Menopause basics:
the consultation and management options

Australasian Menopause Society | Jean Hailes for Women's Health | jeanhailes.org.au

Presenters

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The menopause consultation

The consultation with a midlife woman

- Listen and focus on the woman's concerns
- May not want treatment, may just want information
- Full assessment recommended irrespective of presenting reason of the midlife woman
- Evidenced-based information
- Shared decision-making

Template for a menopause consultation

Template for Menopause Consult
A structured approach to menopause consultations

Menopause consult
History
Main concerns
LMP/menstrual history
Menopause/perimenopause symptoms – vasomotor, psychological, musculoskeletal genitourinary, sexual, other
Past medical history – gynaecological, cardiovascular, cancer, VTE, osteoporosis, migraine
Family history – cancer, VTE, CVD, osteoporosis
Breast screening, last MMG
Cervical screening
Bowel cancer screening
Social history
Smoking, diet, alcohol, drugs, complementary therapies, exercise
Cardiovascular risks
Bone health
Contraception
Examination
Plan – don't forget lifestyle advice

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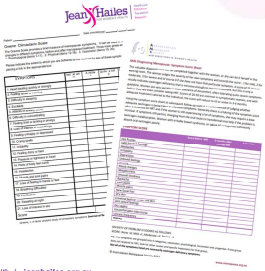
EMPOWERING MENOPAUSAL WOMEN

menopause.org.au/hp/gp-hp-resources/ams-template-for-menopause-consult

Diagnosing menopause - the history makes the diagnosis

- Consider using symptom score
  - AMS
  - Jean Hailes
- Don't need to measure hormone levels to diagnose menopause at the normal age.



Structured approach – main concerns

- What is the patient most concerned about? The 'list'
  - vasomotor symptoms
  - mental health
  - weight gain
  - family history of osteoporosis or breast cancer
  - sexual function

Structured approach - history taking

- Last menstrual period/menstrual history
- Menopause/perimenopause symptoms
- Past medical history
  - Gynaecological, CVD, cancer, VTE, osteoporosis, migraine
  - Medications (incl non-prescribed)
- Family history
  - Cancer, VTE, CVD, osteoporosis

Structured approach – health assessment at midlife

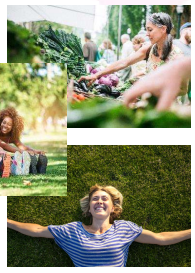
- Breast screening, last MMG
- Cervical screening
- Bowel cancer screening
- Cardiovascular risks
  - type 2 diabetes, hypertension, dyslipidaemia, metabolic syndrome
- Bone health
- Social history
- Lifestyle factors
  - Smoking, diet, alcohol, drugs, exercise
- Need for contraception

Structured approach – examination and investigations

- BP, BMI, ?Other
- Blood tests: hormone tests not usually needed
- Consider lipids, BSL, FBC, ferritin, TSH where appropriate

Structured approach – lifestyle advice

- Healthy diet
- Regular exercise
- Avoid alcohol excess/spicy foods
- Smoking cessation
- Stress management
- Avoid overheating/dress in breathable fabrics



Contraception

- Under 50: Contraception recommended until 2 years after final menstrual period (FMP)
- Over 50: Contraception recommended until 1 year after FMP

Stopping contraception

- Progestogen only contraception with amenorrhoea for 12 months after the age of 50: Single FSH. If over 30IU/L, they can stop contraception after 1 further year of use
- Most women can stop contraception at 55
- Stop contraception at 55 if less than 1 year post FMP?
  - very low risk of pregnancy but not zero
  - shared decision making

Contraception

- Stop COCP and DMPA at 50 (consider stopping DMPA earlier)
- Other progestogen only methods can continue
  - Progestogen only pill (norethisterone and LNG minipills and drospirenone pill)
  - Implant (etonogestrel)
  - Levonorgestrel IUCD. LNG 52mg, LNG 19.5mg
    - If inserted after 45, LNG 52mg can be used for contraception until 55 (off-label extended use)
    - Use LNG 52mg for endometrial protection. Must be replaced after 5 years if using for this indication

Contraception

- Non-hormonal IUD
- Permanent contraceptive methods
- Barrier methods (NB condoms for STI prevention)
- Don't forget emergency contraception
- Menopausal hormone therapy (MHT) is not a contraceptive

