# Menopause basics: The consultation and management options

**Janet Hailes Michelmore:** Welcome to this Jean Hailes webinar. It's an important topic, menopause, and one that's very close to my heart. My mother, Jean Hailes, opened the first menopause clinic in Australia in 1972. What was important about that clinic? It was a multidisciplinary team. And in 1992, when Jean Hailes opened their first clinic, it was modelled on that original clinic, and that philosophy drives us forward today. Health professionals are crucial to everything we do at Jean Hailes. They provide the evidence, the care, and support us in our development of programs and products for women, the community, and other health professionals. Please enjoy this webinar.

**Dr Elizabeth Farrell:** Good evening and welcome to tonight's presentation, menopause basics, the consultation and management options. My name is Elizabeth Farrell. I'm a gynaecologist, medical director, and one of the founding members of the Jean Hailes. Firstly, I'd like to start by acknowledging the traditional custodians of the land we're presenting on and the lands we are reaching tonight. I'm in Melbourne, on the land of the Wurundjeri and Bunurong Peoples of the Kulin Nation. I recognise their continuing connections to land, water, and culture, and pay respects to Elders past, present, and future.

Tonight we have two wonderful presenters. We have, joining me is GP and current president of the Australasian Menopause Society, Dr Karen Magraith, and we also have our senior endocrinologist, Jean Hailes endocrinologist and past president of the Australasian Menopause Society, Dr Sonia Davison. We thank you for sending in your questions, and if there is time, we'll answer them at the end of the webinar. You can also submit questions tonight by the question tab at the top-right of your screen. You'll also see that there's a resource tab, and here you'll find a selection of menopause resources, including tonight's presentation slides. Please take a moment to download them. Now if you require a certificate or a CPD points, you will need to complete the evaluation questionnaire. This will come up as a link at the end of the webinar.

We do not have time tonight to go into the definitions or symptoms of the menopause. However, your webinar confirmation email, you will find there two articles and a video on definitions and symptoms. If you are watching the recording of the webinar, then you will find these in the resource tab on the website. I'll now hand over to Karen to start tonight's presentation, where she will be discussing the menopause consultation. We'll then follow with Sonia who will present three different cases, scenarios and management options. Thank you, Karen.

**Dr Karen Magraith:** Thanks Liz. In this session we'll be referring to 'women' at menopause, but we acknowledge that some people who experience menopause don't identify as women. Gender-diverse people can also experience menopause. For the purposes of this talk, we'll be referring to cisgender women. So what happens during a consultation with a midlife woman? There are often more than one consult. First of all, we need to listen to what the women's main concerns are, ust like with any other consultation. Some patients might not want treatment, they might just want information, and that's fine. It's recommended to do a full assessment regardless of the presenting reason for the consult, and we assess both the presenting symptoms, and we think about long-term health, and prevention of chronic diseases. We need to give evidence-based information, whether it's about lifestyle or treatment options. And if we are considering prescribing, it's a shared decision-making process.

I use a template similar to this in my consults. It helps me to be structured, and it helps to ensure that I don't forget an important aspect, such as contraception. And this is available on the AMS website, and I'm going to go through the process in a little bit more detail. It can be helpful to use a symptom score, either before or during the consult. It helps the patient identify their symptoms, and sometimes it can help the clinician and the patient connect those symptoms to menopause. And symptom score sheets are available on the AMS and Jean Hailes websites. And just a reminder that we don't need to measure hormone levels at the normal age of menopause, as least discussed in the introductory video.

So we start our consult, what's the patient most concerned about? And often there will be a list. And the typical menopausal symptoms can include vasomotor symptoms, the hot flushes and night sweats, mental health symptoms such as anxiety or depressive symptoms, weight gain. Patients might be concerned about a family history of osteoporosis or breast cancer, sexual function, concerns about libido or genitourinary symptoms. And we need to just find out what the most important concerns are to the patient. And we take a history in the usual way. When was her last period? And if she's still having periods, what are they like? We're looking for a history of abnormal bleeding. Any bleeding that's heavier than usual, prolonged, erratic, or post-coital needs to be investigated, as does any bleeding after 12 months of amenorrhoea.

We need to check the past medical history and the family history. And you may already have most of this in the notes. And this helps with decision making. And it's a great opportunity to make sure that people are up-to-date with their screening, their mammograms, cervical screening and bowel cancer screening if needed. And to do a cardiovascular risk assessment, checking for diabetes, hypertension, dyslipidaemia, metabolic syndrome. And have a think about bone health. Are they at risk of osteoporosis? Perhaps they have a low calcium intake, perhaps they have coeliac disease or another risk factor. And we check the social history and lifestyle factors. And there's a reminder there to ask whether they need contraception, and I'll come back to that.

In terms of examination, I would do a blood pressure and height and weight. Other aspects of examination are really guided by the history. There are no mandatory blood tests at menopause. We would usually consider doing perhaps lipids and blood sugar to check cardiovascular risk. And other blood tests will depend on the history. For example, we might do full blood count, ferritin and thyroid, if the patient's fatigued or has abnormal bleeding. Everybody benefits from lifestyle advice, including a healthy diet, advice to eat lots of vegetables, avoiding highly processed foods, having an adequate calcium intake is important. Exercise, of course, is important, and I remind women that exercise is very important for cognitive health as women age. And the usual lifestyle advice that we give. And for women who are having vasomotor symptoms, avoiding overheating and dressing and breathable fabrics can be helpful. For women under 50, contraception is recommended until two years after the final period. For women over 50, it's recommended until one year after the final period.

**Janet Hailes Michelmore:** I'm going to butt in here and say, why? Why is it that we always say you have to use contraception for two years if you are under 50?

**Dr Karen Magraith:** Well, for women under 50, there is a higher incidence of spontaneous ovulation in that first two years after the final period. So for the under 50s, it's safer to have that two-year rule.

**Dr Elizabeth Farrell:** Thank you. Thank you.

**Dr Karen Magraith:** And for women who are taking contraception or using hormonal contraception, it can be a dilemma to decide when they can stop, when it's safe to stop. For women using progestogen-only contraception, if they're over 50 and they have 12 months of amenorrhea after turning 50, we can do a single FSH. If it's over 30, they can stop contraception after one further year of use. If it's 30 or under, then you can repeat the process in another 12 months. Most guidelines say that women can stop contraception at 55, but what about if the woman turns 55 and it's less than one year since her last period? She has a very low risk of pregnancy indeed, but it's not zero. And that's where we need to engage in shared decision-making.

In terms of the types of contraception, it's recommended to stop the combined oral contraceptive pill, and the combined vaginal ring, and depot medroxyprogesterone acetate at 50, and I would prefer to stop the depot earlier than that. Other progestogen-only methods can continue, including the progestogen-only mini pills and the newer drospirenone pill. Also the etonogestrel implant and the levonorgestrel IUCDs, both the 52 milligram and the 19.5 milligram. And for the 52 milligram IUD only, if it's inserted after 45, it can be used for contraception until 55. And this is extended off-label use.

**Dr Elizabeth Farrell:** So does that mean that the woman can have it in for 10 years?

**Dr Karen Magraith:** Yes. If it goes in after 45.

**Dr Elizabeth Farrell:** It's not producing, necessarily, hormones after five to seven years, but its presence is providing contraception.

**Dr Karen Magraith:** That's right, but only for that older group of women. And also, if we're using the levonorgestrel IUD for endometrial protection, we should only use the 52 milligram device for that indication, and it must be replaced after five years. Other types of contraception include non-hormonal IUDs, permanent contraceptive methods and barrier methods. And of course condoms are helpful for safer sex. It's great to remind people about emergency contraception, and also to remind patients that hormone therapy is not contraceptive.

So what if our patient has menopausal symptoms? What are the options? And of course the first option is no treatment. Some patients are happy to receive information and they don't want treatment. And it can be helpful to invite them back for review in six or 12 months because things can change. Menopausal hormone therapy is the most effective treatment for symptoms, but for women who can't have hormones, or don't want hormones, non-hormonal treatment options are available. And we're going to be discussing how to prescribe hormone therapy and non-hormonal treatments in our cases.

