MEDICAL MANAGEMENT OF MENOPAUSE

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DISCLOSURES

- I have received honoraria from Bayer and Hologic

MITIGATING POTENTIAL BIAS

- I will not be discussing products solely from the companies I have received sponsorship from

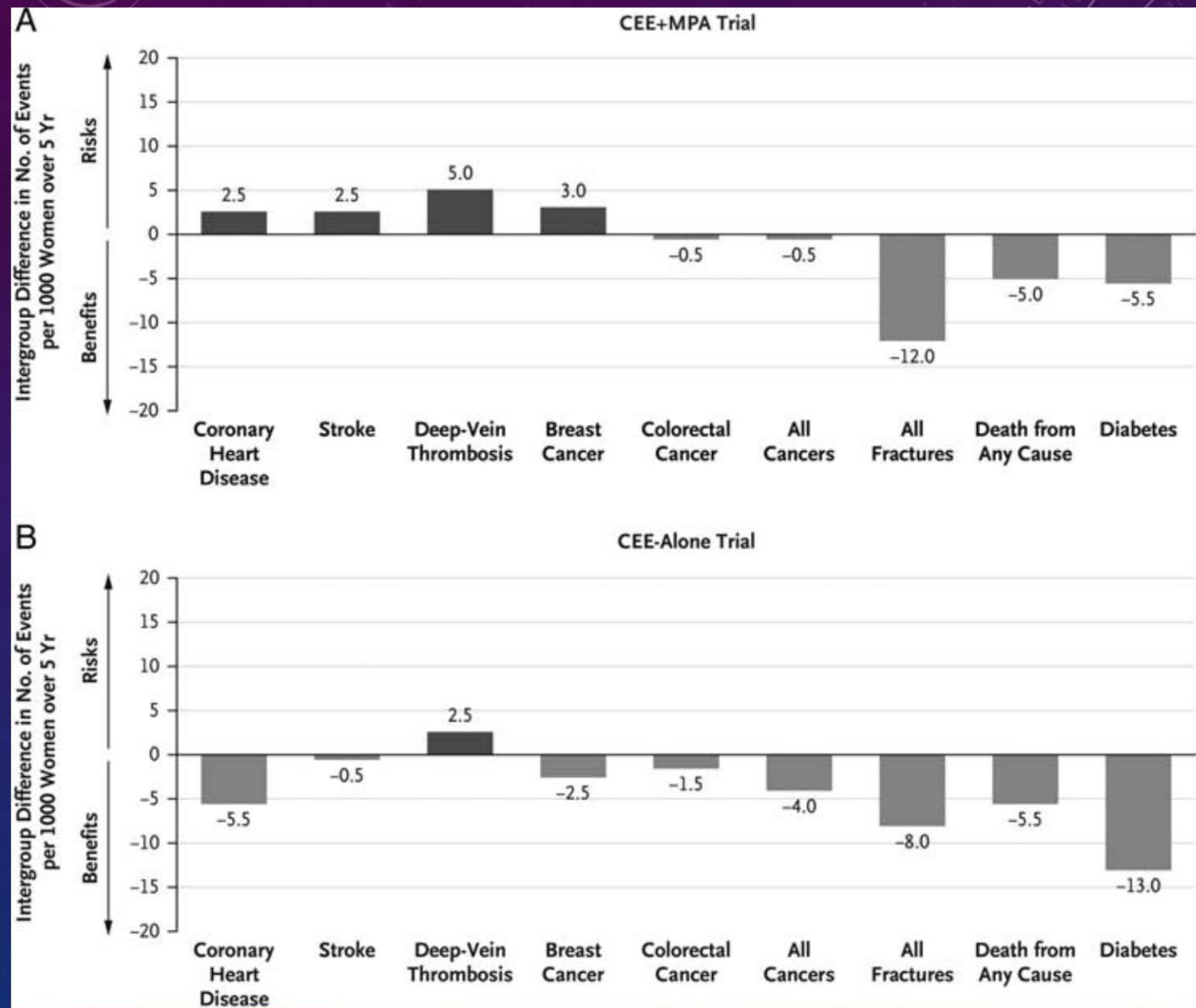
OBJECTIVES

- Develop a patient centered approach to the treatment of menopausal symptoms
- List the hormonal and non-hormonal prescription formulations in Canada and describe how they are used
- Counsel patients on the risks, benefits, and relative safety of menopause therapies