Treatment options for symptoms

- No treatment
- Menopausal hormone therapy (MHT)
- Non-hormonal treatments

When to consider hormone therapy

- MHT is the most effective treatment for symptoms of menopause
- Women can be offered MHT if they have symptoms that bother them (if no contraindications)
- You don't need to wait until after the final menstrual period
- Give information and offer MHT if it is appropriate
- The patient decides what to do - shared decision making

The menopause consultation – set expectations

- Plan to reduce symptoms not necessarily eliminate them
- Set expectations – may have to try other combinations of MHT or non-hormonal therapies
- View the relationship as a partnership – work together to address the issues
- Focus on what matters to the patient

Case study 1

Case study 1 - Eva

- 52 yrs
- Single
- Social worker – works full-time
- Symptoms:
  - Low mood, anxiety, lethargy, sleep disturbance
  - Feels hot generally, night sweats – drenching, frequent flushes
  - Vaginal dryness, dyspareunia, urinary urgency
  - Periods ceased a year ago, erratic for 12 months prior

Management

1. Diagnosis
2. Symptom control
3. Disease prevention

Management of symptoms

Treat symptoms when ***bothersome***

1. Lifestyle measures
2. Hormone treatment (MHT [=HRT], vaginal oestrogen)
3. Non hormonal treatments
   - lifestyle modifications
   - CBT
   - yoga
   - hypnotherapy
   - non-hormonal prescription medications
   - complimentary or alternative products

MHT

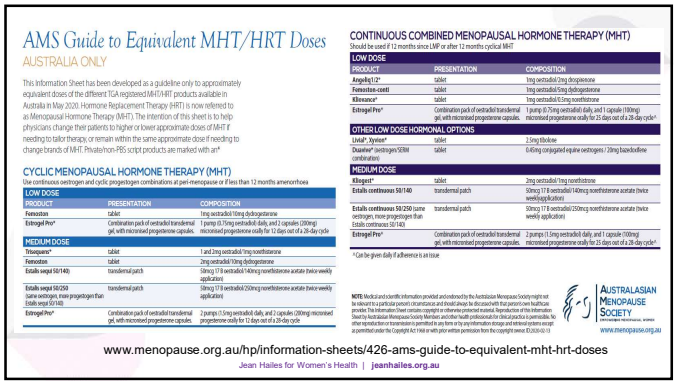
- The benefits far outweigh the risks in healthy women around the time of perimenopause / menopause (consensus statements + guidelines)
- Increased risk of breast cancer after 5 years of use
- Multiple trials support the 'safe window' for prescribing
- Timing of initiation: <60 years or within 10 years of last menstrual period
- Younger women more likely to be symptomatic, have lower background risks for VTE and stroke, are more likely to derive cardiovascular benefit

Before you prescribe

- Ensure there are no contraindications to MHT
  - Breast cancer and hormone sensitive e.g. endometrial cancer > stage 1
  - Thrombophilia / past venous thrombo-embolic event (VTE)
  - Undiagnosed vaginal bleeding
  - Active liver disease
  - Uncontrolled hypertension
  - CVD risk or disease
- Ensure screening is up to date
- Start with a mid-range dose (can be titrated up or down at first review) and use for the shortest duration for symptom control

Key considerations

1. Likelihood of bleeding (sequential vs. continuous)
2. Oestrogen only or oestrogen + progestogen or localised (PV oestrogen)
3. Risk factors
4. Presenting symptoms
5. Need for contraception (perimenopause)
6. Cost (PBS vs. non PBS)
7. Premature menopause (dose and duration)



AMS Guide to Equivalent MHT/HRT Doses

AUSTRALIA ONLY

This Information Sheet has been developed as a guideline only to approximately equivalent doses of the different TGA registered MHT/HRT products available in Australia in May 2020. Hormone Replacement Therapy (HRT) is now referred to as Menopausal Hormone Therapy (MHT). The intention of this sheet is to help physicians change their patients to higher or lower approximate doses of MHT if needing to tailor therapy, or remain within the same approximate dose if needing to change brands of MHT. Private/non-PBS script products are marked with an*

CYCLIC MENOPAUSAL HORMONE THERAPY (MHT)

Use continuous oestrogen and cyclic progestogen combinations at peri-menopause or if less than 12 months amenorrhoea

LOW DOSE

PRODUCT	PRESENTATION	COMPOSITION
Femoston	tablet	1mg oestradiol/10mg dydrogesterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle

