# Menopause: An overview

**Dr Fiona Jane:** Okay, we got it. So these are the things that I want to talk about and that you have some idea about. What menopause actually means. What happens within the body at menopause. What does a woman present with? And what are the sort of lifestyle recommendations that we can give women, moving on to what are the medical things that are suitable. And what happens in health after menopause. I'm trying to coordinate two computers here, so excuse me if I get out of sync. So the definition of menopause is the day of the final period. I just love that cartoon. And it's a retrospective diagnosis and we make it 12 months later. So a woman has her final period, 12 months later, she's had no period, we say, 'You were menopausal back at that point in time.' It's a little bit more difficult if women have a Mirena IUD in, or they've had a hysterectomy and they don't have a bleeding pattern, or they've had a cervical ablation. So you can see it's not always easy to diagnose clinically, but for most women, that is the definition.

The average age for Australian women is 51 years, and we call early menopause from 45 years onwards, and we call primary ovarian insufficiency if women go through menopause before the age of 40. It's really important to pick up these women, because they're going to be going a long time in their life without oestrogen, and without protection for their bones, their hearts, and other body organs. So the simplest definition is that it's the loss of production of oestrogen, progesterone, and testosterone from the ovaries. And it's quite a complex hormonal change, based from the brain secreting FSH and LH from the pituitary, and then going down and affecting the ovaries, which then produce oestrogen and progesterone, which then feed back to the brain. What happens leading up to the menopause is the ovaries start winding down their production of hormones, the brain picks it up, so super-shoots the stimulating hormone down. The ovaries rev up for a little while and maintain it for maybe a few weeks, maybe a few months.

And then they gradually wind down again, the brain picks it up, supers-shoots the stimulating hormone down. And so essentially what happens is we get this rollercoaster ride of hormones, and that's what drives women crazy in those years around the menopause. And it also shows why it's useless to do blood tests for menopause, because if you take blood levels when they're at the top of the rollercoaster ride, it's going to show one thing. If you take it at the bottom, it will show completely different, and that can flip back and forward in a number of weeks. This time of rollercoaster ride of hormones is called the perimenopause. So the clinical consequences are related to the loss of ovarian oestrogen production, and the symptoms can be quite debilitating. And it can contribute to central weight gain, insulin resistance, cardiovascular risk, osteoporosis and dementia. Great, isn't it? So much to look forward to!

So about 20% of women will have mild or no symptoms. 60% of women will have symptoms that are distressing or debilitating, and about 10 to 15% of women may continue to have symptoms into their sixties and seventies. I have an 84-year-old who, if I take her off her hormones, she comes in with a beach towel to mop up all the sweat from her hot flushes. That's so not fair. But not only are the symptoms an issue, it's also the metabolic consequences. I'm so not getting this right. Hang on. And those things we spoke about. Now when we talk about central weight gain, and I'll speak a little bit more about this later, it doesn't mean an increase in body weight. It means that there's a change in fat redistribution around the centre of the tummy, and we know that's metabolically active.

So how do women present? Women will often describe that this is how they feel, and so do their partner, their families, their work colleagues. So the symptoms, they may present with symptoms. It may be one of these, it may be several. Some of women come in and they tick every single box. So the hot flushes and the night sweats are very common, and they're probably the most commonest symptoms. Pragya Gartoulla in 2015 studied just over 2000 Australian women, and 32% of perimenopausal women, and 75% of postmenopausal women were having vasomotor symptoms. And in her study, 42% of women over 60 were still having vasomotor symptoms. But I have women who present just with the mood changes. I remember a 51-year-old who came in and she had panic attacks. Never had a panic attack in her life, never had an anxiety disorder, but suddenly couldn't drive on the freeway, which was a real problem because her daughter was going to school down in Geelong, she could not get on the road to go down and see her daughter. So when we managed her menopausal symptoms, it actually improved. They may present with just urogenital symptoms. Dryness, irritation of the vagina, painful sex. Or I have quite a few women who have only disturbed sleep, and yet when we treat their menopausal symptoms, the disturbed sleep gets better. And disturbed sleep is a function independent to the night sweats.

