HealthPathways Melbourne

Putting knowledge into practice

CASE STUDY 21:

HealthPathways Melbourne assistance with menopause

Nadine is 47 years old and presents to her local GP with a nine-month history of night sweats, low mood, fatigue and sleep disturbance. She reports that her work as a community mental health worker has been very stressful lately and things have not been going well at home. She has recently found out that her 16-year-old daughter has been drinking alcohol, smoking, and skipping school to spend time with a boy that Nadine doesn't know.

On top of this, her relationship with her husband has been strained and they have not been intimate in a long time.

At night, she lies awake ruminating about work and her daughter, but is also troubled by drenching night sweats which started a few months ago. She hasn't had a menstrual period in about three months and feels she could be perimenopausal.

She has a history of depression in her 20s and 30s but doesn't feel she is depressed at the moment – "just flat". She knows the GP can't help with her issues at home or work, but if they could just help her with the night sweats then she feels she could carry on. She has heard about a new non-hormonal medication that might help her hot flushes and she's interested in this because of "the cancer risks with HRT".

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Menopause is not an area in the GP is very experienced with, so he consults the Menopause pathway on HealthPahways Melbourn to guide the consultation. This leads him to the Australasian Menopause Society's (AMS) Symptom Score Card, which he goes through with Nadine. He finds that she has also noticed irritability, vaginal dryness, joint aches and a loss of libido.

2. Take a detailed history – ask about:

- associated symptoms.

Associated symptoms

- Hot flushes
- Night sweats
- Sleep disturbance
- Vaginal dryness
- Dyspareunia
- Joint pains
- Urinary or sexual dysfunction (often not reported)
- Mood disturbance (particularly in those with a previous history)
- Other symptoms

Consider using a symptom score card

Nadine has no other medical conditions and is not taking any medications. She is up-to-date with cervical and bowel screening. She has not started routine breast screening yet, but will do so from age 50. She admits to drinking more alcohol than usual lately to wind down at the end of the day (two or three glasses of wine most nights). She tends to eat on the go at work so sometimes doesn't make the best dietary choices, and she has not been able to find the time or energy to exercise in about a year, despite previously enjoying about three five kilometre runs per week.

She has no significant family history of cardiovascular diseases, diabetes or cancer, but both her mother and her grandmother have osteoporosis and have had fragility fractures - something she is desperate to avoid.

On examination, Nadine looks exhausted. She is 75kg with a BMI of 27 and her blood pressure is 133/92. The GP suspects Nadine is perimenopausal but considers other differential diagnoses like thyroid dysfunction.

Following the Menopause pathway, he explains to her that perimenopause is a clinical diagnosis because hormone levels in this time period are variable. However, he recommends doing some blood tests to rule out other conditions and do a midlife health assessment before moving on to management.

6. Arrange investigations if indicated.

Investigations

- Hormone blood tests are not routinely required or recommended for menopause diagnosis. Arrange investigations for menopause diagnosis only if necessary.

Investigations for menopause diagnosis

- If aged ≥ 45 years and symptoms are consistent with menopausal changes, do not routinely arrange hormone blood tests. Hormone levels may fluctuate daily and be misleading.
- If aged < 45 years, or menopause is not clear on history and confirmation is required, take 2 follicle-stimulating hormone (FSH) and estradiol measurements at least 6 weeks apart. Elevated FSH (greater than around 25 units per litre) and low estradiol < 100 pmol/L strongly suggests menopause.

He also encourages Nadine to read some information sheets (found in the "Information for Patients" section of the Menopause pathway) before the next appointment, especially those on the risks and benefits of menopause hormone therapy, and the details of non-hormonal and non-pharmacological alternatives.

Nadine is happy with this plan and leaves with a pathology request and some printed information.

She returns the following week for a long appointment, as suggested. Her blood tests are unremarkable aside from an increase in LDL and triglycerides. Notably, she does not have diabetes and her thyroid function is normal.

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After reading the information sheets, Nadine feels better informed about the real risks of menopause hormone therapy, and the GP is able to return to her particular concern around cancer risk by referring to the resources provided on the Menopause Hormone Therapy pathway. He explains that the added risk of breast cancer when on MHT is very much dependent on the patient's age, individual risk factors, and both the duration and type of MHT used – something that would be discussed in great detail if she was interested in hormone treatment.

5. Discuss risks versus benefits with the patient in detail prior to prescribing MHT.

> **Risks versus benefits**
>
> MHT can provide significant benefits for some patients but it can also increase the risk for other medical conditions, such as breast cancer and thromboembolic events, depending on the patient's age, personal risk factors, and the type and duration of MHT prescribed. See:
>
> - NICE – HRT and the Likelihood of Some Medical Conditions: A Discussion Aid for Healthcare Professionals and Patients

At this stage, Nadine would still like to try a non-hormonal option first. Although initially interested in the newly approved fezolinetant for vasomotor symptoms, she now understands that this won't help with any other symptoms of menopause and is keen to see if she can also improve her sleep and mood.