MEDIUM DOSE

Trisequens*	tablet	1 and 2mg oestradiol/1mg norethisterone
Femoston	tablet	2mg oestradiol/10mg dydrogesterone
Estalis sequi 50/140	transdermal patch	50mcg/ 17.8 oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis sequi 50/250 (same oestrogen, more progestogen than Estalis sequi 50/140)	transdermal patch	50mcg/ 17.8 oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules	2 pumps (1.5mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 12 days out of a 28-day cycle

CONTINUOUS COMBINED MENOPAUSAL HORMONE THERAPY (MHT)

Should be used if 12 months since LMP or after 12 months cyclical MHT

LOW DOSE

PRODUCT	PRESENTATION	COMPOSITION
Angeliq(1/2*	tablet	1mg oestradiol/2mg drospirenone
Femoston-conti	tablet	1mg oestradiol/5mg dydrogesterone
Kliovance*	tablet	1mg oestradiol/0.35mg norethisterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^

OTHER LOW DOSE HORMONAL OPTIONS

LIVIAL*, Xyntos*	tablet	2.5mg tibolone
Duavive* (oestrogen/SERM combination)	tablet	0.45mg conjugated equine oestrogens / 20mg bazedoxifene

MEDIUM DOSE

Kliogest*	tablet	2mg oestradiol/1mg norethisterone
Estalis continuous 50/140	transdermal patch	50mcg/ 17.8 oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis continuous 50/250 (some oestrogen, more progestogen than Estalis continuous 50/140)	transdermal patch	50mcg/ 17.8 oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^

^Can be given daily if adherence is an issue

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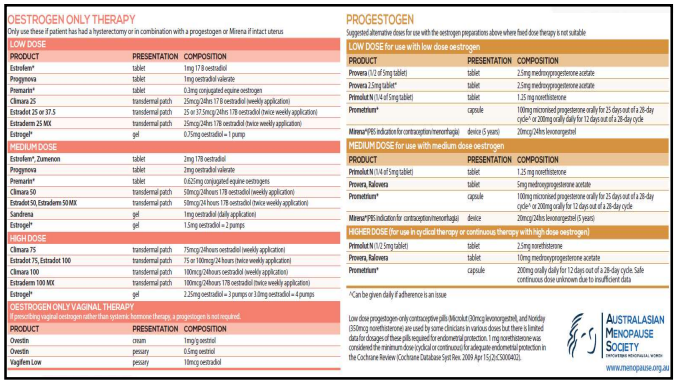
www.menopause.org.au

www.menopause.org.au/hp/information-sheets/426-ams-guide-to-equivalent-mht-hrt-doses



OESTROGEN ONLY THERAPY

Only use these if patient has had a hysterectomy or in combination with a progestogen or Mirena if intact uterus

LOW DOSE

PRODUCT	PRESENTATION	COMPOSITION
Estrofem*	tablet	1mg 17 B oestradiol
Progynova	tablet	1mg oestradiol valerate
Premarin*	tablet	0.3mg conjugated equine oestrogen
Climara 25	transdermal patch	25mcg/24hrs 17 B oestradiol (weekly application)
Estradot 25 or 37.5	transdermal patch	25 or 37.5mcg/24hrs 17B oestradiol (twice weekly application)
Estraderm 25 MX	transdermal patch	25mcg/24hrs 17B oestradiol (twice weekly application)
Estrogel*	gel	0.75mg oestradiol = 1 pump

MEDIUM DOSE

Estrofem*, Zumenon	tablet	2mg 17B oestradiol
Progynova	tablet	2mg oestradiol valerate
Premarin*	tablet	0.625mg conjugated equine oestrogens
Climara 50	transdermal patch	50mcg/24hours 17B oestradiol (weekly application)
Estradot 50, Estraderm 50 MX	transdermal patch	50mcg/24 hours 17B oestradiol (twice weekly application)
Sandrena	gel	1mg oestradiol (daily application)
Estrogel*	gel	1.5mg oestradiol = 2 pumps

HIGH DOSE

Climara 75	transdermal patch	75mcg/24hours oestradiol (weekly application)
Estradot 75, Estradot 100	transdermal patch	75 or 100mcg/24 hours (twice weekly application)
Climara 100	transdermal patch	100mcg/24hours oestradiol (weekly application)
Estraderm 100 MX	transdermal patch	100mcg/24hours 17B oestradiol (twice weekly application)
Estrogel*	gel	2.25mg oestradiol = 3 pumps or 3.0mg oestradiol = 4 pumps

OESTROGEN ONLY VAGINAL THERAPY

If prescribing vaginal oestrogen rather than systemic hormone therapy, a progestogen is not required.

