YOUR HEALTH

Newsletter August 2021

Health Partners

- THE MENOPAUSE: TIME FOR CHANGE
- MSK, POSTURE & WORK

(SEPARATE STAND-ALONE)

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LET'S TALK ABOUT THE MENOPAUSE

The **menopause literally means** the last menstrual period. **Perimenopause** means "around menopause" and refers to the time during which a woman's* body makes the natural transition to menopause, marking the end of the reproductive years. Natural menopause is recognised to have occurred after 12 consecutive months of no periods, for which there is no other obvious pathological or physiological cause. Menopause occurs with the final menstrual period known with certainty, only in retrospect a year or more after the event.

Physiologically, it is characterised by a **change in hormones:** oestrogen levels diminish, and there is an increase in the production of certain ovarian stimulating hormones such as Follicular Stimulating Hormone (FSH).

An adequate biological marker (blood test) for the event does not exist; however, the National Institute of Clinical Excellence (NICE) recommends measuring the levels of FSH in women aged 40 to 45 years with menopausal symptoms, including a change in their menstrual cycle and in women aged under 40 years, with whom menopause is suspected.

On average, the menopause occurs at 51 years of age in the UK, although it can vary between 40 and 58 years of age and it is slightly earlier among smokers by about two years. Sometimes it may be difficult to define precisely when the menopause occurs, especially if the woman begins to take hormone replacement therapy during the menopause.

Menopausal symptoms are thought to affect around two thirds of women and some 10-20% describe the symptoms as distressing. The duration and severity of symptoms varies and cannot be predicted. The effects of the menopause may be reviewed in terms of a range of factors as set out below.

Vasomotor symptoms: An uncomfortable **hot flush** or individual feeling of warmth. It affects up to 85% of menopausal women but fewer than half are seriously disturbed by them. About 20% of women first notice symptoms while they are still menstruating regularly. The flush may be accompanied by nausea and sweating and be followed by a chill and palpitations. Symptoms can be particularly troublesome at night interfering with sleep.

For most women, flushes are brief, improve within a few months and resolve within about five years, as the body adapts to the new level of oestrogen. In 90% of cases, hormone replacement therapy (HRT) will relieve symptoms and other medications can also be effective.

Psychological symptoms: a wide variety of psychological symptoms are noted in menopausal women, including irritability, confusion, lethargy, memory loss, loss of libido and depression. It is uncertain whether these are primary effects of oestrogen deficiency or simply manifestations of other processes. Insomnia, for example, is probably due to night sweats.

In general, a trial of HRT may be beneficial before the woman is prescribed specific psychological medication, e.g. anti-depressants.

Urogenital symptoms: the vagina, urethra and bladder are oestrogen-dependent and gradually atrophy/waste away after the menopause. The absence of oestrogen results and thinning of the vaginal skin, resulting in painful intercourse and bleeding, an increased risk of infection and a reduced elasticity of the bladder, which produces urinary frequency, urgency and pain.

Treatment is with a topical oestrogen cream or a short course of oral oestrogen replacement. Vaginal bleeding after menopause is an ominous sign and you should speak to your GP as soon as possible.

*Women, trans men, people who are non-binary who were assigned female at birth, and cis gender women.

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Cardiovascular disease (CHD): this is unusual in women before the menopause but post-menopausal women are at much higher risk. This is thought to be due to the withdrawal of the protective effect of oestrogen around the time of menopause, although this explanation is not universally accepted. Around the menopause, many women experience obesity, high blood pressure and a rise in cholesterol levels; collectively these will contribute to the risk of CHD.

Postmenopausal osteoporosis: during and after the menopause women are at an increased risk of bone fractures and osteoporosis.

Breast disease: the risk of breast cancer increases with age but the rate of increase slows after the menopause. A woman who has a menopause in her late 50s has twice the risk of developing breast cancer as one whose menopause occurred in her early 40s.

Treatment: despite the controversy surrounding the risks and benefits, HRT is the mainstay of treatment in this condition. See below for more information. The following can be used as alternative therapies to HRT in the management of symptoms of menopause:

- **Lifestyle measures:** regular, sustained aerobic exercise can improve several menopause -related symptoms. Avoidance/reduction of alcohol and caffeine intake may also help to reduce the severity and frequency of vasomotor symptoms (hot flushes).

- **Pharmacological alternatives:** certain medications, which need to be prescribed by a GP, can help to reduce hot flushes.

- **Stellate ganglion blockade:** an injection of local anaesthetic into the collection of nerves in the lower end of the neck can be effective against hot flushes and sweating where a person cannot take HRT/other treatments don't work.

- **Diet and supplements:** calcium and vitamin D supplements and exercise for prevention of osteoporosis.

- **Complementary therapies:** the efficacy and safety of these are not proven and some may be possibly harmful, so it is best to speak with your GP before using these.
- **Psychological support:** cognitive behavioural therapy may help to alleviate low mood or anxiety that arises because of menopause.

HRT: this aims to replace oestrogen in the postmenopausal woman and so reverse the adverse effects of lack of oestrogen. The aim is to improve a woman's quality of life.

The appropriate type of HRT depends on several factors: whether or not an individual has had a hysterectomy, the woman's menopausal status (perimenopausal versus postmenopausal), preference for type of treatment (oral versus non-oral), the individual's past medical history and the current prescribed medication. Risks:

- **Breast cancer:** studies show that for women around menopausal age, oestrogen-only HRT causes little or no change in the risk of breast cancer. HRT containing oestrogen and progestogen may increase breast cancer risk. This risk may be higher if you take HRT for longer but falls again when you stop taking HRT.

- **Cardiovascular disease (heart disease and stroke):** if you start HRT before you are 60, it does not increase your risk of cardiovascular disease. However, HRT tablets (but not patches or gels) slightly raise the risk of stroke. The presence of cardiovascular risk factors is not a contraindication to taking HRT, as long as the risks are optimally managed.

- **Blood clots (venous thromboembolism):** Postmenopausal hormone therapy has been associated with an increase in the risk of venous thromboembolism (including deep-vein thrombosis and pulmonary embolism/ clots on the lungs).

If you would like more information on the menopause please visit www.imsociety.org/

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Refs: The International Menopause Society (IMS). Menopause Terminology Grady D. Clinical practice. Management of menopausal symptoms. N Engl J Med. 2006;355(22):2338-47 Rao SS et al. Health maintenance for postmenopausal women. Am Fam Physician. 2008;78(5):583-91 NICE (November 2015). Menopause: diagnosis and management Currie H, Cochrane R. Current options in the treatment of menopausal symptoms. Prescriber 2010;21(13) http://www.ncbi.nlm.nih.gov/pubmed/17135587 Grady D. Clinical practice. Management of menopausal symptoms. N Engl J Med. 2006;355(22):2338-47. NICE (November 2015). Menopause: diagnosis and management https://www.nice.org.uk/guidance/ng23/ifp/chapter/Benefits-and-risks-of-HRT