So they also may present, not because they've got any symptoms, but they've actually got concerns. They might have a mother who's in a nursing home who's had a fractured hip and can't get home to independent living. They could have a relative who's in care with dementia. And they're pretty strong reasons to make women present to say, 'Please, how do I prevent this from happening?' 'What good things can I do with my lifestyle, or possibly medication, that might help prevent this?' So in my consultation with a midlife woman, I don't call them middle-aged women, I think that sounds terrible, particularly as it's me too. So I call them midlife women. So the really important thing is to listen and focus on the woman's concerns, because she may not want treatment, she may not want any management, she just may want information. There is a lot of bloggy stuff out there and there's a lot of incorrect bloggy stuff out there.

So I think it's really important, if you are going to be coming in contact with women who may present in this sort of way, is to be able to direct them to really good evidence-based information. I always take this time to do a full assessment. Women who are in midlife who are really fit and healthy may actually not go to the doctors very much. And so it's a great time to grab them on the spot, do all their routine screening tests, examine them and give them a full checkup. Providing evidence-based medicine, and what I'll do is at the end of the talk, I'll give you some details of where you can go for really good information and where you can direct women to go for really good information. And it's important, I always make sure that we make a decision together about what she might choose to do, because nobody's going to be compliant with management if they didn't have a part of choosing what they want to do.

So it's important also to remember that there could be other reasons that women present at this time with those symptoms like hot flushes, fatigue, joint aching. There may be an underlying mental health issue, or could be thyroid disease. So if the symptoms are significant, they really do need to be assessed by a medical practitioner. So important for a general medical checkup. Now we're missing one of the slides here. So I will talk to you about this. And this is about the ethnic variation of symptoms. So there was a big study done in America called the SWAN study. It was the Study of Women's Health across the Nation, and it was looking at the menopausal experience of five racial ethnic groups. And it was, they looked at Japanese, Chinese, non-Hispanic, Caucasians, African-American and Hispanics. And what they found is that women from a Japanese or a Chinese background had very low complaints of vasomotor symptoms, and the highest were complaints were in the Hispanic and the African-American women.

Another study looked at Filipino women in metropolitan Milan, Manila, Milan, we wish, and rural Greek women felt that hot flushes were just a part of life, 'pull your socks up and get on with life'. Studies in many Asian countries have shown that the prevalence of vasomotor symptoms is very low, around about five to 10%. And some groups in India, it's been shown that there have been no reports of VMS, they don't see it as being a problem. Makes you wonder if it's just because India is so hot they don't notice the hot flushes, doesn't it?

So what are the options available for menopausal women in this day and age? The very first thing is education, and just allowing a woman to sit there and talk to you about how she's tired because she's not sleeping properly because she's been waking five times with night sweats. It's very useful. I'm going to go through all of these in a little bit more detail, so I'll just flip through them at this point in time. So the lifestyle things that are important and may affect menopausal symptoms are diet, exercise, smoking, alcohol, stress management and caffeine intake.

We can look at menopausal hormone therapy. Now, menopausal hormone therapy is just the new nomenclature. It's actually exactly the same as HRT. There's the non-hormonal therapy. Some women really just don't want to touch hormones. So there are other options. And there are the complementary and alternative medications or therapies, which we call CAMs, and I'll go through some of those for you as well. So the really important thing is using evidence-based information, and it may be the only management, and they need to have access to more than one source of information in the medical or allied health area. These are the sort of areas that women might be involved in. Seeing a GP, someone who understands menopause therapy and is willing to look at all of the treatment options. If they have metabolic consequences, then an endocrinologist may be appropriate. If they've got high cardiovascular risk, then you're looking at referral to cardiologist. Or for women who are really struggling with weight and are in the high risk groups, then possibly a weight loss physician. There are more and more of those around now, which is great. And a bariatric surgeon, and/or a bariatric surgeon. The allied health areas that may be involved, dietician, exercise physiologist, a continence physiotherapist, which is very different to a normal physiotherapist because there can be an increase of urinary incontinence at this time with the lack of oestrogen in the urogenital tract. And they may need linking up with support.