**Dr Elizabeth Farrell:** There's a question come through saying, why would you prefer to stop the depot earlier than 50? Is it because you are concerned about bone health?

**Dr Karen Magraith:** Yeah, that is the concern. I think there's a concern that if we use the depot right up until menopause, then it can lower bone density. And if we use it up until menopause, the woman doesn't have a chance to have some oestrogen back in her system to restore that bone density.

**Dr Elizabeth Farrell:** Thank you.

**Dr Karen Magraith:** So who should we consider prescribing hormone therapy for? And really we can offer it to women if they have symptoms that bother them, providing they don't have contraindications. They don't have to reach a specific degree of severity, it's up to them to decide how much it bothers them. And we don't need to wait until after the final period. So we give information, and we offer the hormone therapy if it's appropriate, and the patient decides what to do. And it's important for us to set expectations. It's not a quick fix. We should plan to reduce symptoms but not necessarily eliminate them. And we need to set expectations that what we first start might not be perfect. We might need to try a different dose, or a different type, or combination of hormone therapy or non-hormonal therapies. For example, if the patient's perimenopausal, we'll be using a cyclic progestogen, and she should expect a bleed at the end of the progestogen phase. And sometimes during that initial period there can be irregular bleeding and spotting, so it's important to tell the patient about this. And going forward, it's important to view the relationship as a partnership, and we work together to address the issues. And of course it's always important to come back to that original main concern, and focus on what matters to the patient. So I'm going to hand over to Sonia for case studies.

**Dr Sonia Davison:** Excellent. I'm delighted to be here with you. I'm really happy to be talking about this, and I hope that you are enjoying the webinar and I hope you gain a lot from it. I also want to focus on the fact there's lots of resources out there. So if you're thinking, oh, this is all right, but I need more information, there's loads of resources. Jean Hailes for Women's Health has so many information sheets for consumers and for health professionals, and so does the Australasian Menopause Society. And there are many other great resources. But I'm going to start by telling you about Eva. Eva comes to you, she's 52 years of age. Ahe's single, a social worker and works full-time. She comes with very typical symptoms, low mood, anxiety, lethargy and sleep disturbance. She feels hot generally, and she has night sweats, which are drenching. And some of my women and my patients have described sleeping on beach towels because their night sweats so drenching, and they're sort of ringing them out and then getting another beach towel. So this can be a very vigorous process. Menopause isn't just about being a little bit hot and then cool again. For some women it can be really debilitating. So just remember that when you're dealing with someone who might be really symptomatic. She's having quite frequent flushes, vaginal dryness, dyspareunia, urinary urgency. Her periods ceased a year ago and were erratic for 12 months prior to that.

So when we're looking at someone around the time of perimenopause or menopause, the first thing is diagnosis. Women would like to know what they're going through and what their life change is, because some will get through their reproductive life and then come to perimenopausal or menopause and be quite surprised by the changes that are happening in their body. So diagnosis is very important. Symptom control, that's what's brought that person to you and that's what your role is, most of you who are watching this. So symptoms we must, and again, what Karen said was very important, what is worrying that person? And also I'm sneakily thinking of someone who comes to me at around the age of 45 to 60 or so, what are their risks for future problems like cardiovascular disease, osteoporosis, et cetera, and how can I intervene now to give them a better health outcome in the future, when they might not be thinking about that at all?

We treat symptoms when they are bothersome. Women might have flushes, sweats, they might feel tired. If they can manage their life, and if they don't have anything else that worries them, we treat to bother. So someone will come to me and say, 'I can't sleep at all. I wake up at three o'clock and I'm like this,' definitely that's a bothersome symptoms. Lifestyle measures, Karen has touched on. Hormone therapy definitely has a role. It used to be called HRT, patients and laypeople will generally know it still as HRT. That's been a term that's been around for a long time, hormone replacement therapy. We now tend to call menopause hormone therapy or menopausal hormone therapy 'MHT', so you might see that in some of the literature. And vaginal oestrogen is part of that as well. Non-hormonal treatments, there's many of those. Lifestyle, Karen's already gone through. Cognitive behavioural therapy, in studies it's very effective. Yoga, I'm going to be presenting some information at an upcoming menopause conference about yoga. Hypnotherapy, in the hands of an experienced hypnotherapist, can be very useful. There are prescription medications which are non-hormonal, and there are complementary or alternative products. Individual women may respond to any of these strategies, and there is no one right answer for women, it's the right answer for them, and to try different things until they get an answer that's the right one for them.

Hormone therapy is a very difficult area, and I know some health practitioners struggle with hormone therapy. They might not do a lot of menopause, and they worry about risk. And most of the women coming to you for advice about this will worry about risk, and mostly breast cancer risk. But there's a very powerful statement at the top of this slide, and I often will state this very clearly to women, that the international menopause societies and expert societies around the world have stated that for healthy women around the time of menopause, the benefits of hormone therapy far outweigh the small risks involved with it. So that's a very powerful statement if you think about it. There is an increased risk of breast cancer after five years of use. Multiple trials, however, support a safe window for prescribing. We usually would use hormone therapy less than 60 years of age, mind you, some women will be menopausal at 57, it's a little bit out there, but it can happen, or within 10 years of that last period. Younger women are more likely to have bothersome symptoms, have lower background risk for VTE and stroke and heart disease, and are more likely to get a cardiovascular benefit rather than a cardiovascular detriment.

**Dr Elizabeth Farrell:** Today I saw a young woman who is perimenopausal and considering hormone therapy and she said, 'But here in the PI of one of the patches, it's got a whole paragraph on the WHI and the negativities of being on hormone therapy.' And in the vaginal oestrogen PI, it's got still about thrombosis and breast cancer risks, when for vaginal oestrogen they actually don't exist. And yet they've still got this in those packagings, and we're fighting against what you've just been saying, that for the 10 years, or between 50 and 60 and with 10 years of the final period, the risks are so small, and yet women are being given this misinformation, and health professionals are being given the misinformation if you read the PI.

**Dr Sonia Davison:** It's a very difficult process to register a medication in Australia and elsewhere. They have their systems and guidelines of stuff that they have to put in there. This is all about, tonight, getting you the education and the information that you can convey to women that's evidence-based, that will help them make the right decision. It is a very tricky world, the menopausal world, for lots of reasons. Before you prescribe hormone therapy, we want to make sure there's no contraindications to it. Breast cancer and any hormone-sensitive cancer, for example, endometrial cancer, that's more than stage one, thrombophilia or a past venous clot, undiagnosed vaginal bleeding, active liver disease, uncontrolled hypertension, you'll see that's 'uncontrolled'. If they're on an anti-hypertensive and it's controlled, you can do hormone therapy. Cardiovascular disease, risk or disease, current disease. You must ensure screening's up to date. That's very important. And throughout the pandemic it was very difficult for some women to get a mammogram, for example.

Now Liz is going to take me up on this I'm guessing, but I will start with a mid-range dose, because most of the women who are coming to me are used to having a higher level of oestrogen in their bodies. And I will start with a mid-range dose for that product, because then, when they've come along for review, I can go up or down. And I don't want them to stop a treatment because they don't think it's being effective. And some of the lower dose products won't be effective. For most women who've been used to having, in reproductive life, a much higher level of oestrogen in their bodies. We do say to use this for the shortest duration for symptom control, and for premature menopause I would usually try and use a higher dose, and for women who are very worried and reluctant to use hormone therapy, I would go definitely for the lowest dose. And I'm going to hand over to Liz now to see if that's pre-empted the question that you were going to ask.

**Dr Elizabeth Farrell:** It has, yes it has.

**Dr Sonia Davison:** I got that one. I got it. Nailed it.

**Dr Elizabeth Farrell:** Because if you look at a lot of the literature, it will say, 'Start with the lowest effective dose.' And sometimes I would do the opposite because I would start with a low dose, but I would say to them, to the woman, that it may not be the right dose and that we may have to increase it. So it's just two ways of doing it. But there is a lot more discussion out there about starting with the lowest dose. The other thing is, how do we know what the shortest duration of symptoms is?

