Guideline on Menopause

Prepared by

MENOPAUSE Society of Nepal

MESON Guideline on Menopause

Introduction

Menopause is defined retrospectively as the time of the final menstrual period followed by twelve months of amenorrhoea. Postmenopause describes the period following the final menses. The transition from regular menstrual cycle to ceasation of menstrual period is rarely a sudden phenomenon. Most women can tell if they are approaching menopause when their menstrual periods start changing. For a year or two, periods may be regular. But scanty or less menses may occur at larger intervals or heavy menstruation with or without clots may be reported before menopause is reached.

Manifestation of various symptoms and problems at menopause is not uniform. Tolerance of different women for these symptoms also varies. That is why it is important to understand as much about it as possible.

The age at menopause appears to be genetically determined and is unaffected by race, socioeconomic status, age at menarche or number of prior ovulations. Factors that are toxic to the ovary often result in an earlier age of menopause; women who smoke experience an earlier menopause, as do many exposed to chemotherapy or pelvic radiation. Women who have had surgery on their ovaries, or have had a hysterectomy, despite retention of their ovaries, also may experience early menopause. Premature ovarian failure, defined as menopause before the age of 40 years, occurs in approximately in 1% of women. It may be idiopathic or associated with a toxic exposure, chromosomal abnormality or autoimmune disorder.

Although menopause is associated with the changes in the hypothalamic and pituitary hormones that regulate the menstrual cycle, menopause is not a central event, but rather primary ovarian failure. At the level of the ovary, there is a depletion of ovarian follicles, most likely secondary to apoptosis or programmed cell death. The ovary, therefore, is no longer able to respond to the pituitary hormones, follicle-stimulating hormone (FSH), and luteinizing hormone (LH), and ovarian estrogen and progesterone production cease. Menopause occurs due to decline in female hormone levels. These levels fluctuate for several years before eventually becoming so low that the lining of uterus becomes thin and the bleeding stops. Menopause occurs at a mean age of 47 years in Nepal and 51 years in the Western countries.

Principal health concerns of menopausal women include vasomotor symptoms, urogenital atrophy, osteoporosis, cardiovascular disease, cancer, cognitive decline and sexual problems. Many options now available including hormone therapy make caring for postmenopausal women more rewarding as well as more challenging.

Objectives

To assist health care practitioners in providing optimal and holistic care to the women in transition phase.

To aid primary care physicians to decide when to refer patients with difficult problems to the relevant specialists.

To sensitize the healthcare professionals, policy makers toward the health of the aging woman and thus promote the concept of menopausal clinics.

To stimulate interest in research on all aspects of menopausal medicine.

Methods

The guideline is based on clinical practice guidelines on menopause by the Indian Menopausal Society, NICE guidelines, a guidebook on menopause.

Symptoms of menopause, issues related to menopause transition and aging

Change in pattern of menstrual cycle

The most common indicator of irregular periods is a shorter than a normal interval between periods, often as little as two weeks. In other cases, symptoms of irregular periods during menopause may consist of more widely spaced periods, including menstruation that comes every six weeks or even less frequently. Some women will even miss a period or several in a row before resuming their regular menstrual cycle.

When menstrual pattern changes during perimenopause, bleeding may last for as long as a week or as little as 1-2 days. In some cases, the menstrual flow itself will vary, some women will experience lighter periods than what is normal for them, while others may have heavier flow.

One or more of a combination of range in pattern of menstrual period given below may occur in a woman.

- More frequent periods
- Shorter periods
- Longer periods
- Skipped periods
- Months without periods
- Noticeable blood clots during menstruation
- Bleeding in between periods
- Changes in menstrual flow
- Abdominal cramps
- Breast tenderness

Hot flushes

It is a momentary sensation of heat that may be accompanied by a red, flushed face and sweating. Hot flushes occur when the blood vessels near the skin's surface dilate. So, blood flow comes closer to the outer skin surface. This produces the red, flushed look on the face. A woman may also perspire to cool down the body and some may feel cold sensation. In addition, some women experience a rapid heart rate or chills. Hot flushes accompanied with sweating can also occur at night (night sweats). All these interfere with sleep.