So these are the websites that provide information for health practitioners, but they also provide information that's written for the layperson that's really easy to understand. Some of them have got them in multiple languages. The difficulty is that very often a lot of it is in English. So if we look at lifestyle, nutrition is always really important. Physical activity, getting up and moving, is incredibly important. And the latest studies show that the sedentary nature of a lot of our work and what we do during the day is causing a lot of health issues. In fact, there was a study from Queensland University which showed that sitting for four hours was the equivalent of smoking a pack of cigarettes. Or you could do an hour of gym, and then you went to your job and sat for four hours, then you just negated your hour at the gym. So getting up and moving, really important. Smoking is pretty much a no-brainer. A lot of women are not aware of what the safe drinking guidelines are. Does anybody know what the guidelines here in Australia are for safe drinking? What was that?

**Seminar participant:** I said, 'Sort of.'

**Dr Fiona Jane:** Sort of. So currently, although they do believe that any alcohol is associated with disease risk, but I figure there's got to be some quality of life in there somewhere, two glasses a night, and that's the, or, two standard drinks. So that's not a restaurant glass of wine, that's a hundred mils as opposed to a restaurant which normally pours 150. Two standard drinks five days in a week with two alcohol free days.

**Seminar participant:** Sorry. Does that change according to the type of alcohol though as well?

**Dr Fiona Jane:** No, but there are different, so wine is a hundred mils. If you go to spirits, it's a lower, you can get on any of the, Better Health Victoria is a really good website and it's actually got a picture and it's got the different sorts of alcohol and how many mils in each one. I just didn't include that slide in this one.

**Seminar participant:** It's all based on standard drinks. So—

**Dr Fiona Jane:** Yeah, it's all a standard drink. It's all based on a standard amount of alcohol in a drink. So I am sure you're aware that the ABS data shows that very few Australians are actually eating the recommended daily intake of appropriate food groups. And many are actually unaware of what the physical activity guidelines are. Does anyone know what the National Heart Foundation guidelines are for physical activity?

**Seminar participant:** 30 minutes, five days...

**Dr Fiona Jane:** 30 minutes, moderate intensity, six days a week. Yeah, they just keep upping it. Changing the goalpost. Stress management can be very important that, we talk about this midlife time as being a 'sandwich generation'. People have had their babies a bit later, so they've often still got school-aged kids or tertiary-aged kids, they may be leaving home and coming back again, plus they're caring for older parents at the same time. And trying to run the house and have a job and do whatever else they may be doing. Caffeine. Does anyone know what safe guidelines for caffeine is?

**Seminar participant:** Less than four a day.

**Dr Fiona Jane:** Less than four a day. How many do we actually have? Do you know? There's more coffee in instant coffee in a cup than there is in an espresso coffee, which is really interesting. A barista told me that. Okay, so let's look at some of the management. So menopause hormone therapy is the same as hormone therapy. And basically because menopause is an oestrogen insufficiency state, nothing alleviates symptoms better than hormone therapy. And that's been shown in many, many large clinical trials. It also shows that it improves bone density and reduces fracture risk. And it's also associated with a decreased risk of colorectal cancer in relation, which is really interesting. And there's a lot of evidence that hormone therapy will actually reduce cholesterol levels and reduce the risk of diabetes, which are both risk factors for developing heart disease. So they're the benefits. So what are the types of hormone therapy that are available now? If a woman has had a hysterectomy, she only needs oestrogen. If a woman has a uterus, then they need to have oestrogen plus a progestogen, either cyclically or continuous depending on where they are in the menopausal transition. If a woman is less than 50 years old, you can use the low dose contraceptive pill, the 20 microgram pill, or possibly the NuvaRing, which is 15 micrograms of oestrogen. There's also tibolone, which is a synthetic steroid, that's known as Livial, which has both oestrogen and progesterone-like activity. And TSEC is a combination of oestrogen and a SERM, that's a very new medication that has just been released on the market in the last 12 months. How can it be delivered? Can be given orally, can be given transdermally either in a patch or a gel, can be given vaginally or intrauterine. That's actually a mistake, the vaginal is actually progestogen, not oestrogen. Micronised progesterone can be delivered intravaginally.

So what are the side effects? Women may experience breast tenderness, or progestogenic symptoms may be more prominent. And these can be modified by changing how that progestogen is delivered. Some women still have poor control and of symptoms and may need other forms of therapy. A lot of women will say they started hormone therapy and they put on weight. The reality is that weight increase around that time of life is actually due to age, it's not due to the menopause per se. Hormones themselves will not put on weight. And in fact, if you have a 20-year-old in front of you talking about the Pill say, 'Oh, well I don't want this pill because my friend put on five kilos.' It's not the pill putting on the weight, the studies have shown that the most weight you put on with oestrogen is 1.2 kilos. The rest is lifestyle issues.