**Dr Sonia Davison:** We do know that Liz, because it's a piece of string. How long is a piece of string? I know we're getting a bit animated here, but for good measure. A woman might have symptoms for two months. A woman might have symptoms for 20 or more years. This is very individual, and some evidence says that we can use hormone therapy for a long time if the woman is safe and well and healthy and doesn't have a lot of comorbidities. If we're doing the screening, if we're monitoring her properly and we're giving her the lowest dose for the shortest duration, which might be 20 years. The key considerations with hormone therapy, are they going to bleed? And the way of looking at this is, if they've just fresh to menopause and they have just stopped having periods a year or so ago, they're going to be much more likely to have bleeding, because their uterus is used to bleeding when oestrogen is entering their system.

So sequential is when you use progestogen for some of the month, or sometimes long-term, but we can talk about that in another time, versus continuous, where progestogen is given throughout the month, oestrogen's always given throughout the month, it's only the progestogen for bleeding. Oestrogen-only, if they've had a hysterectomy, definitely that's appropriate. Oestrogen and progestogen, if they have a womb in, even if they've had an endometrial ablation. Localised oestrogen is very useful, if there's really just urinary symptoms or vaginal dryness, PV oestrogen is very useful. Also, risk factors is very important. So what Karen went through is really, really important. The person in front of you, if they're obese, a smoker, hypertensive that's not controlled, they're a risk. So you need to take those into consideration. Karen's nicely talked about perimenopause and talked about their symptoms. Cost is also a big factor, and there's going to be some more news on this soon that we don't really probably want, but PBS is very important to some women, whereas others say, I don't care what it costs, just give me the best stuff for me.

Premature menopause, we do want to be on hormone therapy, if there's no contraindication. It can be the combined oral contraceptive pill, or maybe the ring, until they're at the age of natural menopause, which is about 50 years. And we do usually want to be on a higher dose just to protect their bones, to replicate the hormones that they would've had until that age. And menopause for some women can be at 20. So just keep that in mind. This is a lovely information sheet that my predecessors spent so long in making. There's a New Zealand equivalent, too, if you're watching from New Zealand. But this is an Australian sheet which says all of the different hormone therapy products available on the Australasian Menopause Society, very easily online. You can see what's on the PBS, what's low dose, what's cyclical, what's continuous and combined. It has oestrogen-only and progestogen.

So if you've got one lady on one product and she didn't do quite well or needed a higher dose, you can see what else is out there. Especially during the pandemic, when there were terrible hormone therapy shortages and we were all tearing our hair out thinking, 'This lady's great on this, what am I going to do now?' So again, resources are extremely important and frequent here. So Eva, she wanted to pursue natural treatment, and many of my women come along, 'I don't like my symptoms, I don't like the things you're telling me about hormone therapy, I don't want to be at risk. I want to be on something natural.' She had a three month trial of black cohosh. At the three month review, and I usually bring them back at three months because that takes time to settle in, and over that time, most bumps and, sort of, troughs in the ride will have bumped out.

The bothersome symptoms persisted. So we talked about a trial of body identical hormone therapy. We started with an oestradiol patch, twice weekly, and micronised progesterone every night. We use it at night. It's very good for sleep, it's calming for mood and it can be a life changer for some women who don't sleep well, if they take it at night. Six months on, and I would normally do a six-month review if they're very steady. there was some scant bleeding and breast tenderness which settled instantly. Some patch site irritation. We need women to change the patches frequently and use different sites, but some just do not tolerate it. She had excellent symptom control. So we changed to a daily oestradiol gel, there's two available, and kept going with the micronised progesterone. And Eva was, can I say it, a happy camper.

**Dr Elizabeth Farrell:** So I would like to just discuss a little bit more with you here, and that is about the instructions that are given to women about how and where to apply the patch and the gels. And a lot of women on the oestradiol twice-a-week patches are not always strict with their three-and-a-half days. And women have said, 'Well, I've been told to use it twice a week.' And some doctors have said you can use it three and four days, but in fact that sometimes is enough to cause breakthrough bleeding in some women. And I think the other area that isn't well done is the instruction regarding the use of the gels. So if I can use the product name, Sandrena gel has an alcohol preparation to it, and that requires a smaller surface area for a higher dose, whereas EstroGel requires a larger surface area, and I think that that's often not instructed very well by some GPs. I've had women put dots of Sandrena or EstroGel over their bodies, a bit here and a bit there, and they wonder why their symptoms aren't working. So I think that's a very important, is about, very important thing is about the instruction to the patient about how they use transdermal preparations. And I've got one more thing.

**Dr Sonia Davison:** Oh, I thought you might.

Yes, and that is that I think it's important for us to talk about 'body identical' and what that means. And really it's all a great deal of misinformation that's come from post-WHI and pharmacy compounded hormones being "bioidentical". And really what we're using are human hormones that are synthetically made, because they only exist in the human body. And so I think we have to get round this 'bioidentical', 'body identical', what does it really matter? It means that they're human hormones, and the pharmaceutical companies have made them, and even if you go to the compounding pharmacy, they'll have bought their raw products from the pharmaceutical companies to make up their hormone preparations. So they're all the same.

The trouble is that you might have, hello, I'm with you again. The trouble is that women may come to you looking at something on the internet or having discussed it with a prescriber or whatever. 'I want to be on natural bioidentical hormones the same as my body's hormones. I've heard that that's a lowest risk.' Sometimes they come in troches and gels and creams and various, they're custom compounded. They say that they're individually targeted to a woman, sometimes on salivary levels and things like that. It might be a very fine way of administering hormones, but we don't have any study data, we don't have any safety data. And there was a journal in the medical, article in the Medical Journal of Australia some years ago now that talked about how some women were using these products and didn't have adequate endometrial protection, and three of the women were reported to have endometrial cancer having had bioidentical custom compounded oestrogen, and progestogen, and one woman died.

So be very careful if a lady says, 'I want to have this stuff I've found on the internet, bioidentical custom compounded hormones.' Well you can say, 'Aha, there's a lovely information page at Jean Hailes for Women's Health, and a lovely information page on the Australasian Menopause Society. Please read those.' We can easily do body identical hormone therapy, which is made in a lab and undergone extreme rigorous testing, and we know about the safety, and that's very important. So just be aware. That's a trick. There's a lot of tricks in menopause, as I said before. Genitourinary syndrome of menopause is also a very important area. Some women will not get these symptoms. I always think of that and I think, oh, why not? But some will be really bothered by these symptoms, and you need to ask. They might be very embarrassed about these. But I always say when I give a talk, once you ask a lady something and they feel supported and looked after, then that woman will actually, floodgates might open. She might talk about anything.

So consider vaginal lubricants or a moisturiser. So a vaginal moisturiser is not for use with intimate moments. It's like you moisturise your face, you get up in the morning, you do it. Well, this one, you go to sleep at night and you use your vaginal moisturiser, and there are products available at that. The genitourinary syndrome might be, maybe, very capably relieved by systemic hormone therapy, but it takes about two to three months to kick in. So you might want to use vaginal oestrogen as a first measure with systemic hormone therapy. You can drop the vaginal oestrogen later if they don't need it. Consider referral to a pelvic floor physio if appropriate. And that can be, again, a game changer with some of these ladies with terrible symptoms.

**Dr Elizabeth Farrell:** Do you have a recommendation for lubricants, either of you?

**Dr Sonia Davison:** Well, I know, sneakily, that Jean Hailes has looked into this, and silicon-based one and a water-based one. We have looked into this previously, Liz, and again, I know we don't want to mention brand names particularly, but the product Astroglide is a water-based one that does, what you want with a lubricant is something that replicates the vaginal secretions. So the product Astroglide, we thought, was pretty close to that and I can't say the name, but it's Pjur, that's a silicon-based lubricant, and we thought there was some good research to support that they were quite close to vaginal secretions.