Hot flushes may last from about one to five minutes. The severity and duration varies among different women going through menopause. Some have for a very short time during menopause while others have, at least to some degree, for rest of their life. Generally, it becomes less severe as time passes.

Night sweats

Sudden intense overheating, flushing and drenching perspiration are the primary symptoms of menopause. It may be accompanied by rapid and irregular heartbeats. It may cause nausea or headache and may also contribute to the development of insomnia or nightmares.

Most common night sweat symptoms are:

- Sweating
- Excessive perspiration
- Irregular heartbeats (arrhythmia)
- Rapid heart rate
- Headache
- Nausea
- Chills
- Panic attacks
- Bizarre or disturbing dreams
- Insomnia
- Exhaustion
- Difficulty in concentrating

Reasons that trigger night sweats:

There are also many external triggers that can set off night sweats.

- Environmental factors: warm weather or an overheated bedroom
- Dietary factors: consuming hot or spicy foods, alcohol, caffeine and smoking

- Psychological factors: stress and anxiety

Vaginal dryness

With the onset of menopause, there is dryness, thinning and loss of elasticity in vaginal walls leading to itching, flaking, burning sensation of genital skin and dyspareunia. In some cases, bleeding may also occur due to vaginal atrophy.

Aches and Pain

One peculiar symptom of menopause is an increase in frequency of headache, neck, joint pain and backache.

a. Headache: There may be persistent pain, pressure and tension in the head due to hormonal imbalance. These related symptoms are considered menopausal headache. These may vary from surging, pulsating pain in the head and throbbing in the forehead or temples. Headache may be associated with one or more of the following:
    - Neck pain
    - Visual distortion
    - Sinus pressure
    - Tension
    - Nausea
    - Vomiting
    - Sweating palms
    - Sensitivity to sound
    - Light sensitivity

b. Joint pain: This occurs when the joints become swollen, stiff or painful during menopause. This is also known as ‘menopausal arthritis’. There may be pain and soreness in the back, knee joints and hips. Some may find fingers and wrists become especially sore, particularly with repetitive motion. Joint pain may vary as follows
    - Stiff joints
    - High impact pain
    - Swelling around joints
    - Painful joints
    - Limited range of motion
    - ‘Creaking knees’
    - Swollen ankles

- Finger and wrist pain
- Pain that subsides with rest
- Difficulty in walking or running
- Backache
- Burning sensation
- Numbness

Urinary incontinence

There are two primary types of urinary incontinence related to menopause:

a. Stress urinary incontinence: This is the common one which occurs when there is increased pressure in the urinary bladder by laughing, sneezing, coughing or lifting of heavy weights.
b. Urge urinary incontinence: There is a sudden need to urinate, often leading to uncontrollable release of urine.

Both of this incontinence occurs as a result of the hormonal imbalance of menopause, primarily, lack of estrogen. In addition, bladder muscles tend to weaken during menopause.

Skin problems

Skin becomes thinner at menopause as the estrogen level decline. There is reduction in collagen production that makes the skin more cushioned and flexible. This increases the appearance of wrinkles around the face particularly around the eyes and mouth. Menopausal changes also affect the body's ability to retain moisture leading to itchy skin.

Itching during the menopause may also occur in secondary situations, accompanied by rashes, skin flushing, eczema or other skin problems. Women may experience itches on the face, T-zone, forehead, nose and chin. Menopause itching can also affect throughout the body, such as chest, abdomen, extremities especially elbows, and back. Some even experience itching under their fingernails.

Weight gain

About 90% of menopausal women experience some amount of weight gain. It occurs because the body mass increases, as a result of fat deposits. This weight gain typically involves increased amounts of fat around the abdomen. On an average, weight gain is about 8-10 kilograms between the ages of 45 and 55, the stage in life when menopause occurs. This extra weight generally does

not evenly distribute itself throughout a woman's body. The weight tends to accumulate around the abdomen or thighs.

