Common questions patients ask about menopause and related issues - addressing their fears, concerns and myths

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The internet and social media has transformed the patient experience. Previously, if a patient required information about menopause, a doctor would be the first "port of call". Patients relied heavily on their doctors to give them the most relevant and up-to-date information. This was usually obtained from journals, congresses and academic sources that only the doctor was privy to. General practitioners referred patients to specialists when necessary. Opinions of friends and information obtained from popular print media like newspapers and magazines were of secondary value.

Today, the situation is vastly different: the first reference that a patient will have to request information from, is the internet.[1] Google has now become the first "port of call". Information previously only available to the medical profession is now available to all. In addition, recommendations from family and friends via social media and online reviews, play a significant role not only in choosing a doctor or specialist, but also in deciding the diagnosis and planning any treatment strategies.[2] So in this age of information, often a patient will present to a doctor to confirm what they already suspect, and to get help in obtaining the necessary treatment, which they already know about. The doctor then merely becomes the facilitator of this process or a sounding board to finalise an already prepared treatment plan.

The issue of hormone replacement therapy (HRT) for menopause is no exception to this process. When the WHI was published in 2002 most women were taken off HRT due to fears around the increased incidence of cardiovascular disease, breast cancer and stroke, shown in the initial analysis.[3] However 16 years down the line, after many re-analyses and new studies, the information regarding the initial safety concerns of HRT has been revised. These revisions have been slow to make it to mainstream media and internet sites, most of which still carry dire warnings regarding HRT.

I am constantly amazed at how much negative publicity HRT still has. This has led many women, including those who present to my practice on a daily basis, to seek alternatives to HRT and often self manage their menopause symptoms with expensive and sometimes even potentially dangerous products that do not have proven efficacy.

My intention with this article is to highlight and dispel some of the myths regarding HRT and related issues in the menopause that has been part of my own patient experience. In so doing, I hope to assist my fellow health professionals and increase confidence levels with advising and treating patients in the menopause. I understand that every practice is unique and while what follows may not be applicable to all circumstances, the discussion will be aimed at all clinicians willing to incorporate and adapt the information into their own experience.

Common comments from patients:

- *"I am only in my forties. That is way too early for menopause"*
- *''Menopause is temporary and short-lived. If I am patient and wait, it will fix itself."*
- *"Do I have to take HRT? What happens if I don't want to? I don't want to age prematurely."*
- *"My previous doctor was amazing with my pregnancies but now that I am older, I feel unheard. I feel like my concerns are being brushed away."*
- *"HRT is bad for me. I heard it causes breast cancer."*
- *"HRT is not for me. My GP says it will give me a heart attack."*
- *"Bio-identical hormones are safer for me."*
- *"I don't know enough about menopause. What do you think I should do?"*
- *"What is going on with me? Am I going mad?"*
- *"Sex is more painful since my period stopped. This is normal at my age right?"*

If this was an article written for a women's health newsletter in Roman Times, (would that even have been a thing), it would address very different questions. In those times, the average life expectancy of a woman was 25 years. What happened was that soon after puberty, women got pregnant, had babies, and then died. Very few women made it to menopause. Today, the average life expectancy of a woman is much more than a paltry 25 years. We can expect a woman in the first world to live well into her eighties and a woman in the third world, well into the fifth decade of life and even beyond.[4] This essentially means that a woman could spend a third if her life in the menopause. With the demands of modern living, women need to be happy and healthy.

We need to function at our peak because this is what society demands of us. More importantly, this is what we demand for ourselves!

The patient comments above, highlight the fears and concerns of women who not only want to age well, but want to do so in a manner that is respectful of their wishes to function at their full potential, with minimal self inflicted health risks. Recognition of her individuality and her own unique set of issues are key to her. An unwillingness to listen empathically and involve her in important decision making will alienate her and drive her to seek counsel elsewhere.

Giving a woman the latest, most up- to- date information will maintain credibility. We cannot be naïve. They will double check information received from us, not only verifying with "Dr Google" but also obtaining certainty from friends and peers. Admitting that we don't know something and then committing to researching it and getting back to them, suggests that we are merely human and cannot know everything all the time. In my experience this earns respect.

My own counselling

The conversation around perimenopause /menopause usually starts with a discussion of what the patient is currently experiencing. This covers not only physical symptoms but also her quality of life experience and how the changes have impacted her and those around her. We discuss her attitude to aging in general and her expectations for her life and future health. Unique personal and family health history is also considered. We then talk about her opinion of HRT, whether she has one or not, and if she has any burning concerns or questions related to this. We talk about literature she has read and I refer her to relevant information as required.

We also talk of tests necessary to elicit underlying issues. Mammograms, bone density scans, cholesterol tests and other relevant hormone tests like thyroid tests are discussed.

My finding is that once the initial panic of a diagnosis of menopause has abated, when a woman understands what is happening to her at this stage of her life, she is able to engage in a decision making process where she feels empowered to retain ownership of her health and her life.