**Dr Elizabeth Farrell:** Do you recommend any particular lubricants for people?

**Dr Karen Magraith:** I usually recommend the one starting with P that Sonia mentioned. Some patients actually just prefer something that's plant-based or something natural, and that's fine. You just have to be careful about condom use, if they're using condoms, to make sure it's compatible with condoms.

**Dr Elizabeth Farrell:** So you can't use condoms in a silicon-based one either, can you?

**Dr Sonia Davison:** I think you've got to use the water-based.

**Dr Elizabeth Farrell:** I think they've got to be water-based. I think also that one of our physios recommends just plain old kitchen olive oil, or sweet almond oil, that smells a bit nicer than olive oil.

**Dr Sonia Davison:** There's lots of different ways to approach menopausal problems, as you are hearing tonight, or this afternoon or whenever you're clicking in. I'm going to now tell you about Helen. Helen is 48, married, accountant, she works part-time. She's been unfortunately diagnosed with breast cancer, which is hormone receptor positive. Her periods stopped after chemotherapy, and she's quite worried about bone health having gone through a pretty tough journey. Then at the other end of that, women start to worry about their bones. Her mother has a history of osteoporosis and fracture, and those women are always much more worried about bones. 'I don't want to do what mum did,' is what they say to me. She's asking about hormone therapy though. Her friends have described this as been life-changing and there's been a bit of a hormone therapy revolution out there, where in the UK, I understand at the moment, it's very hard to get hormone therapy because there's been such a pendulum shift towards using it again.

So a lot of people are asking about it. Her symptoms are low mood, anxiety, lethargy and sleep disturbance. She feels hot generally. Again, she's got the night sweats, which are drenching, the frequent flushes. She has vaginal dryness and dyspareunia. So much like the symptoms we heard before, but there's an added complexity to Helen's situation, and you want to make sure you do exactly the right thing and advise her appropriately. Remember I said about the resources? Well, I'm going to really wow you this time. So you can see the non-hormonal treatment options for menopausal symptoms from the Australasian Menopause Society. There's actually three of those information sheets. One is an infographic for women who really can't deal with a lot of words. That one that you're seeing there is less wordy than the one I'm going to talk about in a minute. So that's good for most people I think.

And the next one is very good for women with a bit more education, or want a bit more information, or for you as a practitioner. And there's also some beautiful information and a podcast on this from Jean Hailes and Health Ed at the Jean Hailes website. So don't be afraid to do some searching when you need some information, or to ask someone. We will happily, you can see all three of us are here now, happily wanting to tell you more about this. Non-hormonal medications are medications that have a serendipitous finding that they were good for flushes and sweats or sleep disturbance or whatever, and they weren't for the purpose of menopause. So we were quite lucky that there's a few of them out there. You'll see there that this slide talks about the SNRIs and the SSRIs, and you'll see again the percent reduction in flushes.

Remember, for every study that has a placebo control, you're going to get about a 30% placebo response. So you'll see there between 47% and 60% reduction. And again, these medications can be life-changing, but you need to also consider that some of these women can have an idiosyncratic reaction and actually have more flushes and sweats from these medications. So often I'm getting ladies presenting later on, so they might be sixties or 70, with a new onset of vasomotor symptoms or sweats and I'll say, 'Actually I don't think this is menopause. I think this might be their medications.' So again, don't be afraid to look at things like that, because that can be, again, life changing. Clonidine is an older agent. It's pretty brilliant if they're hypertensive because it's good for blood pressure, it's also good if they've got migraine. It tends to be a bit drying. I usually use it last for that reason. You start it slow, 25 microgram twice daily, and you can build it up, you can probably push it a bit higher.

**Dr Elizabeth Farrell:** There is no 25 microgram pill anymore, and there is only a 100 microgram and 150 micrograms. So it's very hard to start at 25. We used to have that, and that was often a first line treatment for menopause in the '80s, before your times.

**Dr Sonia Davison:** People can get creative. I do have people who have quartered the 100 one. It's definitely useful. I've got ladies and women on all of these products, and it just depends on that person, how effective it's going to be and how it's tolerated. Gabapentin is very useful if there is pain, if there is sleep disturbance, and if there are vasomotor symptoms. As you know, it's an epilepsy agent and very good for pain, pain modulator too. Good improvement in sleep disturbance, reduction in flushes. Now Liz is going to try and ask me a question here. I do start at a low dose, 100 milligrams at bedtime, and then I very gradually increase this. I give them a schedule. Every three to four days I increase this by a hundred milligrams. I start with the morning and evening doses, and then if necessary you can add a lunchtime dose and go up to maximum 300 milligrams tds, three times a day. Sometimes it will be stacked like 300 in the morning, 600 at night. That can be done, it's about tolerance. But I do that very low dose first because some of my women have said that they are very sleepy and groggy and drowsy, and they got a bit cross with me for doing that. So I do a very 'go slow' approach.

**Dr Elizabeth Farrell:** So before you go on to the black cohosh, do you use gabapentin very much?

**Dr Karen Magraith:** I do occasionally use it. Usually in breast cancer patients. And, like Sonia, I like to start low and go slow. I think it's often poorly tolerated. Sometimes we don't get all the way up to 300 milligrams tds, but for people who can tolerate it, it can be great.

**Dr Elizabeth Farrell:** So I tend to start with 300 and I work up from that. Many will respond to 600. And what I get them to do, to stop them being groggy in the morning, I get them to take it somewhere between seven to nine in the evening so that they take it well before, and very often it works. But sometimes you can also use the combination of them. And there's one that we haven't talked about that's been in the literature a little bit, and that's oxybutynin. Do either of you use oxybutynin? Never used it. Have you?

**Dr Karen Magraith:** I have used it. Apparently there are no tablets available in Australia at all at the moment, I have been told. At least not in Tasmania. So I recently tried a patch, and it was reasonably successful. So it's certainly an option that does have some evidence.

**Dr Elizabeth Farrell:** There is some evidence, there are short-term studies, and there's been another study using a higher dose slow release one that seems to be helpful, but I noticed that we haven't got any information on our websites about it. So I think we are going to change that and put a little bit on oxybutynin in the—

**Dr Sonia Davison:** I did a literature search and I wasn't convinced, hence I do not use it at this point, but again, it's whatever woman, whatever strategy.

**Dr Elizabeth Farrell:** So there were two reputable teams, and Loprinzi, who's the person who did the original venlafaxine study, his department has done the oxybutynin study. And the other publication is from Jim Simon who's a very good researcher in the US. So they are from reputable research teams.

**Dr Karen Magraith:** And can I just add, just to talk about these therapies in general, it's important that we mention to our patients that these are off-label use, so they're not registered uses. Apart from clonidine, which is actually registered for vasomotor symptoms. But I think it's important that we discuss it with our patients.

**Dr Elizabeth Farrell:** And the other interesting thing about these particular therapies are that if they're going to work, they'll work within the first four weeks, whereas hormone therapy can take up to six to eight weeks to get a maximal response. So those non-hormonal ones are, and some women might not necessarily be cancer patients but don't want to be on hormones, and they might like to do that, take those as well. So I think it's very important that you say it's off-label, and it's also important to say that if it's going to work at the recommended dose, then it will be within the first four weeks. Would you agree with that?

**Dr Sonia Davison:** Yeah, but there's individual physiology.

**Dr Elizabeth Farrell:** Absolutely.

**Dr Sonia Davison:** Humans, and women, do things at their own pace.

**Dr Elizabeth Farrell:** Yes. Okay.

**Dr Sonia Davison:** I'm now going to talk about Remifemin. That's a brand name. Black cohosh. There is another brand name as well. Black cohosh is used a lot in Europe, they're not very, not as afraid of it as we are. It does relieve mild symptoms. If a lady is drenching a beach towel, I don't think it's going to do much for her overnight with sweats. We do say six months duration, based on some very contentious evidence that said there was potential liver toxicity. A recent meta-analysis was done, which really said, I don't think there really was liver toxicity there. So sort of changed their mind. This can be a good option to relieve mild vasomotor symptoms. Just be aware if someone does have a bit of hepatic dysfunction, I probably wouldn't go there as my first line, and just be very aware of that.