CASE 1: HILDA HAS HOTFLASHES

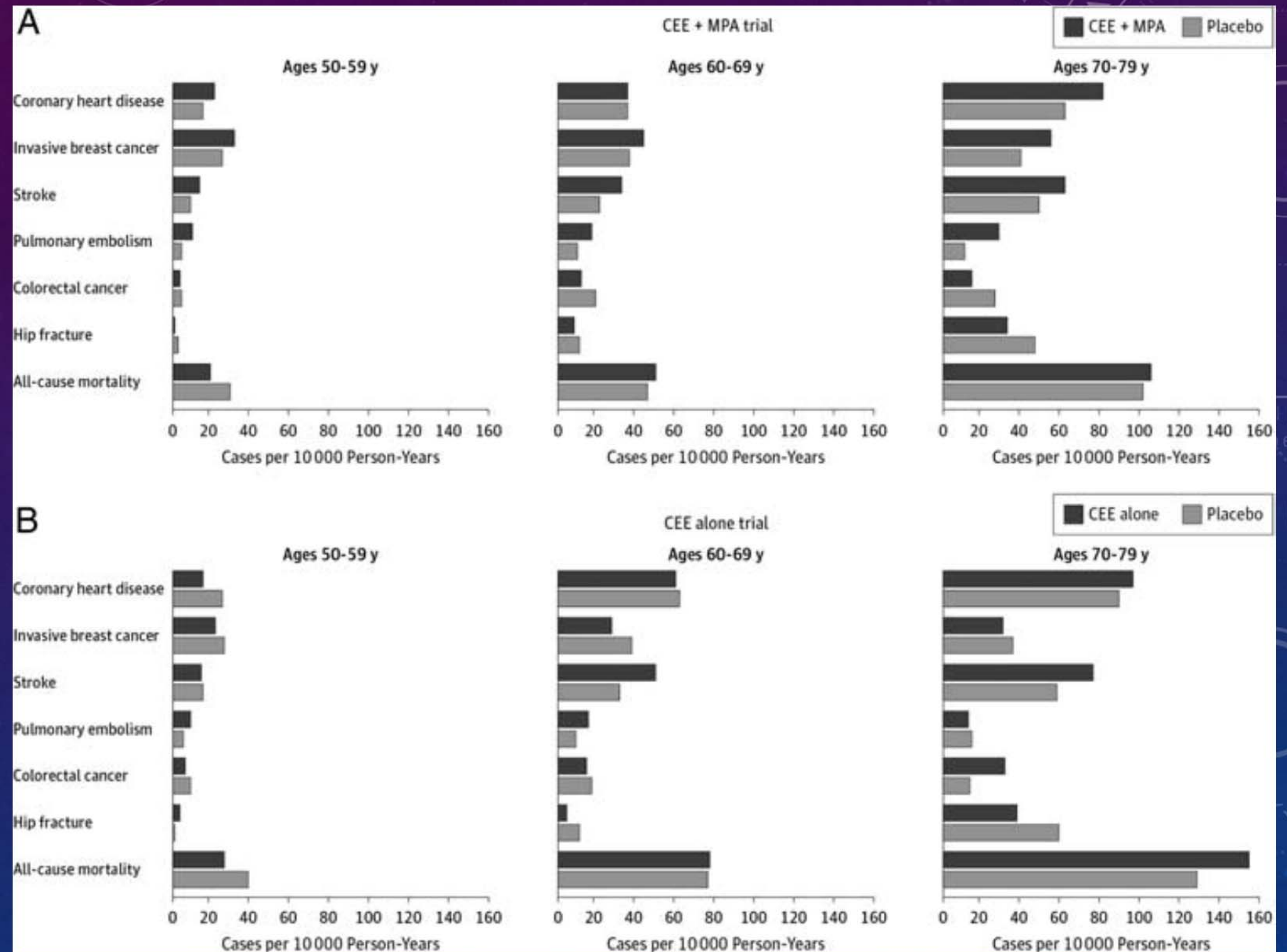
- 52 year old with bothersome hot flashes and night sweats, nocturnal waking, LMP 1.5 years ago
- Healthy, G2P2, hypothyroidism, BMI = 26
- Total cholesterol 4.0, HDL 2.0, BP = 132/80
- Eltroxin
- Family Hx: Maternal DM (age 85), paternal stroke (age 70)
- Non-smoker, has extended health benefits
- ”I’m too scared to take hormones because I don’t want to have a stroke”

