A *Two Houses* patient's consultation guide

Managing the menopause

The House of Discovery: work out what matters

To the patient

How do you feel about being menopausal? Is fertility an issue?

Do you want confirmation of the menopause, general advice, or are you looking for treatment of symptoms?

Which symptoms bother you the most? This will guide which treatment you might consider – Hormone Replacement Therapy (HRT) is best for flushing, topical oestrogen for dryness, maybe antidepressants or Cognitive Behavioural Therapy (CBT) if primarily a mood problem.

What are your views on HRT? Are there any personal, friend or family stories that have influenced you?

What do you think about alternative treatments? Your doctor might not want to initiate the idea of alternatives, and may not know much about them, but should be happy to discuss or explore if it is on your agenda. Most alternatives, such as *agnus castus* or *black cohosh*, are herbal remedies that may work in a similar way to the oestrogens in HRT, although how they work is far from certain.

To the doctor

Is it the menopause, or something else? Heavy or frequent periods may be due to the menopause, but there are many other causes.

Red flag symptoms? (these are symptoms that might be worrying and could indicate cancer) see below).

Does she need contraception? (see below).

Need to check her blood pressure before starting HRT.

Are there contraindications/cautions to HRT? There are few absolute contraindications to HRT (breast cancer being the main one), but it is important to consider the risk of breast cancer, risk of blood clots (deep vein thrombosis or pulmonary embolism) and Cardiovascular disease (CVD). Might need bloods to assess CVD or blood clot risk if there is a strong family history or personal risk factors.

What to look out for in the *House of Discovery*

Finding dry rot

There are two main areas where the GP might uncover unexpected bad news

The GP suspects the menopause, but you have not considered it. If this is premature then this could clearly be bad news, especially. if your family is not complete, but even if normal age for the menopause it can be an unwelcome milestone of ageing.

You have assumed it is the menopause, but symptoms are more worrying and a Two Week Rule referral is needed to rule out cancer.

Tools in your toolbox

"How do I know if this is the menopause?"

"What will happen if I do nothing about this?

"Do I need to be worried about these symptoms?"

"What is the best way to stop these symptoms?"

"What is the risk for me with HRT?"

"Should I still take contraception?"

Tending the garden

The GP will need to consider CVD risk when prescribing HRT, so this is a good time to see if this needs attention.

Is your BP ok?

Do you smoke?

Is weight an issue?

Is there family history of CVD?

If you are having blood tests, would it be an opportune time to check your cholesterol and a test for diabetes?

Foundations

Based on on 2017 NICE CKS on the menopause and MHRA Update Aug 2019 following key study in *The Lancet*.

Key symptoms of the peri-menopause: Change to menstrual cycle (usually fewer periods, but could be more frequent), flushing, night sweats, joint pains, mood and sleep disturbance, including an increase in restless legs syndrome, sexual dysfunction.

Key symptoms of post-menopausal state: Absence of periods, vaginal dryness, weakness of pelvic floor

Investigations: These are **not** usually needed as the menopause is a clinical diagnosis. Consider FSH/LH/Oestradiol in women <45 when symptoms are atypical, or if using a Mirena coil as amenorrhea occurs anyway. Impossible to interpret when taking oestrogens (e.g. when on HRT or combined pill) and guidance unclear about value of blood tests when on progesterone alone.

Symptoms to investigate: If age >45 a sudden change in bleeding pattern, irregular or post-coital bleeding usually needs referral (Two Week Rule if cervix looks abnormal). Postmenopausal bleeding needs Two Week Rule Referral

Contraception: A woman can be considered infertile due to the menopause once she is 55 years old, or has had 2 years without a period if < 50 years, or 1 year without a period if aged > 50 years. HRT does **not** provide contraception

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The House of Decision: decide together what to do

Rooms to look out for

Empty Rooms

You might expect too much from 'hormone' blood tests. The test is for FSH/LH levels and is purely binary – it tells you if you are at the menopause or not, but nothing more.

Hidden Rooms

You might not be aware of alternative treatments for the mood swings that can be associated with the menopause, which include cognitive behavioural therapy and antidepressants (SSRIs), don't be surprised if your GP mentions them.

Room 101

How do you feel about HRT? If this is premature menopause (age < 40) then declining HRT could have significant implications for bone strength. If you are young for the menopause and are worried about HRT it might help to see that you may only have to take it up to the natural age of the menopause, and breast cancer risk only really starts by extending the exposure to hormones well beyond 50. If this is an early menopause then you will need to balance the risks of HRT with the risk of osteoporosis (bone thinning that can lead to hip fractures and a crumbling spine) – do you have family members affected by this?

Key decisions in the *House of Decision*

Are investigations needed?

See Foundations for straight-forward menopause, but are there any odd symptoms that don't fit and might need looking into?

HRT or not? Which type of HRT?

HRT is for Quality Of Life (QOL) reasons and only has other health benefits in premature menopause. Don't forget lifestyle changes/CBT/SSRIs. See Foundations for whether to use oral or patches. Route of administration (oral/transdermal) has no bearing on breast cancer risk.

Contraception needed?

If so then the Mirena (hormone) coil and taking oestrogen on top can be ideal, but the idea of a coil is a very personal one. Remember that the combined pill will work as both contraception and HRT, so is a great alternative to HRT in younger women who need contraception and are low risk.

How long to use HRT for?

Generally 3-5 years, but depends on QOL when coming off it. No upper age limit if prepared to take the risks (esp oestrogen only)

The High Tech Room

Difference between peri- and post-menopause

The perimenopause could be seen as the ovaries misbehaving and sending out hormones in a random way, while the post-menopause is when the ovaries have gone to sleep.

Purpose of treatment

It is important to know that it is fine to go through a natural menopause, but also that treatment can really improve quality of life – which is the only reason to consider HRT.

There is a lot to explain in respect to the menopause – you don't want to be overloaded! Here are key messages to look at

Explaining Risks of HRT

If you want actual numbers your GP should be able to help with this, or show you Cates plots (charts with smiling/frowning faces!). Or you may just prefer to know if risks are big or small. Remember, the risks are due to extending the natural age of the menopause, so HRT under 50 is different to taking it beyond 50.

Risks of HRT

Per 1000 women age 50 for 5 years:
Breast cancer risk is biggest concern
Baseline: 13 cases
Oestrogen only HRT: +3 cases
Combined sequential HRT: +7 cases
Combined continuous HRT: +10 cases
With 10 years of HRT, risk doubles
Risk of Venous Thromboembolism (DVT/PE)
Baseline: 5 cases
Oestrogen only HRT: +2 cases
Combined HRT: + 7 cases
Other risks very low +1 case of stroke; no increased heart risk.

Foundations

Combined HRT or not: You can use oestrogen only HRT oestrogen if you have had a hysterectomy, but otherwise you must have progesterone as well (either systemic or in a hormonal coil) to prevent irregular bleeding and uterine cancer.

Sequential or Continuous HRT: Sequential (with either monthly or 3 monthly bleeds) is best in peri-menopause or you are likely to get abnormal bleeding. Use continuous in post-menopause – but some room for your own preference here when periods are infrequent. Slightly lower risk of breast cancer with sequential HRT.

Patches, transdermal gel, oral or vaginal: This is largely down to your preference, but patches can be better in some circumstances e.g. if you are also taking epilepsy drugs like carbamazepine. Vaginal oestrogen alone for vaginal dryness, no need to oppose with progesterone (no extra breast cancer risk).