Beginning at about the age of 30, an individual's physical abilities begin to decrease and continue deteriorating until the age of 60 or 70. The body's abilities then level off and decline at a slower rate. The rate of decline depends on an individual's physical activity and lifestyle. Stress, reduced physical activity, change in eating habit, certain medication may also lead to weight gain. This can itself lead to very serious health conditions, e.g.; heart disease, stroke, high blood pressure, osteoarthritis, breast cancer, high cholesterol, renal disease, sleep apnea, insulin resistance or more severe menopausal symptoms.

Mood swings

Mood swings are defined as extreme or abrupt fluctuations in mood. It is an emotional reaction that is inappropriate to its cause or trigger and during this period, people often experience drastic shifts in their emotional state. Because each woman has her own unique way of managing her emotions, stress and her environment, all women experience the symptoms of mood swings differently. However, many symptoms of mood swings are common among women going through menopause. Frequent mood changes are:

- Unexplained emotions
- Sadness
- Aggression
- Increased stress
- Depression
- Lack of motivation
- Irritability
- Impatience
- Nervousness
- Anxiety

Mood swings during menopause are caused by the hormonal transitions women go through during this time. Estrogen influences the production of serotonin, which is a mood regulating neurotransmitter. However, other menopause symptoms such as hot flushes, night sweats, physical changes and fatigue can cause or intensify mood swings.

Risk factors for mood swings:

Health factors: diabetes, heart disease, thyroid disorder, cancer, early menopause, sleep disorders.

Behavioral factors: smoking, alcohol intake, poor diet, inadequate exercise.

Psychological factors: past history of psychological disorders / trauma, stress, relationship issues, coping with change.

Sleep disturbance

A healthy adult needs approximately 7-8 hours of undisturbed sleep. Yet, many women do not receive the proper sleep leading to weakened immune system. For menopausal women, the most commonly reported sleep disorders are insomnia, sleep apnea, snoring and restless leg syndrome. Women who wake up more often during the night get tired and cannot concentrate on work during the day.

The symptoms caused by sleep disorders are often closely related to other symptoms of menopause, for e.g.; night sweats, the night time version of hot flushes can disrupt sleep patterns by causing a woman to awaken several times during the night. Sleep disorders can also lead to further depression and anxiety which may make sleep difficult. This can cause vicious cycle of lack of sleep, fatigue and other symptoms of menopause.

Below is a list of risk factors that can make a woman more susceptible to sleep disorders:

Obesity, elderly people, use of drugs, smoking, alcohol and caffeine intake, a job with rotating/night shifts, inactivity/lack of exercise, high blood pressure.

Diagnosis of perimenopause and menopause

Diagnose the following without laboratory tests in otherwise healthy women aged over 45 years with menopausal symptoms:

- Perimenopause based on vasomotor symptoms and irregular periods.
- Menopause in women who have not had a period for at least 12 months and are not using hormonal contraception
- Menopause based on symptoms in women without a uterus.

Take into account that it can be difficult to diagnose menopause in women who are taking hormonal treatments, for e.g., for the treatment of heavy periods.

Do not use the following laboratory and imaging tests to diagnose perimenopause or menopause in women aged over 45 years:

- Anti-Mullerian hormone
- Inhibin-A
- Inhibin-B

- Estradiol
- Antral follicle count
- Ovarian volume

Do not use a serum FSH test to diagnose menopause in women using combined estrogen and progestogen contraception or high dose progestogen.

Consider using a FSH test to diagnose menopause only:

- In women aged 40 to 45 years with menopausal symptoms, including a change in their menstrual cycle.
- In women aged under 40 years in whom menopause is suspected.

Information and Advice

Give information to menopausal women and their family members or carers (as appropriate) that includes:

- An explanation of the stages of menopause.
- Common symptoms and diagnosis.
- Lifestyle changes and interventions that could help general health and wellbeing.
- Benefits and risks of treatments for menopausal symptoms.
- Long-term health implications of menopause.