RESULTS OF THE WHI



Y-axis: number of events per 1000 women over 5 years

RESULTS OF THE WHI



“

Don’t give HT to your grandmother

”

Dr. Laura Power

NAMS 2017 GUIDELINES

- HT is appropriate for the treatment of vasomotor symptoms in women who are considered low risk for cardiovascular disease and have no personal history of hormone dependent cancers
- HT is the **MOST EFFECTIVE** treatment of vasomotor symptoms and also prevents bone loss and decreases fracture risk
- Studies support a **decreased cardiovascular morbidity and mortality** and **decreased all cause mortality** in women taking HT with initiation aged less than 60 and less than 10 years out from menopause
- Goal is to remove the fear of HT and encourage **individualized** shared decision making

DIFFERENT FORMULATIONS: ESTROGEN

Oral	CEE	Mare urine
	17B-estradiol	“body-identical”
Transdermal	17B-estradiol	Avoids first pass metabolism

DIFFERENT FORMULATIONS: PROGESTINS

Oral	Norethindrone acetate	Indicated for AUB
	Micronized progesterone	”body-identical”
	Medroxyprogesterone acetate	Strong action on endometrium
Intrauterine	levonorgestrel	
SERM	Bazedoxifene	Antagonizes E effects on endometrium

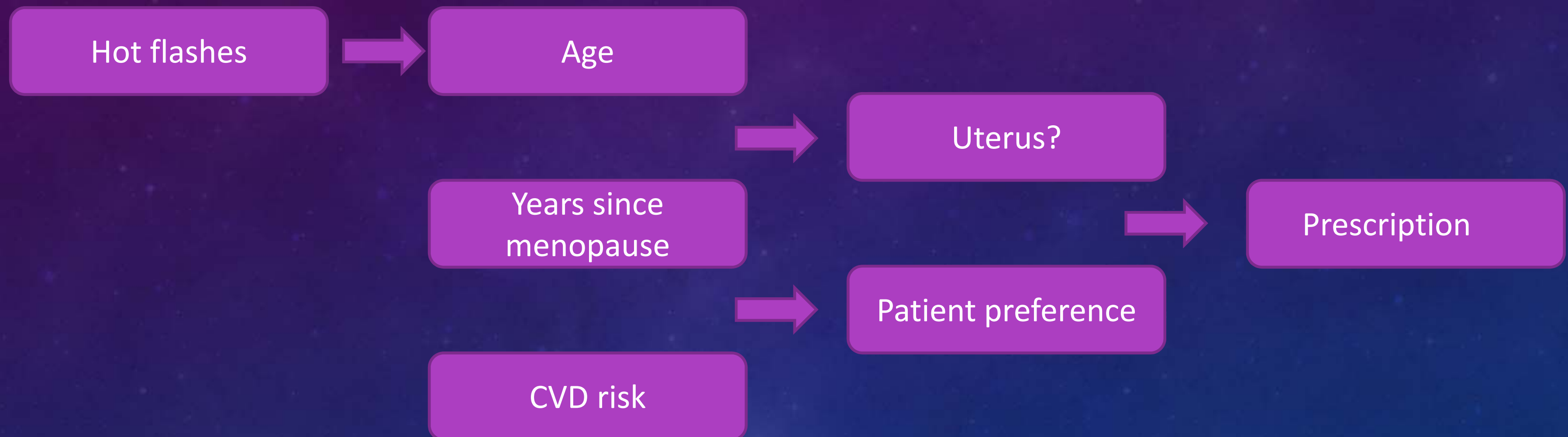
Progestins were associated with increased risk of breast cancer. Progestins can increase appetite but also cause drowsiness

SERM can be used instead of progestin

ACTUAL CONTRAINDICATIONS TO HT

- Unexplained vaginal bleeding
- Acute liver disease
- Estrogen dependent or progesterone dependent cancers
- Coronary heart disease or previous stroke
- Active thromboembolic disease