So what are the adverse effects of hormone therapy? So the biggest risk of oestrogen is blood clots. It's the same risk if you're 20 and going on the contraceptive pill, or if you're 50 and going on hormone therapy. Just at 20, you just don't care, you don't want to get pregnant, and at 50 you think about things a little bit deeper. The issue in midlife is that you have the aging risk of a blood clot as well as the oestrogen risk. Now the risk is really, really low. It's really low, but it's something that we always speak to women about, and we screen for women that if they have a clotting tendency that they may not be appropriate for oestrogen therapy.

And you can see cardiovascular disease, there's no impact in women under 60 years, and there may be a very, very small impact in women over 60. And in actual fact, if hormones have started around the time of the menopause and less than 60, it may actually reduce risk of cardiovascular disease. So breast cancer is what women always worry about, and there's been a lot of work to look at what's happened here. There was a study released in 2001 called the Women's Health Initiative that was looking at cardiovascular disease and oestrogen. But what got printed up was, 'Oh my god, you have to stop hormones because they will give you breast cancer and you will die.' And there was a whole generation of women who missed out on the option of using hormone therapy because nobody wanted to prescribe it because they all thought this was it.

What's happened is the data was reanalysed 15 years later, and it was showing that that wasn't the case at all. And in fact, the risk of breast cancer from using hormone therapy is about the same as having two glasses of wine a day, or not breastfeeding, or being overweight or obese. So I often speak to women with those kinds of day-to-day risks that they can see what the difference. Is and the risk of breast cancer can be further reduced if we choose an appropriate progestogen. So if a woman's had a hysterectomy and she only needs the oestrogen, she doesn't need a progestogen, currently it looks, after a big study with a 12-year follow-up, there has been no increase in breast cancer at all. So it's something to do with the combination of the oestrogen and the progestogen.

So when we look at using hormones, and I guess this is a question that women might come to you and speak about, 'Is this okay for me?' If we look at the lowest effective doses, we assess the risks annually. We look at decreasing doses as time goes on, but being aware that some women have ongoing symptoms, and if they understand the risks, they may choose to keep going with it. It's like my 84-year-old patient who says, 'Do not take me off, ever.' She knows the risks, she knows the numbers, and she's happy to take those, she wants quality of life.

So what are the non-hormonal treatments? There are women who may have had breast cancer, who have had a stroke, who have uncontrolled blood pressure. There could be a number of reasons why they choose not to use hormone, or they just don't want it. Family history of a clotting disorder. So we look at other options that are available. So the SSRI/SNRI is the next group. And these you might recognise as being antidepressants, anti-anxiety medication, but some of these been very widely studied in vasomotor symptoms, hot flushes, night sweats, sleep disturbance, and they're great for the mood changes of the menopause. In fact, we use those medications in much younger women who present with premenstrual mood disorder, and we often use much lower doses than we use for somebody who's got depression and anxiety. But there are a whole range of other medications.

Gabapentin, pregabalin were epileptic drugs, but they were shown to be effective for vasomotor symptoms. Clonidine is a blood pressure medication, that's also shown to work in hot flushes and night sweats. Cetirizine is an antihistamine, which in a small study showed to be effective. Oxybutynin is medication we use in urinary incontinence, that can have a positive effect on hot flushes. Stellate ganglion blockade is pretty drastic, that's when they put an injection of local anaesthetic into the stellate ganglion in the neck to stop the neural response of hot flushes. The most effective is oestrogen, and all of these are in a descending order from here. There has been shown to be a positive effective of hypnosis in one small trial, and cognitive behaviour therapy as well. I just think that probably makes you not care very much about them. I'm not sure that it actually stops the hot flushes, it just changes how you perceive them and what it's doing in your life. Now, weight loss. We know that women who are very, very overweight have much worse vasomotor symptoms and weight loss can help with that.