Cognitive behavioural therapy. There is a beautiful book by Myra Hunter who is an expert in the UK. I was not a believer in cognitive behavioural therapy. I thought, well how can it actually modify sweats? It doesn't. It modifies how the body and the mind respond to the sweats and flushes. It's very good for sleep. It's very good for mood. I read her book, I thought it was excellent and I thought, do you know what? I would give this a try if I were in that position. Hypnosis, again, with a person who knows what they're doing with hypnotherapy can be very useful. And the right woman of course. Acupuncture, again, in the right practitioner's hands. Breathing, paced respiration or relaxation training, mindfulness, those sort of things. Again, it depends who's delivering it and depends on who's receiving it. Stellate ganglion block is something in studies that has been useful. Interrupting the sympathetic nervous chain, because we think a lot to do with vasomotor symptoms is about the sympathetic nervous system. However, it's very hard to find someone who can do a stellate ganglion block. I've tried to do it. I did not do very well at that.

**Dr Elizabeth Farrell:** What's the literature on acupuncture and paced respiration?

**Dr Sonia Davison:** So it comes and goes. Every year I present a bit of clinical trial update at our conference, and sometimes for Jean Hailes as well. And I look at the literature and there's always something new on acupuncture. It's like a little rolling sea. Some say it works, some say it's better against sham, some say it's better against no treatment. The overall opinion I have about acupuncture, if a lady would like to go down that pathway, I'd give it three months or so, if it's not doing anything then, I don't think it's going to do anything. Again, it's about preference and what she's happy to do. Pace respiration. I don't know anyone who does pace respiration, but again, I think it's about controlling the mind, stepping back, being a bit mindful. I think that's probably the precursor to mindfulness. And again, an individual who's very regimented and very well controlled could probably do that on her own, I'd say. Yoga, definitely can be useful and I am presenting some information that says it is very beneficial, or mildly beneficial, for moderate to severe symptoms.

**Dr Elizabeth Farrell:** And my last comment before you go on is that I actually went to the course on cognitive behavioural therapy that comes out of Myra Hunter's work.

**Dr Sonia Davison:** Wow, good.

**Dr Elizabeth Farrell:** And they run it every year. The British Menopause Society runs it, and you can attend it and then take away the manual and go and do it.

**Dr Sonia Davison:** And I bet you were a fan after it as well?

**Dr Elizabeth Farrell:** Well, I thought it's a very important done armamentarium. The problem is that I don't know that we've got anybody who can run a six weeks program.

**Dr Sonia Davison:** No, but that's where the self-help book is brilliant.

**Dr Elizabeth Farrell:** The self-help book, that's right.

**Dr Sonia Davison:** Because if I'm in a room with a computer that works, I will click on the internet and I'll see this beautiful book, and it will always come up with a list of price options. So it's accessible. It's only about $35 Australian dollars. So those things can be done. And if you are in a rural or a remote place, to click on a book and to be able to access that, and to take yourself through a self-help cognitive behavioural therapy program, I think is brilliant. Helen did not do that though. Helen did some escitalopram, initial dose of 5 milligrams. She was very worried. 'Don't stigmatise me, don't give me an antidepressant. I'm not depressed.' It's very hard. You've got to negotiate your way through this. You've got to say. 'We're not labelling you. This is for your flushes and sweats. Sometimes it is for mood and this is what we do. And if you're very worried, we start with very low dose.' We increase this to 10 milligrams after four weeks. And I always say with SSRIs and SNRIs, the first two weeks can be very rough. You might have a funny taste in the mouth, yawn, you might not sleep, you might sleep too much. But you'll get over that. Don't give it up after three tablets. We recommended for Helen vaginal moisturiser and lubricants. And we also wanted to think about bone health, which was very important for her. Maximising calcium in the diet, diet, not to supplement, 1300 milligrams daily if possible. Vitamin D3, I know the evidence waxes and wanes there, but for bone health, definitely I am wanting to make sure they're not vitamin D deficient and they've got an adequate supply. Weight-bearing exercise is crucial. At the three-month review, she was doing really well, reduction in vasomotor symptoms.

She had ongoing sleep disturbance. We discussed a trial of melatonin, which can be very useful for sleep, and she did pretty well with all of that. There's a beautiful resource from Healthy Bones Australia. It's very comprehensive. I was amazed when I opened it, and it's very prescriptive with the types of exercise you can do that will help maintain bone density, good for fitness as well and it's easily accessible online. Healthy Bones Australia was the formerly named Osteoporosis Australia. Brilliant website. Lots of information about bone health of all types. I'm going to now get onto case study 3. Stephanie, 54 years of age. New relationship. She's a teacher and works full-time. She had a DVT after an ankle surgery three years ago. She's also had migraine long-term. She comes along with very similar symptoms. You could almost do the talk now. Low mood, anxiety, lethargy and sleep disturbance.

She feels hot generally, with night sweats which are drenching, and frequent flushes. She was told she couldn't use hormone therapy because of the migraine history and because of her past venous clot. So we're going back to resources. This is a lovely Jean Hailes resource, it's a foldout tool. You can get it online very easily, and it looks at different situations and different approaches to menopausal management, because we acknowledge that this is a complex area, you might not be doing much menopause management. Liz and Karen and I are drenched in menopause all day long with our women, but you might not do a lot. So there are lots. This has been very carefully thought of, very carefully worded. There's lots of different things, different situations, and I just want to point your direction to that resource, which is very useful. I also want to say that women in hormone therapy, doses, delivery systems and regimens really matter in some situations, like this one where we're looking at VTE risk. Lower dose therapy has less effect on VTE risk, but less effect on breast cancer risk too. So obviously a lower dose would be useful. Transdermal therapy, less effect on thromboembolic risk and on stroke risk. Oestrogen-only has less effect on cardiovascular risk and less effect on VTE risk, less effect on breast cancer risk and also colon cancer risk reduction. And that was one of our questions before this webinar. Oestrogen and progestogen tend to protect against colonic cancer, at least in the biggest study WHI, whereas oestrogen-only did not do that. So that was one of the benefits there that we saw from WHI. Not all progestogens are created equal. There's only really two main oestrogens out there now, and mostly we're using body identical oestrogen in different forms, but there are lots of different progesterones, and this is where people can become unstuck with menopausal management and hormone therapy. Micronised progesterone and dydrogesterone have less effect from studies on breast cancer risk, versus the more androgenic progestogens, which have been the main ones used around the world to date, and in most of the studies. And when we are looking at migraine, there's a beautiful—

**Dr Elizabeth Farrell:** Can I interrupt? There's been a question about breast cancer risk with the Mirena, and whether that has a different breast cancer risk compared to progesterone or dydrogesterone. Have you got a comment there?

**Dr Sonia Davison:** I have definitely got a comment. There was a beautiful Finnish study that looked at, because they keep very good records in Finland, and what's been prescribed in incidences of disease, they looked at all the women who were on different contraceptive preparations, and they looked at their breast cancer risk. There was an increased risk associated with Mirena use, and it was higher with repeated devices, but it was extremely low. I think it was about one case in 7,000 or something. So it's not nothing, but it certainly is low, and I certainly wouldn't be put off using a Mirena when we're talking about breast cancer risk. Compared with the other progestogens, the risk is much lower. There is a beautiful information page on the Australasian Menopause Society about migraine menopause and hormone therapy. When we look at the Pill, for example, if there's migraine with aura we don't want to go anywhere near the Pill, and we pretty well know that.