APPROACH



CASE I: HILDA HAS HOT FLASHES

- Low risk of CVD – Framingham score was 0.3%
- She has a uterus
- What are her fears?
  - Transdermal lower risk of VTE/stroke heart attack
  - HT lowers the risk of CAD, bone loss and death
  - Poor sleep? – try taking progestin at night

CASE 2: FANNY HAS A FAMILY HISTORY

- 55 year old with bothersome hot flashes and night sweats, LMP was 3 years ago
- PMHx: cholecystectomy, appendectomy, hysterectomy, BMI = 33
- No medications, vitamin D and Ca supplements when she remembers
- Family Hx: Older sister had breast cancer 6 years ago, maternal aunt had breast cancer > 10 years ago
- Non-smoker, has extended health benefits
- ”I can’t take hormones because my sister had breast cancer”

CONTRAINDICATIONS TO HT

- **Personal** history of breast or endometrial cancer is a contraindication to **systemic** HT
- Family history of breast cancer is **not** a contraindication to HT
- Patients with BRCA who have had risk reducing salpingo-oophorectomy and no personal history of breast cancer should have HT to reduce the symptoms of menopause and provide cardio-protection and bone protection

CASE 2: FANNY HAS A FAMILY HISTORY

- Consider her risk of cardiovascular disease
- Even according to the WHI, younger women with Estrogen only HT had a LOWER risk of breast cancer
- If she still had a uterus, consider cyclic P or SERM plus E
    - Cyclic progestin vs SERM may have lower risk of breast cancer vs taking progestin daily
    - Cyclic progestin can cause cyclic bleeding

CASE 3: OLA IS TOO OLD

- 60 year old on HT since age 55 for bothersome hot flashes
- G4P4
- Mammograms normal, no family history of breast cancer, pilates/swimming, normal blood pressure, blood work within normal limits, slightly low bone density, BMI 28, active sex life
- “I feel great and I don’t want to stop”

WHEN TO SAY WHEN:

- ~~Shortest dose for the shortest period of time~~
- No routine discontinuation of HT at age 60 or after a certain period of time
  - Reassess risk periodically
  - Highest risk of VTE is with initiation
- For women over the age of 60 or more than 10-20 years from menopause the risk benefit ratio is less favorable because of the absolute risk of CHD, VTE and stroke based on age alone
  - The best time to stop is not clear

CASE 3: OLA IS TOO OLD

- Overall cardiovascular risk is higher than when she was 55
- We don’t know the risk of VTE/CHD/stroke in this patient population
  - Different than initiating HT at this age
- Does she still have hot flashes?
- Can we decrease the dose?
- Does she need vaginal estrogen?

WARNING CASE

- 79 year old on Wiley protocol since age 55, one episode of scant spotting 6 weeks ago
- She has essentially been on unopposed estrogen for 24 years
- She looks amazing
- PMHx: nil
- Meds: compounded E + P + T (transdermal)
- Endometrial biopsy: adenocarcinoma
- **THIS SHOULD NEVER BE PRESCRIBED**

ADDRESSING BARRIERS TO CHANGE

- Become familiar with the symptoms of menopause
- Become familiar with a few formulations
- Don’t be afraid to consult
- Use the SOGC HT desk reference

REFERENCES

- https://www.menopauseandu.ca/wp-content/uploads/2018/07/SOGC_10633_Menopause_Eng_Web.pdf
- https://www.menopauseandu.ca
- The 2017 hormone therapy position statement of The North American Menopause Society. Menopause: The Journal of The North American Menopause Society. Vol. 24, No. 7, pp. 728-753
- Schufelt, C., Manson, J. Managing Menopause by Combining Evidence With Clinical Judgment. Clinical obstetrics and gynecology. Volume 61, Number 3, 470–479.

Session Evaluation and Outcome Assessment

These short forms serve important functions!

- For **speakers**: Your responses help them understand their strengths and weaknesses, participant learning needs, and teaching outcomes
- For **the CEPD office**:
  - To plan future programs
  - For quality assurance and improvement
  - To demonstrate compliance with national accreditation requirements
- For **YOU**: Reflecting on what you've learned and how you plan to apply it can help you enact change as you return to your professional duties

Please take 3-5 minutes to fill the evaluation form out. Thank you!