So let's look at the complementary and alternative medicines, because there's some women who say, 'No, I don't want to take anything for it.' What could be useful? These are a lot of the over-the-counter medications from the pharmacy. And I'm going to talk about some of these because, certainly by the time a lot of women have come to see me, they've already tried these. So there's limited good trials. They're often of short duration, looking at the herbal medications. And the problem is that women may be self-prescribing and influenced by advertising. The commonest ones that they talk about is the phytoestrogens, you know, 'If I have a lot of soy, then my menopausal symptoms will be better.' There are some studies which show that they may have some effect on bone and cardiovascular health, however, it behaves very different to our own natural oestrogen. And it's dependent whether a woman is still in her reproductive years or actually postmenopausal. And about a third of women actually don't have the gut bacteria necessary to convert the phytoestrogens that they're eating into the oestrogen-like substances, so it's not always going to work. Because they may have oestrogen-like activity, we're suggesting that they not be used in breast cancer.

Black cohosh, that's in a lot of the over-the-counter preparations. I'm very wary of black cohosh. There were six Australian women who died of acute liver failure, they were midlife women taking the recommended dosing. It's rare, but you would hate a 51-year-old to suffer because you told them to go down and get Remifemin. What I normally do is, I would check their liver function tests before they tried it, and then a month in and a month after that, I would recheck their liver function tests and make sure they're okay. Bioidentical therapy. So these are often advertised as being like our own hormones. They're often marketed as being natural, but in actual fact they're produced as synthetically as any other hormone. Women may get relief, however, the concerns are that they've actually got exactly the same risk profile as normal hormone therapy.

They're produced individually in the back of the pharmacy, compounded up. So they're usually very expensive. And our major concern is that they are unregulated. And the pharmacists are not required to adhere to a professional code of conduct of Medicines Australia. And the problem is that we're really concerned that the progesterone that they provide in troches underneath the tongue doesn't get absorbed very well, and therefore actually isn't protecting the lining of the uterus and is increasing the risk of endometrial cancer. In fact, it's been such an issue that all the International Menopause Society groups put out a consensus statement in 2016 saying that the use of these compounded hormone therapy is not recommended because of lack of regulation, rigorous safety and efficacy testing, batch standardisation and purity measures, and that they may not protect the endometrium.

So oestrogen insufficiency, that's menopause. It gives clinical consequences of menopause. And then we have to think about health after menopause because of those clinical consequences. Contributes to central weight gain, insulin resistance, cardiovascular disease, osteoporosis, GSM. Genitourinary syndrome of menopause used to be called 'vulvovaginal atrophy'. And that's just really the symptoms in the vaginal wall and urethra because of the lack of oestrogen. And dementia. Dementia has just taken over as the leading cause of death in Australian women. Used to be heart disease, it's now dementia, as of this year.

So let's talk about central weight gain. Menopause doesn't cause weight gain. There is a thing called 'weight creep'. Helena Teede in a very nice study where she showed that, and we know this from other large studies as well, that women from age 30 put on about four to 700 grams a year. So if you eat exactly the same and you exercise exactly the same as you age, you will put on weight. So not fair. And women, what happens at the menopause, as I said, is that we go from being gynoid shape to being pear shaped. So previously we would carry body stores of fat around bums and thighs. Around the menopause, when we lose our oestrogen, it goes around the waist. So women change body shape, they lose their waist. And that's distressing for a lot of women.

The problem is that the weight around the stomach is metabolically active. It produces inflammatory proteins which can then lead to resistance to your own insulin, which can lead to metabolic syndrome and therefore diabetes, heart disease and stroke. So it's really important that we have these discussions with women because they get very distressed about it, but it's also really important. I have a girlfriend, she said, 'I've just come to love that extra tyre around my tummy.' And I say to her, 'No, don't get to love it because we should be working against that all the time, because those are the sorts of things that will make us sick.'

We have really got a different presentation up on here, but that's fine. So these are places where you can get well-informed evidence. You can get handouts that you can hand out to women that you're seeing, or if they've got access to computers, can get on themselves and the information's readily available. So, take home messages. Listen to the woman in front of you and find out what she's really concerned about. Does she just want information or does she want you to direct her towards where she might get management? They should all be advised about a healthy lifestyle. And we've talked about some of the things there. And give well-informed up-to-date advice. If you give advice that was around 10 years ago, that will be incorrect now. So Jean Hailes has a number of tools on their website, which goes through all of these sorts of considerations. And I think these are all printed in your handout as well. And there are webinars that you can listen to if you prefer to listen rather than read.

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Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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