I realize that the process above requires a long un-interrupted consultation-something that may be difficult to achieve in a busy GP practice. My advice is to refer to the appropriate specialists, who should have the time to initiate this process. A GP can then take over once the initial groundwork has been done and manage the uncomplicated scenarios.

Of course no consultation is complete without a full examination. That should go without saying.

Special comments

Bio- Identical hormones

Oprah Winfrey and the resident doctor on her show, Dr Oz have really brought this option into the spotlight. Patients arrive armed with information obtained from high profile endorsements like celebrity gynaecologist , Dr Christianne Northrup. Not all of it may be factually correct.

What I am always surprised by, is when patients relay stories of their gynaecologists' anger and rudeness when broaching the subject of bio-identicals. Patients feel chastised, confused and alienated by their doctor's attitude and refusal to even discuss the idea. Some colleagues have even refused treatment to patients if they were even thinking of considering bio-identicals as part of a menopausal treatment plan.

This is disappointing: In my opinion, even though there is no clear evidence for the safety and efficacy of bio-identical hormone creams over that of conventionally available prescription HRT, not to mention the lack of regulation of such products by local regulatory bodies, physicians can certainly use this opportunity to discuss the issue in an objective, non -emotional way. We would be remiss in ignoring the value of educating a patient on risks that were not highlighted on online platforms and in the media. It seems that we may be failing our duty in this regard when despite cautionary advise by British, American, and even South African academics and consensus groups[5,6,7] regarding non endorsement of the use of bio-identicals, many women still gravitate towards this as an option.[8] An important motivating factor is often an "overarching distrust of a medical system perceived as dismissive of their concerns and overly reliant on pharmaceuticals."[9]

HRT and cardiovascular disease

Cardiovascular disease is a major cause of death in older women.[7] This is what I emphasise to my patients.

Key points to bring up

- HRT is most effective in reducing risks of cardiovascular events when used in women within 10 years from the onset of menopause or under the age of 60.[6]
- Women who initiate HRT more than 10 years from the onset of menopause have an increased risk of cardiovascular disease. This risk is higher when estrogen is combined with a progestogen (medroxyprogesterone acetate) than when estrogen is used alone.[3]

I also like to incorporate the following NICE guidelines[5] in planning treatment:

- The presence of cardiovascular risk factors is not a contraindication to HRT
- It is essential to optimally manage any underlying cardiovascular risk factors (e.g. blood pressure, cholesterol) whether or not a patient chooses to take HRT.

Atrophic Vaginitis

This can be an extremely distressing symptom affecting quality of life and relationships. Dyspareunia, vaginal dryness, urge incontinence, frequency and recurrent urinary tract infections are the common manifestations. Low dose vaginal estrogen preparations are generally considered safe.[6,7] Application of a local estrogen product may still even be necessary in 15% of women who use systemic hormone therapy.[7] When used correctly, there is no need to use progesterone for endometrial protection. Local estrogen can be continued indefinitely. An interesting fact that I often share with my patients is: that a year's supply of low dose vaginal estrogen (10ug twice weekly) is equivalent to one oral estrogen tablet.[10] Because of even this minute potential increase in plasma estradiol levels, the decision to use vaginal estrogen in a woman with breast cancer should be made in consultation with her oncologist. This is particularly important for women on aromatase inhibitors (AIs) where suppression of plasma estradiol levels is a crucial therapeutic goal. No increased risk was seen in an observational study of breast cancer survivors on Tamoxifen or AI therapy with low dose vaginal estrogen after 3.5 years mean follow up.[11]

Vaginal lubricants and moisturisers are also of benefit. So is the newer drug ospemifene.[12]

HRT and breast cancer

Anyone who is involved in the business of seeing patients daily understands the emotions that a potential diagnosis of cancer can generate in a patient. No woman wants to willingly participate in treatment that will increase her risk of developing breast cancer no matter what other benefits may be achieved by the same treatment. So let me put things into perspective:

- All woman should have a normal mammogram prior to instituting HRT.[7] When increased breast density impedes diagnostic accuracy of a mammogram, cessation of HRT for 2-4 weeks and re-imaging may be helpful.[13]
- Differences exist in breast cancer risk depending on the HRT preparation used. The risk is highest when conjugated equine estrogen (CEE) is combined with medroxyprogesterone acetate (MPA)[3,6,7]
- The increase in risk with the CEE+MPA combination is only slightly up compared to the risk of a daily glass of wine; less than with two daily glasses and similar to that of obesity or low physical activity.[6,14]
- Limited observational evidence suggests that HRT use does not further increase the breast cancer risk in women with a family history of breast cancer or in women after oophorectomy for BRCA1 or BRCA 2 mutations[6]
- The use of systemic HRT in not advised in breast cancer survivors unless under special consideration in consultation with the oncologist.[6]

Final thoughts

This article highlights just some of the most common issues raised by patients in a typically affluent, high socio-economic gynaecological practice in Johannesburg. It would be interesting to hear from other clinicians elsewhere regarding their own challenging experiences.

References available on request.