PEER REVIEWED FEATURE **2 CPD POINTS**

How to conduct a ‘heartsink’-free menopause consultation

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After more than a decade of confusion, HRT can be confidently prescribed again to healthy women who have significant symptoms at menopause. Structuring consultations enables GPs to identify the women’s concerns and individualise their treatment (if it is needed), and helps women to understand the fluctuations in symptoms they are experiencing and the treatment they would like to receive.

KEY POINTS

- Plan to manage the woman’s concerns about menopause over two or three long consultations.
- Take time to listen to the patient’s individual list of menopause symptoms and concerns so you can personalise advice. Initially focus on the woman’s top three symptoms of concern.
- Use a menopause rating scale to evaluate symptoms.
- Update routine checks and perform any required tests based on symptoms. Hormone blood tests are unnecessary.
- Include information and lifestyle advice for all women and hormone replacement therapy (HRT) or nonhormonal options for symptomatic women.
- Review all women taking HRT or any other therapy at menopause at least yearly.
- Use the 45- to 49-year-old health check to proactively educate women about menopause.
- Remember about the increased risk of osteoporosis after menopause.

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Caring for women at menopause is just one of many topics a busy GP needs to be knowledgeable about. However, for the past decade managing menopause has been in the ‘too hard’ basket for many GPs because of the conflicting and confusing information presented both in the medical literature and to patients in the media. Recently published guidelines on menopausal hormone therapy and a toolkit for managing the menopause, both from the International Menopause Society, have made assessing and managing women at this time of life clearer and less complicated and every GP can now be confident again in caring for these women.[1,2]

It can be helpful to have a structure in mind for consultations at which menopause is discussed. This article provides guidance about conducting menopause consultations.

How and why does the patient present with menopause problems?

There are many reasons why women present to their GP at the time of menopause. It is not unusual for a woman to come to the consultation with a long list of symptoms and questions and the request that her GP ‘fix my life!’ This can be daunting if you have only a 15-minute consultation in which to manage her problems, and can lead to the feeling that menopause is all too difficult. Often the women will have preconceived ideas about what she is hoping to get out of the consultation, but she will not necessarily volunteer this information unless directly asked.

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1. MENOPAUSE WEBSITES FOR HEALTH PROFESSIONALS AND PATIENTS

- Australasian Menopause Society: www.menopause.org.au
- Jean Hailes: www.jeanhailes.org.au
- International Menopause Society: www.imsociety.org

There is still silence and ignorance in the community about menopause. For many women menopause comes as a big surprise that can be quite distressing, patients often saying they 'didn't think it would happen to them.' Despite several excellent sources of information available now (see the Australasian Menopause Society [AMS] website, www.menopause.org.au, and the Jean Hailes website, www.jeanhailes.org.au), women often say that they cannot find good information – perhaps partly because there is, disappointingly, a lot of misinformation out there. Reliable sources of information on menopause are listed in Boxes 1 and 2.

A GP should be able to give women evidence-based information about menopause that is individualised to each woman's personal and family history. Treatments offered also need to be individually tailored. It is important for all female patients at this normal stage of life that their GPs are comfortable and knowledgeable about how to care for them, regardless of whether they have symptoms. Women are very grateful when their own GP is willing to discuss this stage with them and offer options for treatment if needed.

The 45- to 49-year-old health check can be used as an opportunity to proactively educate women about menopause and prepare them for it as well as managing any presenting issues they may have.

Diagnosing menopause

Explain to a patient presenting with symptoms of menopause about this time of her life. Points to cover include the following:

- the term menopause means a woman's final menstrual period
- it is a clinical diagnosis made only retrospectively after there has been no menstrual period for 12 months
- this final period ('last menstrual period' or LMP) comes as the ovaries stop producing oestrogen
- only about 20% of women are asymptomatic, but these women are still at risk of longer term chronic diseases such as osteoporosis due to the loss of oestrogen
- a proportion of the 80% of women who experience symptoms will find them debilitating and that they impair quality of life – various treatments can reduce these symptoms.

Women can present at any stage of the perimenopause (less than 12 months since LMP) or after menopause with a range of symptoms. Cycle irregularity is often one of the first signals of the beginning of menopause. Other symptoms may be present at this stage but it is unnecessary and unhelpful to perform hormone blood tests if a woman is in her 40s or 50s because hormone levels, symptoms and bleeding patterns fluctuate widely throughout the perimenopause.

Should a menopause symptom score be used?

