

Menopause - a summary of management

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Resources



[Menopause treatment algorithm](#) The Jean Hales Foundation for women's health. Menopause, a treatment algorithm. (Australian Family Physician 2006, adapted from the Royal Australian College of General Practitioners) [102 Kb]

Menopause usually occurs in women aged between the ages of 45-55 years. In general women in their peri-menopausal years are more likely to seek medical advice than the post-menopausal woman.

Peri-menopause is a period of transition: emotional, psychosocial, and physical.

Peri-menopause is a period of transition: emotional, psychosocial, and physical. Women may have other factors impacting on their psychosocial wellbeing: children leaving home, parents aging, work and changes in the relationship with spouse/partners.

Symptoms of peri-menopause

The symptoms of peri-menopause include (1):

- *Menstrual cycle*
 - The first change women notice will be a change in usual menstrual cycle;
 - this can be longer, shorter or irregular menstrual cycle;
 - there may be lighter bleeding or heavier bleeding;
 - heavier bleeding should be investigated;
 - the peri-menopause is the most common time when hysterectomy for excessive bleeding may be required;
 - as oestrogen levels decrease periods will eventually cease;
 - contraception is required until at least a year after cessation of periods.
- *Psychological*
 - Impaired concentration and memory;
 - loss of confidence;
 - anxiety and depression;
 - changes in sexual function;
 - likely related to a combination of hormonal imbalance, sleep disturbance and fatigue.
- *Vasomotor*
 - Related to oestrogen withdrawal;

- hot flushes, night sweats, palpitations.
- *Urogenital*
 - From decreased oestrogen, testosterone;
 - vaginal dryness, dyspareunia, dysuria, urinary frequency
- *Other*
 - Insomnia;
 - breast discomfort;
 - sensory disturbances such as formication, joint pain and stiffness;
 - changes in libido.

Vasomotor and urogenital symptoms are often late symptoms of peri-menopause.

Management of the peri-menopausal woman

Management includes (2):

- *Diet and lifestyle*
 - stress management strategies;
 - exercise;
 - smoking cessation;
 - regular pap smears and breast checks.
- *Bone health*
 - adequate calcium intake (Aim 3-4 serves daily of calcium or 1000 mg);
 - vitamin D (15 min daily sunlight, or calcium with vitamin D supplements);
 - exercise.
- *Phyto-oestrogen rich diet*
 - found in soybeans, legumes, vegetables, cereals;
 - **note:** there is limited evidence regarding a particular food linked to increased health benefits; it may be that a phyto-oestrogen rich diet simply reflects a healthier diet in general.
- *Urinary and vaginal health*
 - pelvic floor exercises;
 - lubricants (Replens, Sylk);
 - topical oestrogens (creams or pessaries);
 - systemic hormone therapy.
- *Contraception*
 - is required until at least a year after cessation of periods.
- *Chronic disease risk assessment*
 - Assess risk factors for: osteoporosis, stroke, cardiovascular disease, thromboembolic disease, breast and endometrial cancer;
 - important in determining whether hormone therapy is indicated.

Hot flushes

Non-pharmacological management

- Decreasing core body temperature
 - avoiding hot drinks;
 - fans.
- Relaxation techniques
 - paced breathing.

Pharmacological management

- Complementary therapies
 - [black cohosh](#) (marketed as Remifemin);
 - [isoflavone](#) supplements (soy or [red clover](#)),
 - [dong quai](#).
- Non-hormonal therapy
 - [clonidine](#) 0.1 mg daily. (*side effects*: dry mouth, hypotension, insomnia);
 - [SNRI/SSRI](#): studies in [venlafaxine](#), [fluoxetine](#) and [paroxetine](#).

Hormonal Therapy: see later

Paced breathing

- Stand or sit erect;
- inhale steadily through the nostrils;
- fill the lower part of the lungs, lower the diaphragm;
- fill the middle part of the lungs, push out the ribs;
- fill the upper portion of the lungs, the inhalation is continuous;
- retain the breath a few seconds;
- exhale slowly;
- breathe at a rate of 6-8 cycles per minute.

Hormonal therapy (HT)

Hormonal therapy can be useful in women for (3) (4):

- treatment of menopausal symptoms such as hot flushes, night sweats, vaginal atrophy (although topical treatments are preferred for isolated vaginal symptoms);
- prevention of osteoporotic fractures in high risk women where first line treatments are unavailable or contraindicated;
- women who have undergone early menopause are advised to continue HT until they reach the age of natural menopause (usually between 50-55 years of age).