Using the Menopause pathway, the GP explores the other non-hormonal options with her and they agree to trial desvenlafaxine alongside other measures such as reducing alcohol intake, increasing exercise and beginning some mindfulness exercises. She declines a referral for cognitive behavioural therapy at this stage. For her bone health, the GP also encourages her to commence a vitamin D supplement due to her limited sun exposure, as well as engage in weight-bearing exercise.

4. If MHT is contraindicated or the patient has a preference for non-hormonal options, consider alternatives to MHT.

> **Alternatives to MHT**
>
> Most non-hormonal treatments are only effective for vasomotor symptoms and are used "off-label" for this indication. Prior to prescribing, see Therapeutic Guidelines, Australasian Menopause Society, or similar authoritative source.
>
> - Selective serotonin reuptake inhibitors (SSRI) or selective noradrenaline reuptake inhibitors (SNRI):
> - Fezolinetant
> - Oxybutynin

Four weeks later, Nadine reports she is having significantly fewer night sweats and she is starting to feel a bit more like her old self. She is keen to continue.

She returns to the GP six months later reporting that although she is better than when she first came to see him, menopausal symptoms are still making life difficult for her. She managed to start running again, has reduced her alcohol intake to a few glasses of wine on the weekend only and practises daily mindfulness. She feels less anxious than she did, sleep has improved somewhat, and her night sweats have reduced from multiple times a night to multiple times a week.

The improvement in night sweats has been appreciated but they still trouble Nadine greatly and her vaginal dryness is making intercourse with her husband uncomfortable, despite non-hormonal measures like lubricant and vaginal moisturiser use. She wonders whether a hormonal option might be worth considering.

After discussing options such as adjusting the dose of her desvenlafaxine, exploring other non-hormonal medications, and considering vaginal oestrogen for her genital symptoms, she expresses that she would rather try systemic hormone treatment. Turning to the Menopause Hormone Therapy pathway, the GP explains to her that because she has an intact uterus, she would need combined hormone therapy (oestrogen, plus progesterone for endometrial protection).

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Using the pathway to guide him, the GP checks that Nadine has no contraindications to the use of hormonal therapy and they have a lengthy discussion of Nadine's personal risks, with the help of the NICE decision aid linked to from the Menopause Hormone Therapy pathway. Although a low dose contraceptive pill or a combination of transdermal or oral oestrogen plus a 52mg levonorgestrel IUD are also discussed as options, Nadine favours cyclic MHT because she does not need cycle control and her husband has had a vasectomy.

5. For patients in the menopausal transition (still menstruating or < 12 months since last period), consider treatment that could incorporate menstrual cycle management, contraception, and menopausal symptom control.

Hormonal treatment options for patients in the menopausal transition

Choices include:

- low dose AMH combined oral contraceptive pill (if no contraindications).
- continuous transdermal or oral AMH estrogen with a 52 mg AMH evonorgestrel IUD for endometrial protection, contraception, and cycle control.
- continuous transdermal or oral AMH estrogen with cyclic 4 mg AMH drospirenone [2] (a contraceptive also thought to be adequate for endometrial protection in MHT, but not currently approved by the TGA for this indication)

The Menopause Hormone Therapy pathway then directs the GP to a resource with specific options and dosing information which he shares with Nadine. After learning that transdermal oestrogen carries a lower risk of thromboembolism than oral, and micronised progesterone is associated with a lower breast cancer risk than older synthetic progestogens, Nadine opts for a combination of daily estradiol gel plus oral micronised progesterone taken for 12 days out of a 28-day cycle.

Combined MHT

- Combined MHT refers to a combination of estrogen and progestogen, which can be administered orally or transdermally.
- Estrogen via the transdermal route carries a lower risk of thromboembolism so should be considered in all patients, but especially those with other risk factors (e.g., overweight, smoker).
- AMH Norethisterone is the only progestogen that is reliably absorbed through the skin (and thus used in AMH combined MHT patches). Other progestogens need to be taken orally or delivered locally via the AMH 52 mg levonorgestrel IUD in order to confer adequate endometrial protection.
- If using an oral progestogen, AMH micronised progesterone is associated with a lower breast cancer risk than older synthetic progestogens

The GP reviews Nadine two months later to find her symptoms have dramatically improved and she has no concerns. She continues to present six to 12 monthly thereafter for scripts and review, at which time the GP uses the MHT pathway to guide him through discussions of treatment duration, any new contraindications, and the management of any side effects as needed.

13. When the patient is stable on MHT, review efficacy, side-effects, and risks every 6 to 12 months, with specific discussion of

- management of side-effects of systemic MHT .

Management of side-effects of systemic MHT

- Breast tenderness
- Nausea
- Unscheduled vaginal bleeding