Explain to women that as well as a change in their menstrual cycle, they may experience a variety of symptoms associated with menopause, including:

- Vasomotor symptoms (for e.g., hot flushes and sweats)
- Muskulosketal symptoms (for e.g., joint and muscle pain)
- Effects on mood (for e.g., low mood)
- Urogenital symptoms (for e.g., vaginal dryness)
- Sexual difficulties (for e.g., low sexual desire)

Give information to menopausal women and their family members or carers (as appropriate) about the following types of treatment for menopausal symptoms:

- Hormonal, for example, hormone replacement therapy (HRT)
- Non-hormonal, for example, Clonidine
- Non-pharmaceutical, for example, cognitive behavioural therapy (CBT)

Give information on menopause in different ways to help encourage women to discuss their symptoms and needs.

Give information about contraception to women who are in the perimenopausal and postmenopausal phase.

Offer women who are likely to go through menopause as a result of medical or surgical treatment (including women with cancer, at high risk of hormone sensitive cancer or having gynecological surgery) support and:

- Information about menopause and fertility before they have their treatment.
- Referral to a healthcare professional with expertise in menopause.

Managing short-term menopausal symptoms

Vasomotor symptoms

Offer women HRT for vasomotor symptoms after discussing with them the short-term (upto 5 years) and longer-term benefits and risks. Offer a choice of preparations as follows:

- Estrogen and progestogen to women with a uterus
- Estrogen alone to women without a uterus

Do not routinely offer selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) or Clonidine as first-line treatment for vasomotor symptoms alone.

Explain to women that there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms. However, explain that:

- Multiple preparations are available and their safety is uncertain.
- Different preparations may vary.
- Interactions with other medicines have been reported.

Psychological symptoms

Consider HRT to alleviate low mood that arises as a result of the menopause.

Consider CBT to alleviate low mood or anxiety that arises as a result of the menopause.

Ensure that menopausal women and healthcare professionals involved in their care understand that there is no clear evidence for SSRIs or SNRIs to ease low mood in menopausal women who have not been diagnosed with depression.

Altered sexual function

Consider testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective.

Urogenital atrophy

Offer vaginal estrogen to women with urogenital atrophy (including those on systemic HRT) and continue treatment for as long as needed to relieve symptoms.

Consider vaginal estrogen for women with urogenital atrophy in whom systemic HRT is contraindicated, after seeking advice from a healthcare professional with expertise in menopause.

If vaginal estrogen does not relieve symptoms of urogenital atrophy, consider increasing the dose after seeking advice from a healthcare professional with expertise in menopause.

Explain to women with urogenital atrophy that:

- Symptoms often come back when treatment is stopped.
- Adverse effects from vaginal estrogen are very rare.
- They should report unscheduled vaginal bleeding.

Advise women with vaginal dryness that moisturizers and lubricants can be used alone or in addition to vaginal estrogen.

Do not offer routine monitoring of endometrial thickness during treatment for urogenital atrophy.

Complementary therapies and unregulated preparations

Explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown.

Explain to women who wish to try complementary therapies that the quality, purity and constituents of products may be unknown.

Advise women with a history of, or at high risk of, breast cancer that, although there is some evidence that St John’s wort may be of benefit in the relief of vasomotor symptoms, there is uncertainty about:

- Appropriate doses
- Persistence of effect
- Variation in the nature and potency of preparations

- Potential serious interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants).

Review and referral

Discuss with women the importance of keeping up to date with nationally recommended health screening.

Review each treatment for short-term menopausal symptoms

- At 3 months to assess efficacy and tolerability
- Annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness, side effects or adverse events).

Refer women to a healthcare professional with expertise in menopause if treatments do not improve their menopausal symptoms or they have ongoing troublesome side effects.

Consider referring women to a healthcare professional with expertise in menopause if:

- They have menopausal symptoms and contraindications to HRT or
- There is uncertainty about the most suitable treatment options for their menopausal symptoms.

Starting and stopping HRT

Explain to women with a uterus that unscheduled vaginal bleeding is a common side effect of HRT within the first 3 months of treatment, but should be reported at the 3-month review appointment, or promptly if it occurs after the first 3 months.

Offer women who are stopping HRT a choice of gradually reducing or immediately stopping treatment.

Explain to women that:

- Gradually reducing HRT may limit recurrence of symptoms in the short term.
- Gradually reducing or immediately stopping HRT makes no difference to their symptoms in the longer term.

Women with, or at high risk of, breast cancer

Offer menopausal women with, or at high risk of,breast cancer

- Information on all available treatment options.