Types of hormone therapy:

- *Combined OCP*
 - perimenopausal women;
 - symptom relief;
 - contraception.
- *Oestrogen combined with cyclical progesterone*
 - perimenopausal women not requiring contraception.
 - **Oral**: Trisequens, Climen, Premia 5, Femoston, Divina.
 - **Transdermal patch**: Estracombi, Estalis Sequi.
- *Oestrogen combined with fixed dose progesterone*
 - women in late peri-menopause or are post-menopausal.
 - **Oral**: Kliovance, Kliogest, Premia Continuous, Livial.
 - **Transdermal patch**: Estalis Continuous
- *Oestrogen only*
 - only for women without a uterus.
 - **Oral**: Estrofem, Benoral, Premarin, Progynova, Ovestin, Ogen, Zumenon.
 - **Non-oral**: patches, implants
- *Tibolone*
 - synthetic steroid that is metabolized to a selective oestrogen like drug.
- *Progestogen with oestrogen*
 - enables lower levels of progestin, and less systemic effects.

- o Mirena IUD, or Provera

Tailoring Hormonal Therapy

Problem	Action
Breast tenderness, weight gain, bloating, migraine	Reduce oestrogen dose
Continuing symptoms of oestrogen deficiency	Double oestrogen dose
Premenstrual symptoms on progestogen therapy	Reduce progesterone (e.g., 2.5 mg Provera)
Bleeding on progesterone therapy	Increase progestogen (e.g., 20 mg Provera)
Heavy withdrawal bleeds	Reduce the oestrogen dose
Irregular or atypical bleeding	Endometrial biopsy or diagnostic curettage
Low libido despite oestrogen therapy	Psychosexual counselling. ? testosterone
Intolerable periods	Low dose oestrogen <i>or</i> three month cyclical progestogens <i>or</i> continuous oestrogens/progestogens <i>or</i> endometrial ablation

Once on HT, women should be reviewed at least annually to reassess risk.

Evidence for risk and benefits

The following is based on Women's Health Initiative (WHI) Study USA on effects of HT (5). The study group included women aged 50-79:

HT can be related to slightly increased risk of the following conditions:

- *Coronary heart disease*
 - o an increase of 7 cases per 10,000 per annum;
 - o baseline risk for women 45-54 year old of 39 per 10,000 per annum.
- *Stroke*
 - o an increase of 8-12 cases per 10,000 per annum;
 - o baseline risk for women 45-54 year old of 7-8 per 10,000 per annum.
- *Venous thrombo-embolic disease*
 - o the risk is doubled;
 - o baseline risk for women in their 50s of 1 in 10,000 per annum;
 - o this increases to a baseline risk for women in their 80s of 100 per 10,000 per annum.

- *Breast cancer*
 - an increase of 8 cases per 10,000 per annum;
 - baseline risk for women 45-54 year old of 7-8 per 10,000 per annum;
 - increased risk associated with increased duration of treatment.
- *Endometrial cancer*
 - in women with an intact uterus, unopposed oestrogen should not be used due to increased risk of endometrial cancer;
 - combined (oestrogen/progesterone) oral hormone therapy does not appear to have an increased risk.

HT is protective for:

- *Osteoporosis*
 - HT decreases risk of spine, hip fracture and can be useful in asymptomatic women with a high risk of osteoporotic fracture if other first line treatments are unavailable or contra-indicated.

There is limited evidence linking HT to increased or decreased risk of colorectal cancer, ovarian cancer and dementia. There is no link with HT and increased weight gain.

About 'natural' hormones

These are synthetically made hormones which can be administered in the form of troches or lozenges (6). They usually contain oestrogen in the form of oestrodial, the oestrogen that occurs naturally in humans. However they are still manufactured. Often the oestrodial is in combination with testosterone or DHEAS, which is not approved for use in Australia. As the manufacturers who produce these 'natural' hormones do not have to abide by the code of conduct of Medicines Australia there is often variability in quality control. There is insufficient data regarding the efficacy of these medicines and certainly they are not recommended treatment for peri-menopause or menopause.

Research articles

(1) The Jean Hailes Foundation. Menopause into the Millenium. A National Health Professionals Training Day. Revised edition 2003.

(2) Murkies A. If not Hormones - then what? *Australian Family Physician*. Vol 33, No 11. Nov 2004

(3) Coleman KA. Hormone replacement therapy for women at or after the menopause. *Australian Government National Health and Medical Research Council*. Feb 2004

(4) Australasian Menopause Society. [\[Link\]](#)

(5) Advice to Medical Practitioners regarding the use of postmenopausal hormone therapy. *Consensus Statement issued by the RANZCOG*. August 13, 2004

(6) Teede H., et al. Menopause Forum: A case discussion of Midlife issues. *Australian Family Physician*. Vol 33, No 11. Nov 2004

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