PRODUCT	PRESENTATION	COMPOSITION
Ovestin	cream	1mg/g oestriol
Ovestin	pessary	0.5mg oestriol
Vagifem Low	pessary	10mcg oestradiol

PROGESTOGEN

Suggested alternative doses for use with the oestrogen preparations above where fixed dose therapy is not suitable

LOW DOSE for use with low dose oestrogen

PRODUCT	PRESENTATION	COMPOSITION
Provera (1/2 of 5mg tablet)	tablet	2.5mg medroxyprogesterone acetate
Provera 2.5mg tablet*	tablet	2.5mg medroxyprogesterone acetate
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally daily for 12 days out of a 28-day cycle
Mirena*(PBS indication for contraception/menorrhagia)	device (5 years)	20mcg/24hrs levonorgestrel

MEDIUM DOSE for use with medium dose oestrogen

PRODUCT	PRESENTATION	COMPOSITION
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Provera, Ralovera	tablet	5mg medroxyprogesterone acetate
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally for 12 days out of a 28-day cycle
Mirena*(PBS indication for contraception/menorrhagia)	device	20mcg/24hrs levonorgestrel (5 years)

HIGHER DOSE (for use in cyclical therapy or continuous therapy with high dose oestrogen)

Primolut N (1/2 5mg tablet)	tablet	2.5mg norethisterone
Provera, Ralovera	tablet	10mg medroxyprogesterone acetate
Prometrium*	capsule	200mg orally daily for 12 days out of a 28-day cycle. Safe continuous dose unknown due to insufficient data

^Can be given daily if adherence is an issue

Low dose progestogen-only contraceptive pills (Microlut (30mcg levonorgestrel), and Noriday (350mcg norethisterone) are used by some clinicians in various doses but there is limited data for dosages of these pills required for endometrial protection. 1 mg norethisterone was considered the minimum dose (cyclical or continuous) for adequate endometrial protection in the Cochrane Review (Cochrane Database Syst Rev. 2009 Apr 15;(2):CD003402).

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Case study 1 management - Eva

Initial management
- Eva wished to pursue natural treatment
  - had a 3 month trial of black cohosh

3 month review
- Bothersome symptoms persisted
- Trial of 'body-identical' MHT
  - oestradiol patch (twice weekly) and micronised progesterone (nocte)

6 months from initial consultation
  - scant bleeding and breast tenderness – settled in first month
  - some patch site irritation
  - excellent symptom control
  - changed to daily oestradiol gel + micronised progesterone

Genitourinary syndrome of menopause

- Consider vaginal lubricants or moisturiser
- May be relieved by systemic MHT (if using it for systemic symptoms)
- Consider vaginal oestrogen if ongoing genitourinary symptoms
- Can use vaginal oestrogen alone
- Don't forget to ask!
- Consider referral to a pelvic floor physio if appropriate

Case study 2

Case study 2 - Helen

- 48 yrs
- Married
- Accountant – works part-time
- Diagnosed with breast cancer, Hormone receptor positive (HR+)
- Periods stopped after chemotherapy
- Worried about her bone health – mother with osteoporosis and fracture
- Asking about MHT - her friends have described this as 'life-changing'

Symptoms:

- Low mood, anxiety, lethargy, sleep disturbance
- Feels hot generally, night sweats – drenching, frequent flushes
- Vaginal dryness, dyspareunia

Resources - non-hormonal treatment options


Non-hormonal treatment options for menopausal symptoms

MAIN POINTS

- Patient fact sheet
  - AMS
  - www.menopause.org.au/health-info/fact-sheets/non-hormonal-treatment-options-for-menopausal-symptoms
- Health professional podcast
  - Jean Hailes/Healthed
  - www.jeanhailes.org.au/resources/non-hormonal-options-for-menopause-management

Non-hormonal medications for symptom control
SSRIs / SNRIs comparison – vasomotor symptoms