- Information that the SSRIs paroxetine and fluoxetine should not be offered to women with breast cancer who are taking tamoxifen.
- Referral to a healthcare professional with expertise in menopause.

Long-term benefits and risks of HRT

Venous thromboembolism

Explain to women that:

- The risk of venous thromboembolism (VTE) is increased by oral HRT compared with baseline population risk.
- The risk of VTE associated HRT is greater for oral than transdermal preparations.
- The risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline population risk.

Consider transdermal rather than oral HRT for menopausal women who are at increased risk of VTE, including those with a BMI over 30 kg/m^2.

Consider referring menopausal women at high risk of VTE (for e.g., those with a strong family history of VTE or a hereditary thrombophilia) to a hematologist for assessment before considering HRT.

Cardiovascular disease

Ensure that menopausal women and healthcare professionals involved in their care understand that HRT:

- Does not increase cardiovascular disease risk when started in women aged under 60 years.
- Does not affect the risk of dying from cardiovascular disease.

Be aware that the presence of cardiovascular risk factors is not a contraindication to HRT as long as they are optimally managed.

Explain to women that:

- The baseline risk of coronary heart disease and stroke for women around menopausal age varies from one woman to another according to the presence of cardiovascular risk factors.
- HRT with estrogen alone is associated with no, or reduced, risk of coronary heart disease.

- HRT with estrogen and progestogen is associated with little or no increase in the risk of coronary heart disease.

Explain to women that taking oral (but not transdermal) estrogen is associated with a small increase in the risk of stroke. Also explain that the baseline population risk of stroke in women aged under 60 years is very low.

Type 2 diabetes

Explain to women that taking HRT (either orally or transdermally) is not associated with an increased risk of developing type 2 diabetes.

Ensure that women with type 2 diabetes and all healthcare professionals involved in their care are aware that HRT is not generally associated with an adverse effect on blood glucose control.

Consider HRT for menopausal symptoms in women with type 2 diabetes after taking comorbidities into account and seeking specialist advice if needed.

Breast cancer

Explain to women around natural menopause that:

- The baseline risk of breast cancer for women around menopausal age varies from one woman to another according to the presence of underlying risk factors.
- HRT with estrogen alone is associated with little or no change in the risk of breast cancer.
- HRT with estrogen and progestogen can be associated with an increase in the risk of breast cancer.
- Any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT.

Osteoporosis

Explain to women that the baseline population risk of fragility fracture for women around menopausal age varies from one woman to another.

Explain to women that their risk of fragility fracture is decreased while taking HRT and that this benefit:

- is maintained during treatment but decreases once treatment stops.
- may continue for longer in women who take HRT for longer.

Dementia

Explain to menopausal women that the likelihood of HRT affecting their risk of dementia is unknown.

Loss of muscle mass and strength

Explain to women that:

- There is limited evidence suggesting that HRT may improve muscle mass and strength.
- Muscle mass and strength is maintained through, and is important for, activities of daily living.

Diagnosing and managing premature ovarian insufficiency

Diagnosing premature ovarian insufficiency

Take into account the woman's clinical history (for e.g., previous medical or surgical treatment) and family history when diagnosing premature ovarian insufficiency.

Diagnose premature ovarian insufficiency in women aged under 40 years based on:

- Menopausal symptoms, including no or infrequent periods (taking into account whether the woman has a uterus) and
- Elevated FSH levels on 2 blood samples taken 4-6 weeks apart.

Do not diagnose premature ovarian insufficiency on the basis of a single blood test.

Do not routinely use anti-Mullerian hormone testing to diagnose premature ovarian insufficiency.

If there is doubt about the diagnosis of premature ovarian insufficiency, refer the woman to a specialist with expertise in menopause or reproductive medicine.

Managing premature ovarian insufficiency

Offer sex steroid replacement with a choice of HRT or a combined hormonal contraceptive to women with premature ovarian insufficiency, unless contraindicated (for e.g., in women with hormone-sensitive cancer).