But transdermal hormone therapy is not contraindicated in migraine. Hormone therapy, you've got to understand, is a lot lower in dose compared with the much bigger doses of progestogen and oestrogen in the combined oral contraceptive pill, which is aiming sort of at replicating a pregnancy and switching off your own androgynous hormone secretion. So that's a very important thing for this lady who has migraine. We did a thrombophilia screen for Stephanie, it was negative. She saw a haematologist who said, 'Oh, she can use transdermal hormone therapy.' So we used the combined transdermal oestradiol and progestogen patch. There's only one product out there that has both combined. At the three month review, symptoms were very well managed, she had no increase in migraine. And some women will actually have a perimenopausal increase in migraine because of the extreme hormonal fluctuations, and they'll actually paradoxically have much less migraine when we steady out their hormones with some hormone therapy use, and they'll often be much better after menopause.

**Dr Elizabeth Farrell:** Key messages. I think, Karen.

**Dr Karen Magraith:** Well I have a few key messages. The first one is that we can't do menopause in a single consult, especially if it's a 15 minute consult. Sometimes we just need to give the patient some resources and get them back for a long consultation, or even two long consults. Always remember to come back to the patient's main concerns, and then you'll have a successful relationship with the patient. Don't forget to work out whether patient needs contraception and address that. And when it comes to hormone therapy, we give information and we offer hormone therapy it it's appropriate, and then the patient decides what to do in a shared decision-making process.

**Dr Elizabeth Farrell:** Thank you. Sonia.

**Dr Sonia Davison:** There is absolutely no 'one size fits all' approach at menopause. Women are all individuals, and we need to tailor the solution for the individual, and given her education and given her psychology. If she's terribly worried about things, we can't push things that will really make her more worried. The benefits of hormone therapy at the time of menopause and perimenopause far outweigh the very small risks, and there's very good resources telling you about that. And find the appropriate resource to assist you, at Jean Hailes, the Australasian Menopause Society and the Women's Health Research Program at Monash University. Also the Better Health Channel has some very good information sheets as well.

**Dr Elizabeth Farrell:** Thank you, Sonia. Thank you both very much for fabulous talks, and I won't apologise for interrupting. Now it's the time for questions, and there is quite a lot of questions. I'd like to first of all go through some of the issues that are often difficult to manage, in the sense of, there's no clear guidelines and that is, how long do you leave a woman on hormone therapy for? And how do you actually work out how to manage whether you stop, what do you do?

**Dr Sonia Davison:** Well, I'm bossy, so I'll take the floor first. Bossier, maybe. It's again, very individual. It depends on what the woman wants to do. It might depend on her bone health. So if she's osteopenic for example, or a high risk of osteoporosis, I'd love to be on hormone therapy for longer. What I normally do is I normally say, well up to five years we're pretty safe in terms of breast cancer risk. After that time, if you need it, and I always annually review the dose, I will always see them every six months if I'm able to. But I'll annually review the strength of oestrogen that they're on and the dose. And then at one point I'll say, why don't we try and reduce? So if they're on a 50 strength oestrogen patch for example, I'll go to a 37 and a half, even if they alternate 50 on Monday, 37 and a half, just gently try and tickle that down. And then I think that's a way of seeing if they're coping. But I'd always do it very gently, the 'cold turkey' approach from studies, there's no difference between gently weaning and cold turkey, but I find the gently weaning to be a lot kinder.

**Dr Elizabeth Farrell:** Excellent. Karen, you have a different approach?

**Dr Karen Magraith:** I probably have a similar approach. I think it's important to review each year, and have a think about why they started it in the first place, and are those symptoms still there? And often we'll find that patients might've had, they might've run late to get their prescription and they might've found that they had a lot of symptoms again and they don't want to stop it. And you can think about stopping it slowly or slowly reducing the dose. But sometimes women will just say, 'Look, I want to keep going because I've still got symptoms whenever I try and stop,' and that's fine. And I'd say, 'Let's see you again in a year's time. We'll go through it again.' And that yearly review is an important opportunity to make sure they haven't developed any contraindications, and do that shared decision making process.

**Dr Elizabeth Farrell:** What if a woman has been on hormones for more than 10 years? Do you worry about keeping them on hormone therapy? How do you manage all of their smears and mammograms and all those sorts of things? How do you, do you put more emphasis on breast cancer risk or cardiovascular risk? How do you manage that woman if she's been on it for 10 years and she says, 'I'm not going off it.'

**Dr Karen Magraith:** Well, I think with everybody, we need to really try and make sure they're up to date with those things like their mammograms. And I wouldn't increase the frequency of mammograms. And with everybody, we should be checking their cardiovascular health. I certainly think for an older woman, if she's got reason to stay on the hormone therapy, I would think about transitioning to transdermal oestrogen, because as they age, their risk of venous thromboembolism is going to go up. So that would be usually what I would do. And also definitely go for the lowest possible dose. So I would really ask them to take the lowest dose.

**Dr Elizabeth Farrell:** Okay. There's another question here about, could you use the gel and a patch at the same time?

**Dr Sonia Davison:** Well, I've got some of these women out there. Again, it's about individual circumstance. I forget what we were doing, but she was quite good on the patch, but I think she was perimenopausal and was having a few breakthrough symptoms towards when she was going to have a bleed. So we discussed that you could just add a little dose, maybe half a pump of the gel, just to tide you over with those symptoms. I think when you're getting to very interesting management like that, I would probably defer to someone with expertise, and a specialist. I think it gets very messy and you don't want to be worried about endometrial protection, for example. If it's a higher dose, they still have a womb, you've got to make sure there's adequate progestogen cover as well. It's easier if they've got the levonorgestrel IUD in, for example, they're covered. But I think when we're getting to creative solutions, I would probably defer to someone who has a lot of expertise in this. It might be GP with menopause expertise, or a specialist.

**Dr Elizabeth Farrell:** So a question is about the risks of MHT-linked cancers, if a woman starts menopause hormone therapy as someone with premature ovarian insufficiency, and does she in fact have a more significant risk?

**Dr Sonia Davison:** I'd love to talk about that. Are you all right Karen? If I say something? I can't stop myself. Alright. The women with premature ovarian insufficiency or premature menopause of any type, we know unfortunately that if we don't add back hormone therapy, it can be, it's any form of oestrogen and progestogen if they need it. It can be the Pill, can be the combined contraceptive ring as well as hormone therapy. Either/or. We know if we don't give them adequate oestrogen, if they're allowed to have it, that their risk of cognitive decline, heart disease and stroke, and bone thinning and fracture, is higher than their age-matched peers. So we do definitely want to treat them, and it is really a form of hormone replacement therapy for that age group, until the age of natural menopause, about 50, 51 years of age. And then within that timeframe, because they normally would've been exposed to that sort of amount of oestrogen, we do not think that there is an increased risk of hormone-sensitive cancers for that group. So that's very important to tell them about that.

**Dr Elizabeth Farrell:** Thank you. I think that's a very, very important message that people seem to forget, that they normally would be having their normal ovarian function over that period of time. Karen, there's one question that I think we need to talk about time and time again, and that is, do we need progesterone add-back or back-up in someone who's using vaginal oestrogen alone?

**Dr Karen Magraith:** If they're using the vaginal oestrogen in the prescribed doses? No, they don't.

**Dr Elizabeth Farrell:** That's right. The dosage of, or the amount of oestrogen that is absorbed through the vaginal epithelium is extremely low once the epithelium has thickened. And in fact, studies have shown that if you use Vagifem daily for, I think it's two or three weeks, and then twice a week, a woman will absorb, over 12 months, 1.14 milligrams, over the 12 months of oestradiol of extremely, extremely low dose. So progesterone is not needed for endometrial protection. Another interesting question is a very simple one, in one sense. How can women who've had a previous hysterectomy know when they've gone through menopause or reach their menopause? It's a very tricky question. And does it have an answer?

**Dr Sonia Davison:** No, there is no answer. Well, what you say, well, I'm butting in again, poor Karen. What I say to women when you're having the onset, if it's an early hysterectomy, for example, in the forties or thirties or whatever, the onset of flushes and sweats and sleep disturbance, really, it could be perimenopause, but we usually would say that that is their menopause. Again, we don't need to do hormone levels. We base their treatment on their bothersome symptoms.