Agent	Dose	% reduction in flushes	Reference
Venlafaxine	75mg SR	60%	Loprinzi et al 2000
Desvenlafaxine	150mg	60%	Archer et al 2009
Paroxetine	12.5mg CR	56%	Steams et al 2005
Fluoxetine	20mg	50%	Loprinzi et al 2002
Escitalopram	10-20mg	47%	Freeman et al 2011

Clonidine – vasomotor symptom control

= α-adrenergic agonist (blood pressure / migraine agent)

Dose:

1. 25 mcg twice daily
2. 50mcg twice daily after 2 weeks
3. 75mcg twice daily – maximal dose

Side effects:

– Dry mouth, visual disturbance, insomnia, drowsiness

Goldberg et al J Clin Oncol 1994

Gabapentin – vasomotor symptom control

= GABA analogue; epilepsy agent

Effects:

Improvement in sleep disturbance, reduction in flushes (45% vs. 29% placebo)

Dose:

1. Start 100mg at bedtime – gradually increase to 100mg tds (increase dose every 3-5 days)
2. Maximal dose 300mg tds

Side effects:

– Somnolence, drowsiness, dizziness

Guttoso et al Obstet Gynecol 2003, Toulis et al Clin Ther 2009

Remifemin

= black cohosh

Effects:

Relief of mild vasomotor symptoms

Duration:

6 months

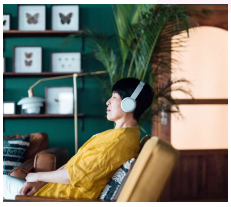
Side effects:

- Potential liver toxicity
- Reports of:
  - abnormal liver function
  - fulminant hepatitis
  - liver failure requiring transplantation

Levitsky et al 2005, Lynch et al 2006

Other options

1. Cognitive behavioural therapy (CBT), mindfulness
2. Hypnosis
3. Acupuncture
4. Breathing (paced respiration), relaxation training
5. Stellate ganglion block



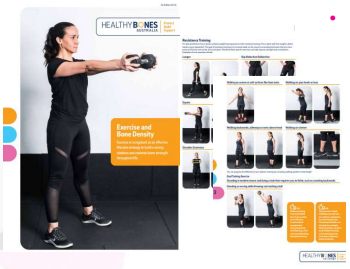
Case study 2 management - Helen

- Trial of escitalopram
  - initial dose 5mg
  - increased to 10mg after 4 weeks
- Vaginal moisturiser and lubricants
- Bone health measures
  - maximise calcium in diet 1300mg daily
  - vitamin D3
  - weight bearing exercise

3 month review

- reduction in vasomotor symptoms
- sleep disturbance ongoing, discussed trial of melatonin

Resource – Healthy Bones Australia



- Patient booklet; exercise and bone density

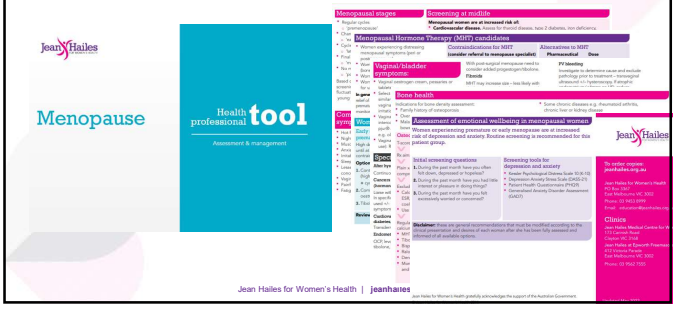
healthybonesaustralia.org.au/wp-content/uploads/2021/02/HBA-Exercise-Brochure.pdf

Case study 3

Case study 3 - Stephanie

- 54 yrs
- New relationship
- Teacher - works full-time
- DVT after ankle surgery 3 yrs ago
- Migraine - long-term
- Symptoms:
  - Low mood, anxiety, lethargy, sleep disturbance
  - Feels hot generally, night sweats – drenching, frequent flushes
- Told she couldn't use MHT because of migraine and past DVT

Jean Hailes health professional menopause tool



Women and MHT:
Dose, delivery systems and regimens matter

Low dose therapy has:
- Less effect on thromboembolic risk
- Less effect on breast cancer risk

Transdermal therapy has:
- Less effect on thromboembolic risk
- Less effect on stroke risk

Oestrogen alone has:
- Less effect on cardiovascular risk
- Less effect on VTE risk
- Less effect on breast cancer risk and colorectal cancer risk reduction

Women and MHT:
Dose, delivery systems and regimens matter cont..