Explain to women with premature ovarian insufficiency:

- The importance of starting hormonal treatment either with HRT or a combined hormonal contraceptive and continuing treatment until at least the age of natural menopause (unless contraindicated).
- That the baseline population risk of diseases such as breast cancer and cardiovascular disease increases with age and is very low in women aged under 40.
- That HRT may have a beneficial effect on blood pressure when compared with a combined oral contraceptive.
- That both HRT and combined oral contraceptives offer bone protection.
- That HRT is not a contraceptive.

Give women with premature ovarian insufficiency and contraindications to hormonal treatment advice, including on bone and cardiovascular health, and symptom management.

Consider referring women with premature ovarian insufficiency to healthcare professionals who have the relevant experience to help them manage all aspects of physical and psychosocial health related to their condition.

Remedies for symptoms of menopause

Irregular periods

Women should add more of green leafy vegetables, fruits, vitamin C and A enriched food in their diet. If the bleeding is heavy and prolonged, endometrial biopsy is required.

Hot flush

To prevent hot flush:

- Drink plenty of water. Avoid caffeinated drinks such as coffee, tea, soda.
- Stay cool: Use fans. Wear light layers of clothes with natural fibers, such as cotton.
- Breathing exercise: try deep, slow abdominal breathing (six to eight breaths per minute), 15 minutes in the morning, 15 minutes in the evening and at the onset of hot flushes.
- Fresh air: go for a short walk or venture out in balcony.
- Exercise daily: walking, swimming, dancing and yoga help women to stay fit.
- Diet: consume diet rich in vitamins, minerals and whole grains and soya. Avoid alcohol and spicy diet.

Night sweats

To prevent night sweats:

- Avoid doing anything that could stress out body or mind.
- Avoid spicy food and caffeinated food/drinks before bedtime.
- Avoid large meals before going to bed. Avoid office/household works before going to bed.
- Deep breathing exercise for 15 minutes every morning and night before sleep.
- Always wear light/loose cotton clothes.
- Keep your bedroom cool.

Vaginal dryness

To reduce vaginal dryness:

Women may use specialized topical moisturizers or water based lubricants in order to reduce the effects of vaginal dryness temporarily.

Aches and pains

To prevent aches and pains:

Exercise, stretching and physical therapy can prevent aches and pains. Calcium and vitamin D enriched food should be taken as part of a balanced menopause diet.

Bladder problems

To prevent bladder problems:

- Kegel's exercise helps to strengthen the muscles of the pelvic floor.
- Drink plenty of fluids during the day, but limit fluid intake 2 to 3 hours before going to sleep.
- Reduce intake of fluids or beverages that increase urination or may irritate the bladder, for e.g., coffee, tea, alcohol.
- Empty the bladder completely when you urinate, bladder training also helps.

Skin problems

To avoid skin problems and itching:

- Consumption of fatty acids, vitamins and minerals (particularly, vitamin B, D and E) and proteins.
- Avoid harsh soaps.
- Avoid scratching
- Use of moisturizing creams that can replenish the skin's lost moisture.
- Drink plenty of water.
- Maintain good hygiene.

Weight gain

To control weight:

- Eat balanced diet.
- Avoid sweets, rice, fried foods, 'maida' based food, etc.
- Avoid alcohol, tea, coffee, soda/cola products.
- Get sleep of 7 to 8 hours daily
- Regular exercise like yoga, walking, etc.
- Drink plenty of water.

Mood swings

Simple changes in life style can give good results in fighting mood swings and achieving a higher overall level of good health. For reducing stress, yoga or meditation, combined with regular exercise and an improved diet can do women a great help. Eating a balanced diet and avoiding sugary foods or excessive amount of caffeine stabilizes mood levels.

Sleep disturbance

For a good night sleep:

- Go to bed only when feeling sleepy.
- Sleep only in the bedroom.
- Get up at the same time each morning.
- Avoid caffeine, nicotine and alcohol.
- Regular exercise.
- Limit fluid intake in the evening.

- Practice relaxation techniques.

Approach to deal with problems of Menopause

- Having a positive attitude towards life
- Cultivate a hobby
- Being religious and spiritual
- Meditation
- Exercise
- Yoga
- Taking advice of a Gynecologist
- Generating family support

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