**Dr Elizabeth Farrell:** Any comments?

**Dr Karen Magraith:** I agree with that.

**Dr Elizabeth Farrell:** Okay. Another also interesting question is how do you confidently distinguish between a woman experiencing menopause hot flushes and sweats, versus other causes of night sweats or flushes, and when do you actually think about that her symptoms may not be necessarily related to menopause?

**Dr Karen Magraith:** Well, I think we need to take a really thorough history. It's going be in the history. So you would expect that if a woman's experiencing night sweats that their menstrual history will be consistent with perimenopausal menopause, but we need to check carefully for other symptoms. And, for example, we need to check for fever and weight loss and pain and so forth. And if we're concerned, then we really need to look very carefully for other causes. But the other thing is that if you've got night sweats or hot flushes, and there's nothing else going on, they'll be relieved by oestrogen, and that will sort of give you the answer too.

**Dr Elizabeth Farrell:** But I think sometimes we see women who have had menopause hormone therapy for their symptoms, but then have stopped their therapy and have stopped their symptoms, and then they've got hot flushes and sweats back again, and they're making the assumption that it's menopause, and therefore I think—

**Dr Karen Magraith:** We need to be very careful.

**Dr Elizabeth Farrell:** Very careful. And also do we look at the type of flushes and sweats? There was a wonderful lecture at one of the Australasian Menopause Society meetings on flushing and sweating, and how you could differentiate between the different types, whether it was a dry flush or a wet flush or whatever. So I think we have to be concerned if symptoms are not managed, or menopause therapy, in appropriate doses. And we have to remember that some women actually require quite high doses to get symptom relief. If you're having that sort of issue, then I think this is where, ask the advice of the expert. And one of the things that I was going to mention before we finished was that you can actually send your questions that you have about difficult patients and difficult situations to the Jean Hailes, to 'ask the expert'. And one of us in the team will answer your question and get back to you with those details. So that's something that you can always think about. Now, the good old testosterone replacement, is there a role?

**Dr Sonia Davison:** Having done a PhD on testosterone, I feel that it's my duty to answer this question. Some women will have lowered motivation, energy fatigue and just feel that there is no wind in their sails and they're just a little boat not really sailing on the sea anymore. So there is a lot of debate about testosterone in this situation, and there is a lovely meta-analysis and a consensus statement about testosterone use. And women will be out there looking for information also on DHEA. The bottom line is, there's not a lot of harm from testosterone, if used appropriately and if used at female levels, and this is where we do check levels because the testosterone level, we don't want to replace it to a male level. You need to know what you're doing if you advise testosterone. You need to use an approved product. There's a 1% cream for women and you need to use it knowing really what you do, and giving the ladies some very good advice. There is some lovely information about this on the Jean Hailes website and the Australasian Menopause Society website. And really the only approved indication is hyperactive sexual desire disorder, which is sexual desire which is low that causes distress.

**Dr Elizabeth Farrell:** One of the other questions that I think also is interesting is, do we have to have any more surveillance on someone who goes through menopause between 55 and 60? Do your antennae spring up when you have somebody who's that old?

**Dr Sonia Davison:** I always just look at the general health of the person. I don't think age, aren't we at this sort of age where age doesn't matter, Liz?

**Dr Elizabeth Farrell:** Well, I suppose as a gynaecologist I would always have a little concern about whether there was any endometrial pathology.

**Dr Karen Magraith:** Yeah, I've had a lady who, a woman who came in with, she would've been in her late fifties and no-one had ever taken a history, and she hadn't volunteered to anybody, and she said, 'Oh yes, I'm still having periods.' And of course she had endometrial cancer. So I think that certainly you'd have a low index of suspicion for taking that very careful history of the bleeding and a low threshold for investigation.

**Dr Elizabeth Farrell:** I've got a question here about, patient with surgical menopause in the early forties. When should they have their first DEXA scan, and how often should you do it? And if you then say that's one scenario, when would you do a bone density in somebody who goes through menopause at the expected age and is on hormone therapy?

**Dr Sonia Davison:** Really tricky question, and Karen may have a slightly different answer. If someone is having both ovaries taken out and they're 40 or lower, I want to do a bone density, I want to know what they're like at baseline so we can see what the response to treatment is. Especially if they're not able to have oestrogen treatment, I definitely want to know that, when both ovaries out, that woman will be instantly menopausal, and I definitely want to know at baseline. She won't necessarily be covered for that. She will be, I suppose, if we use a premature menopause as an indication. The trickier question really is someone at 50 who has got a family history of osteoporosis and fracture, and is worried about their risk. At the moment, they are not covered with a Medicare item number for a bone density scan of the hip and the spine. They can pay out of pocket to do it, it's usually about $120 or so out of pocket. Again, I think if there's a big family history and a risk of fracture, I would be advising to do that, because you can be very surprised, can't we, in perimenopause and menopause, that they might have low bone density?

**Dr Elizabeth Farrell:** They may, and I saw a lady today who at 45 had a minimal trauma fracture and is osteopenic, and so you think you've got to investigate there for secondary causes, I assume, if she's still menstruating, I think she went through an early menopause, which would be consistent. In fact, I've had a number of women recently who've gone through early menopause and have not been on any hormone therapy, and it's absolutely terrible. They should be put on it straight away. Now, HRT or MHT or options for those struggling with perimenopause, including those not wanting contraception, I suppose. A BMI of 30 and a smoker, what would you recommend for contraception in this age group, and treatment for perimenopause?

**Dr Karen Magraith:** So they've got some cardiovascular risk factors?

**Dr Elizabeth Farrell:** Yes.

**Dr Karen Magraith:** And they need contraception and treatment of their menopausal symptoms? Yep. Look, I think that for people with cardiovascular risk factors, the thing to do of course is for us to do what we can to manage the risk factors with the patient. But we would be trying to use transdermal oestrogen for patients with cardiovascular risk. So often the levonorgestrel IUD is a great option to get the progestogen in, and then transdermal oestrogen. That would be my first choice.

**Dr Elizabeth Farrell:** And of course someone who's in the perimenopause with a BMI of 30, she's got a number of risk factors, because in the perimenopause you're going to have increase in anovulatory cycles, although you might have some with double ovulation, but more likely anovulatory cycles. So obesity, anovulatory cycles equals increased oestrogen, equals increasing risk of endometrial hyperplasia and endometrial carcinoma. So in the perimenopause in someone like her, you'd really want to have a Mirena. Now there's another question here about a woman in her late forties who has an Implanon for contraception but is having hot flushes. What does she do about the Implanon?

**Dr Karen Magraith:** Well, she leaves, sorry.

**Dr Sonia Davison:** No, you go. Your floor is yours

**Dr Elizabeth Farrell:** And she's thinking about hormone therapy.

**Dr Karen Magraith:** Yeah, well look, the Implanon can stay in for contraception until menopause, but we can't use it as the progestogen component for endometrial protection. So really the advice is if she wants to stay with the Implanon, then you use your menopausal hormone therapy exactly as you would normally. So your oestrogen and your progestogen, and you just add them in and the Implanon's the extra thing, so that you do it that way.

**Dr Elizabeth Farrell:** So another question about osteoporosis and exercise. And is MHT equivalent to resistive exercise in terms of maintaining bone density? I've heard that there is an exercise program that has been validated for osteoporosis in University of Queensland, is it, Onero, something like that? And that there is actually a physiotherapist, an academic physiotherapist who has developed an osteoporosis exercise program here in Melbourne. Do you want to comment on that?

**Dr Sonia Davison:** I think this is very individual-specific, because some women on hormone therapy tend to do really well with their bone health, and others just don't absorb it or the genetics as such that they just don't do as well. And again, with exercise. I always say, do your weight-bearing exercise, and if hormone therapy is appropriate for you, let's do that too. I'll always do an intervention and then do another bone density after a year, to see if it's going in the right direction. It's about the individual and different strategies do work.