Not all progestogens are created equal
- Micronised progesterone & dydrogesterone has less effect on breast cancer risk (vs MPA and NETA)

Migraine
- Transdermal MHT is not contraindicated in migraine – unlike COCP and oral oestrogen

Case study 3 management - Stephanie

- Thrombophilia screen performed
  → negative
- Saw haematologist
  → 'OK for transdermal MHT'
- Trial of transdermal oestradiol and progestogen patch

3-month review
- symptoms well managed, no increase in migraine

Key messages

Karen

- Don't try to manage menopause in a single consultation
- Don't forget the patient's primary concerns
- Don't forget to address contraception
- We give information and offer MHT if it is appropriate.
- The patient decides what to do - shared decision making

Sonia

- There is no 'one size fits all' approach at menopause – tailor the solution for the individual
- The benefits of MHT far outweigh the risks for healthy women around the time of menopause
- Find the appropriate resource to assist - Jean Hailes / Australasian Menopause Society / Women's Health Research Program - Monash

Questions

Resources

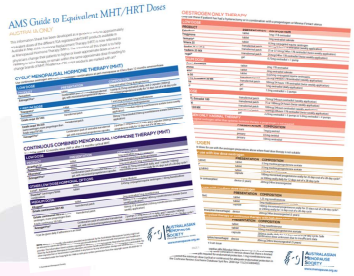
Jean Hailes health professional resources

Health professional tools

Health professional education

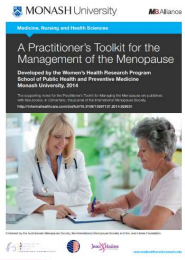
- E-learning course
  - Managing menopause
  - Fertility, infertility and preconception care
  - Diagnosis and management of PCOS
- Webinars
  - Ask an Expert: menopause management
  - MHT cases
  - Using natural therapies in the menopause transition
  - Postmenopausal health
  - What's new: the use of testosterone in women

AMS Guide to Equivalent MHT/HRT Doses Australia only



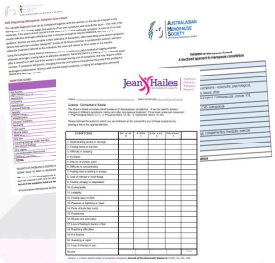
menopause.org.au/hp/information-sheets/ams-guide-to-equivalent-mht-hrt-doses

Monash University health professional toolkit



- A practitioner's toolkit for the management of the menopause
  - monash.edu/medicine/sphpm/units/womenshealth/toolkit-management-of-the-menopause

Menopause symptom score sheets and consultation template



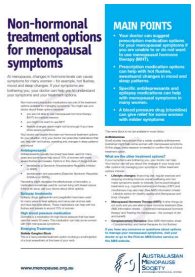
Jean Hailes

- **Greene climacteric score sheet**
  assets.jeanhailes.org.au/Health-professionals/Menopause_symptom_scale_Greene_Climacteric.pdf

AMS

- **Menopause symptom score card**
  menopause.org.au/hp/information-sheets/ams-symptom-score-card
- **Menopause consultation template**
  menopause.org.au/hp/gp-hp-resources/ams-template-for-menopause-consult

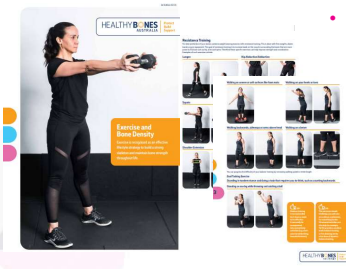
Resources - non-hormonal treatment options



- Patient fact sheet
  AMS
  menopause.org.au/health-info/fact-sheets/non-hormonal-treatment-options-for-menopausal-symptoms
- Health professional podcast
  Jean Hailes/Healthed
  jeanhailes.org.au/resources/non-hormonal-options-for-menopause-management

Jean Hailes – patient booklets and multilingual fact sheets

Resource – Healthy Bones Australia



- Patient booklet; exercise and bone density
  healthybonesaustralia.org.au/wp-content/uploads/2021/02/HBA-Exercise-Brochure.pdf


MAKE MENOPAUSE MATTER
25th Annual Australasian Menopause Society Congress
Cairns Convention Centre, QLD
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Onsite and Online
amscongress.com.au


Thank you
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