# The House of Discovery: work out what matters

## To the patient

How does she feel about being menopausal? Is fertility an issue?

Does she want confirmation of the menopause, general advice, or is she looking for treatment of symptoms?

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

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

Simply asking 'what do you think about HRT?' can be a great way to start this conversation. What does she think about alternative treatments? You might not want to initiate the idea of alternatives, but it is helpful to explore if it is on her agenda.

## 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? (see below).

Does she need contraception? (see below).

Are there contraindications/cautions to HRT? There are few absolute CI to HRT (breast cancer being the main one), but it is important to consider risk of breast cancer, risk of VTE and CVD. Might need bloods to assess CVD or VTE risk if there is a strong family history or personal risk factors.

Need to check her blood pressure before starting HRT.

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

### Finding dry rot

There are two main areas where you might uncover unexpected bad news, so you need to be ready for them.

**You suspect the menopause, but she has not considered it**. If this is premature then this could clearly be bad news, esp. if family not complete, but even if normal age it can be an unwelcome milestone of ageing.

**She has assumed it is the menopause,** but symptoms are more worrying and a Two Week Rule referral is needed.

### Tools for the toolbox

"How would you feel if this was the menopause?"

"Did you just want to know if this was the menopause, or did you want to talk about how we might treat your symptoms?

"What do you think about HRT?"

"Which symptoms bother you the most?"

"How much do you know about HRT?"

### Tending the garden

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

Is her BP ok?

Does she smoke?

Is weight an issue?

Is there family history of CVD?

If you are doing blood tests, would it be an opportune time to check lipids/HbA1c?

## 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 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

# The House of Decision: decide together what to do

## Rooms to look out for

### Empty Rooms

Patients can expect too much from 'hormone' blood tests, when testing FSH/LH is purely binary – it tells you if you are at the menopause or not, but nothing more.

### Hidden Rooms

Alternative treatments for menopausal flushing – e.g. black cohosh. Some women will have heard of these, some will be unaware – what do you think of it as a doctor? Those that work probably contain phytoestrogens.

### Room 101

How does she feel about HRT? If this is premature menopause (age < 40) then declining HRT could have significant implications for bone strength. If she is worried about HRT it might help her to see that you would only be taking her up to the natural age of the menopause, and breast cancer risk only really starts by extending the exposure to hormones well beyond 50. Help her to balance the risks of HRT with the risk of osteoporosis – does she 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 reasons and only has prognostic 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 coil and systemic oestrogen 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

You could describe the first as the ovaries misbehaving and sending out hormones in a random way, and the latter as the ovaries going to sleep.

### Purpose of treatment

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 – don't overload her! Here are key messages to get across

### Explaining Risks of HRT

How to share this – you could use Cates plots, or could just have some of the key numbers to hand. Some women will want actual numbers, others will 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**
Baseline: 5 cases
Oestrogen only HRT: +2 cases
Combined HRT: + 7 cases
**Other risks very low** +1 case of stroke; no increased cardiac risk.

### Foundations

**Combined HRT or not:** Use unopposed oestrogen if a woman has had a hysterectomy, but otherwise she must have progesterone (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 she is likely to get abnormal bleeding. Use continuous in post-menopause – but some room for patient preference here when periods are infrequent. Slightly lower risk of breast cancer with sequential HRT.

**Patches, transdermal gel, oral or vaginal:** This is largely patient preference, but patches can be better in some circumstances e.g. if on enzyme inducing drugs like carbamazepine. Vaginal oestrogen alone for vaginal dryness, no need to oppose with progesterone (no extra breast cancer risk).