**Dr Elizabeth Farrell:** Someone's asked, do you have the name of the CBT self-help book?

**Dr Sonia Davison:** If you google, something, 'managing symptoms at menopause', I believe.

**Dr Elizabeth Farrell:** Myra Hunter.

**Dr Sonia Davison:** Myra Hunter, if you google 'Myra Hunter self-help cognitive behavioural therapy', it's got a pretty cover.

**Dr Elizabeth Farrell:** So there are a couple of things about vaginal oestrogen here. Can it be used in someone with hormone-positive breast cancer, and can it be used in women with urinary incontinence?

**Dr Sonia Davison:** Well, I'll take the first and you take the second. Shall we divvy that up?

**Dr Elizabeth Farrell:** Yeah, that sounds great.

**Dr Sonia Davison:** I usually do not like using any sort of oestrogen if it's a hormone receptor breast cancer. And I'll always try and use lubricants, vaginal moisturisers. But some women, if they do that, they have terrible symptoms, they can be sobbing in front of you and it can be very distressing. I will always use the product Ovestin first. It's oestriol, not oestradiol. If that's not effective or not tolerated, I will use Vagifem, but only if I've discussed it with the oncologist, with the surgeon, and of course with the woman, taking into account risk. It can be done, and it just depends again on the situation. But just get permission.

**Dr Elizabeth Farrell:** Karen, your comment?

**Dr Karen Magraith:** On the second question?

**Dr Elizabeth Farrell:** Yeah.

**Dr Karen Magraith:** So can vaginal oestrogen be used for incontinence? Look, I think that anybody with incontinence should have a full assessment. I don't think we should just jump in and add vaginal oestrogen. So we need to do the assessment and find out what's going on. Is it stress incontinence? Is it urge? Is it mixed? I think there is some benefit for urge symptoms, overactive bladder urgency, et cetera with vaginal oestrogen.

**Dr Elizabeth Farrell:** Can be quite effective.

**Dr Karen Magraith:** It's probably not necessarily going to help stress incontinence, maybe for some people, but I'd really like to get those patients along to the pelvic floor physio or the urogynaecologist, et cetera, and get them looked at.

**Dr Elizabeth Farrell:** And your comment about the use in hormone-positive breast cancer using vaginal oestrogens?

**Dr Karen Magraith:** Yeah, I mean I would like to discuss it with the oncologist or the surgeon. I think there certainly are some patients, and we see these women who've had a distant history of breast cancer, no longer on any treatment, and for many of those women it will be fine to use low-dose vaginal oestrogen. So it's good to have a shared decision.

**Dr Elizabeth Farrell:** So I actually have a totally open view about this. I use it all the time in hormone-positive breast cancer patients, whether they're on adjuvant therapy, so if they're on tamoxifen, I will still use it. I would use oestriol because I think oestriol is a better product in terms of its capacity to reduce atrophy quicker. But the important thing that we must remember about using vaginal oestrogens is that you use it in the lower third of the vagina, because the vagina has a dual blood supply. And if we want it to be effective around the vaginal entrance, we want it to be effective in the bladder, in the urethra, it's got to be put into the lower third. I think that's important. I think that the data we talked about, that Vagifem, the absorption of oestrogen is so small. I think the area in which it becomes a difficulty is in women who are on aromatase inhibitors. And there are other vaginal products not in Australia that are probably able to be used, and hopefully we might have those soon. Now we are getting towards the end of our questions here. There are two questions, one on breast cancer and tibolone. Do you want to do that quickly?

**Dr Sonia Davison:** I'll give you a very quick, if you're all right with that, Karen. At the cell level, tibolone actually inhibits breast cancer growth. They did a big study called LIBERATE, women who'd had breast cancer and had terrible menopausal symptoms, half of them had tibolone, half of them had placebo. The big hope was that the women on tibolone would have a reduction in breast cancer recurrence. Unfortunately, they did not. What we say about tibolone is there is an increased risk of breast cancer. It's a low-dose hormone therapy product. It's a low risk, but still there is a risk.

**Dr Elizabeth Farrell:** Okay. And can you comment on gallbladder disease and MHT?

**Dr Sonia Davison:** Well, I can if you can't.

**Dr Karen Magraith:** Go ahead.

**Dr Elizabeth Farrell:** And gallbladder polyps and stones.

**Dr Sonia Davison:** If you look, it's very interesting. There's a lovely slide, but if you look at the main risks for hormone therapy, one says 'benefits' and one says 'risks'. The main risk is actually gallbladder disease, cholelithiasis, cholecystitis. And I've hardly, I shouldn't say this, touch would, but I've hardly seen those problems on hormone therapy. But if you look at the data, that is the biggest risk.

**Dr Karen Magraith:** And is that really with oral therapy?

**Dr Sonia Davison:** Yeah, it is.

And not with transdermal.

**Dr Elizabeth Farrell:** So it's not with transdermal, is it?

**Dr Sonia Davison:** No, no.

**Dr Elizabeth Farrell:** That's good. The new therapy that's been released today, the oestradiol, progesterone, micronised progesterone product, I mean basically it's a combined oral regimen that has a place in our armamentarium, and it's another one that we have, and it's bioidentical or body identical or whatever, human hormones. So it has a place, but obviously at this point in time it's not on the PBS, so it's a little bit more expensive than some of the others.

**Dr Sonia Davison:** I'd love to say something. When I give these sort of talks, there is no one correct menopausal hormone therapy product. There is no one safe one. Different products are out there at different strengths and different doses for different individual women and for different reasons. And that's great. It's not just 'one size fits all' and there's not one bad product at all. They all have their own individual role, and sometimes it's a bit tricky to get there, but that's also very important to know.

**Dr Elizabeth Farrell:** Now, if you have a woman who you've started on hormone therapy, and she has some breakthrough bleeding, when do you actually start to investigate? What time span do you give her before you start to investigate that bleeding?

**Dr Karen Magraith:** Well, we can tolerate bleeding and spotting for the first six months when we start hormone therapy, although I would like to see that bleeding and spotting settling down over those six months. And if they've got heavy bleeding, I'd investigate earlier. But generally speaking, we can tolerate a little bit of bleeding as spotting initially. If it doesn't settle, then we need to think about changing type of therapy. Or certainly if they get to six months and they've got irregular bleeding, then I would be investigating.

**Dr Elizabeth Farrell:** And what investigations would you do?

**Dr Karen Magraith:** I would do an examination, and make sure there's no structural issues on examination, and probably a cervical screen or co-test depending on the type of bleeding. Think about whether you need to test for STIs, but really importantly, a vaginal ultrasound. And this is ideally done on days five to 10 of the cycle bleeding, if you can.

**Dr Elizabeth Farrell:** Excellent, excellent. I'm just wondering, we've got time for, we've got time for one question more I think. What effect does MHT have on the incidents of bowel cancer?

**Dr Sonia Davison:** We're finishing with a real doozy, aren't we? Not a bad question, just a very tricky one for my brain. So the WHI study very nicely showed us that combined oestrogen and progestogen, which was CEE, equine oestrogens, and medroxyprogesterone acetate, that combination actually decreased the incidence or the risk of colorectal cancer, whereas oestrogen alone did not. So you've got to consider that the bowel does have oestrogen and progestogen receptors. We haven't really totally worked out that area yet. But yes, it's definitely something to consider, but there's more likely to get a benefit from the combined oestrogen and progestogen.

**Dr Elizabeth Farrell:** Thank you. That's great. Now it's time for us to wrap up. If we have any unanswered questions, and I know there are some, we'll aim to have them answered, and to pop them up with the recording in the coming weeks. Don't forget if you need CPD points or a certificate, to complete your evaluation, and a link for this will pop up shortly. Thank you for attending, and a huge thank you to both Karen and to Sonia for presenting tonight, and for me butting in. We look forward to seeing you and the next time at our next webinar. And remember that if you do have a clinical question, send it in to 'ask the expert' at the Jean Hailes website. Thank you very much and all have a good evening. Bye now.

End of transcript

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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