The list of symptoms attributable to decreasing and fluctuating levels of oestrogen is long (see the AMS information sheet *Diagnosing menopause*; this and other sheets are available at www.menopause.org.au/for-women/information-sheets) but the classic common symptoms are:

- vasomotor symptoms
- joint aches and muscle pains
- mood irritability
- dry vagina.

Women can present with many constellations of these symptoms, and using a menopause rating scale can clarify whether the majority of a woman's symptoms fit within the menopause cluster. A symptom score is included in the previously mentioned AMS information sheet *Diagnosing menopause*, and a version is reproduced in Box 3.

2. MENOPAUSE INFORMATION SHEETS

The Australasian Menopause Society (AMS) has information sheets available for downloading from its website (www.menopause.org.au/for-women/information-sheets). These include:

- *AMS guide to equivalent HRT doses*
- *Bioidentical hormones for menopausal symptoms*
- *Complementary and herbal therapies for hot flushes*
- *What is menopause?*
- *Diagnosing menopause*
- *Menopause and body changes*
- *Menopause – combined hormone replacement therapy*
- *Menopause – oestrogen only therapy*
- *Mood problems at menopause*
- *Nonhormonal treatments for menopausal symptoms*

After it is established that menopause is the presenting issue, determine which three symptoms really matter to the woman and tell her that you will initially focus on those. Women may present with classic symptoms but other symptoms may be of more concern to them – for example, they may be having hot flushes but their mood irritability or concern about a family history of osteoporosis is more important to them.

What investigations and tests are required?

Before considering options for treatment, check that the woman is up to date with routine screens such as Pap smear and mammogram. Blood tests are not essential and hormone blood tests can be positively unhelpful; exceptions are younger women with amenorrhoea or oligomenorrhoea in whom you suspect premature menopause and women who have had a hysterectomy or have a hormone (levonorgestrel)-releasing intrauterine device fitted, as these women do not have the signal of menopause of changes in the menstrual cycle.

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Although not mandatory, it can be useful to update routine lipid and blood glucose measurements and to consider other tests (e.g. thyroid function tests and full blood evaluation), depending on history.

As you send the patient away to have these checks, you can also give her information sheets on menopause or recommend reputable websites (such as AMS or Jean Hailes) so she can become better informed.

Does the patient require further consultations or referral?

It is not usually necessary to refer a woman to a specialist for treatment of her menopause symptoms. It is, however, necessary to give yourself time to manage the list of concerns. At the initial consultation, set the expectation with the patient that you will need a further one or two long consultations to do this properly, with regular follow up after that.

Also set expectations that any treatment offered will not be a 'quick fix' but a plan for a reduction in symptoms. This sets the scene for patients being patient and allowing any treatment several months to become effective before being evaluated. Explain that it may be necessary to try several formulations/options/medications to get the 'right fit'. Similar to your explanation of why blood tests to diagnose menopause are usually unhelpful, you can explain that you will be using symptoms, not blood tests, to monitor treatment success.

Treatment options to consider at menopause

Using lifestyle interventions and pharmacological options, it is possible in general practice to offer most women wishing treatment at menopause an evidence-based range of options that are medically appropriate and also take into account the woman's beliefs and preferences.

Information giving

Even women who do not require treatment for symptoms benefit from being given information about menopause.

3. MENOPAUSE SYMPTOM SCORE SHEET*

AMS Diagnosing Menopause: Symptom Score Sheet

This valuable diagnostic tool can be completed together with the woman, or she can do it herself in the waiting room. The woman judges the severity of her own symptoms and records the score - 1 for mild, 2 for moderate, 3 for severe and of course 0 if she does not have that particular symptom. A score of 15 or over usually indicates oestrogen deficiency that is intrusive enough to require treatment, but this is only a guideline. Women are very variable in their tolerance of discomfort, often tolerating quite severe symptoms before they will even consider taking HRT. Scores of 20-50 are common in symptomatic women, and with adequate treatment tailored to the individual, the score will reduce to 10 or under in 3-6 months.

Using the symptom score sheet at subsequent follow-up visits is a useful method of judging whether adequate oestrogen is being taken to alleviate symptoms. Generally there is a halving of the symptom score after 2-3 months on HRT and if the woman is still experiencing a lot of symptoms, she may require a dose increase. If symptoms still persist, changing from the oral route to transdermal may help if the problem is oestrogen malabsorption. Women with irritable bowel syndrome, or taking H2 antagonists commonly absorb oral oestrogen poorly.

