and see if this helps. You suggest she could keep a diary to monitor her symptoms and return if she feels unhappy with any symptoms and wishes to reconsider her options.**

**Helen returns 2 years later, now 47 years of age. She has not had a menstrual cycle for 12 months, her hot sweats are unbearable, and she is not sleeping. She is also feeling very anxious about some family issues.**

**TIP: Ask: ‘Did you have anything in mind that I can help you with?’ or ‘When you made an appointment how did you think I could help?’ Patients often reveal strategies that are useful for them**

Helen’s family, medical and preventive health history needs to be updated. She is due for a mammogram and this needs to be arranged. Check symptoms and stressors – how is Helen feeling, and what is going on in her life?

Helen says she feels she is not in control. She is feeling moody and irritable, and her children say she is grumpy. She also says she is tired and not sleeping well. Helen has elderly parents who both need more care now, and the family business is in financial difficulty. She feels that the money and work issues are putting strain on her marriage. When asked how she was coping with all that, she also added that her partner is a diabetic and her 16 year old son has been taking recreational drugs.

## Empathy and support

Acknowledge her difficulties and clarify the problems by listing them.

## Management plan

Develop a management plan together so that ‘both of us can prioritise the approach to your problems’. It is important to recognise the multifactorial nature of the problem – physical and psychosocial.

**TIP: The key is for ownership of the problems. Exploring the options together means that the doctor is not dictating therapy but working alongside the patient**

Helen’s options include:

- diet and lifestyle including stress management strategies
- Nonprescription therapy (see the article by Alice Murkies page 895 this issue)
- HT – a Mirena intrauterine device and systemic oestrogen may be appropriate for Helen with her history of PMT as it avoids systemic progesterone. Mirena is only listed on the PBS as a contraceptive agent. She could be offered standard combined therapy – oral or skin patches (see the article by

Helena Teede page 875 this issue). Oestrogen should not be commenced until the mammogram has been reviewed

- tibolone – as Helen has now not had a menstrual cycle for 1 year, tibolone is an option. It would give symptom relief from hot flushes. Advantages include no bleeding or sore breasts, and a possible increase in libido
- selective serotonin and noradrenalin inhibitor (SSNI) medication. This would improve mood and anxiety symptoms and (after the initial week or so) probably assist with sleep difficulties. It would also reduce hot flushes. However, decreased libido may be a side effect.

You also suggest Helen might like to consider counselling to assist her in dealing with the difficult issues she is facing (see the article by Amanda Deeks page 889 this issue).

**As Helen is considering these options she says: 'By the way, my partner told me to get something for my libido'.**

Discuss with Helen the complex nature of libido. Libido often suffers under stressful situations. Although hormones may play a part in libido, Helen's significant stressors would certainly be impacting on her libido. Finding ways to tackle these stressors is an important part of treating her decreased libido (see the article by Amanda Deeks page 889 this issue).

**Helen decides to take an SSNI. Six weeks later she returns saying she has had some counselling and that the SSNI is improving her symptoms. She is feeling much better. However, she is still concerned about her lack of libido and is complaining of vaginal dryness.**

Further options include:

- local lubricant (eg. Sylk, Replens, vegetable oil)
- vaginal oestrogen (no progestogens are required if only a topical oestrogen is used)
- systemic HT – potential benefits include improved libido and reduced atrophic vaginitis
- tibolone may increase libido.

**Helen decides to continue with an SSNI and also use topical vaginal oestrogen.**

## An alternative reality

If, instead of the previous scenario in which her periods stopped, Helen had experienced heavy bleeding, been diagnosed with a fibroid uterus and had undergone a hysterectomy, how would her options change?

**Following the hysterectomy, Helen, now aged 51 years, complains of troublesome symptoms and requests HT.**

In this scenario, oestrogen in any form is applicable. There is no indication for progestogens in a woman who has had a hysterectomy.

## Management plan

Helen needs preventive health screening including a mammogram. Again, do not start oestrogen until you have reviewed the results of the mammogram.

**Helen is diagnosed with localised breast cancer, and is referred for appropriate therapy.**

Helen's options for treatment of menopausal symptoms now include:

- support – she is now under additional stress and may need further counselling
- SSNIs – Helen can take an SSNI. It can help hot flushes but will have no effect on her breast cancer
- clonidine – this will provide symptom relief but has some side effects. It has no negative effect on breast cancer
- Helen can use topical vaginal oestrogens for vaginal atrophy.

If these are unsuccessful, consider referral to a specialist for a discussion of the risks and benefits of tibolone or oestrogen therapy in this setting (see the article by Helena Teede page 875 this issue).

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