SYMPTOM SCORE

	Score before HRT	3 months after starting HRT	6 months
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS
SCORE: None =0; Mild =1; Moderate =2; Severe =3

NB: The symptoms are grouped into 4 categories, vasomotor, psychological, locomotor and urogenital. If one group does not respond to HRT, look for other causes and specific treatments for that group.
Not all of the symptoms listed are necessarily oestrogen deficiency symptoms.

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Abbreviation: HRT = hormone replacement therapy.

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Start with information about basic physiology at menopause, explaining the erratic fluctuations in hormone levels, symptoms and bleeding in the perimenopause. This will help women understand that at a time they are 'running out of oestrogen', they may experience both symptoms of low or high oestrogen levels and more 'stable' or normal times. This is a 'lightbulb' moment for many women who have been confused by the fluctuations they feel.

Lifestyle treatments

All women at menopause can benefit from a review of lifestyle factors for chronic disease prevention. Take the opportunity to discuss diet and weight management, exercise participation, alcohol intake and smoking cessation. These interventions do not necessarily directly impact or reduce symptoms, but if a woman is exercising, eating a healthy diet and not smoking she may well feel better and manage menopause better.

Addressing psychosocial issues

Menopause is not necessarily associated with depression but women who have a past history of hormone-related mood issues (such as premenstrual dysphoric disorder or postnatal depression) can be more vulnerable at menopause to mood issues or exacerbation of pre-existing depression. Be aware of the different presentation of depression that can occur at menopause, which can include feelings of irritability, anger and hostility.

Pharmacological treatments

It is appropriate to use medications to reduce the symptoms of menopause when:

- symptoms are moderate or severe and impact on function and/or quality of life
- benefits outweigh the known risks in the individual patient.

Hormone replacement therapy (HRT) is the 'gold standard' treatment but there are nonhormonal options that can be offered to women who have contraindications to HRT or prefer not to take it.

Hormone replacement therapy

For over a decade inappropriate and conflicting advice about HRT from various research and government bodies has made it difficult to counsel women who are considering using this treatment. The Women's Health Initiative trial in particular caused confusion when research based on prevention of chronic disease in older women was extrapolated to symptomatic younger women at the time of menopause.[3] The confusion has now been clarified, and HRT can again be confidently prescribed by GPs to healthy women with significant symptoms around the time of menopause.

Basic principles regarding prescribing HRT include the following:

- HRT consists of oestrogen to treat symptoms and, for those with an intact uterus, progesterone/progestogen to prevent the oestrogen causing endometrial hyperplasia or cancer
- all HRT preparations have oestrogen every day
- for women who have had a hysterectomy, oestrogen is all they need – 'oestrogen-only HRT'
- for women with a uterus, it is essential to pair the oestrogen with a progestogen
- women who are still perimenopausal (i.e. less than 12 months since LMP) should take the progestogen in a cyclical manner, giving a monthly withdrawal bleed – 'cyclical combined HRT'
- women who are postmenopausal should take the progestogen in a smaller dose daily, which does not give a bleed – 'continuous combined HRT'.

The AMS information sheet *AMS guide to HRT equivalents* provides a guide to the different HRT preparations available in Australia in April 2015.

Nonhormonal pharmacological options

Nonhormonal options for treating symptoms of menopause include selective serotonin reuptake inhibitors (SSRIs; off-label use for menopause symptoms other than anxiety and depression), serotonin and noradrenaline reuptake inhibitors (SNRIs; off-label use for menopause symptoms other than anxiety and depression), gabapentin (off-label use) and clonidine (TGA indicated for the treatment of menopausal flushing). Details are available in the AMS information sheet *Nonhormonal treatments for menopausal symptoms*.

Important aspects of the menopause consultation

Important aspects of the menopause consultation not to be missed are listed below.

- **Not all cycle irregularity at menopause is normal.** It is important not to automatically attribute all irregular bleeding to perimenopause (new menorrhagia, intermenstrual bleeding and postcoital bleeding should be investigated).[4]
- **Contraception may still be required for patients who are sexually active.** Contraception should be offered to all women under 50 years of age until two years post-LMP and for women over 50 years for one year post-LMP.[5]
- **What about symptoms that persist despite adequate treatment?** If a woman presents with a long list of symptoms at the usual age of menopause then it is sometimes difficult to work out what is related to decreasing levels of oestrogen and what potentially could be due to other causes. As long as you have done basic investigations for any symptoms, it is reasonable to treat the menopause and see what is left. If vasomotor symptoms for instance persist despite adequate HRT then there is a long list of rare causes and drugs that can cause hot flushes. It is not necessary to investigate for all of these in an otherwise healthy woman at menopause before initiating HRT.
  If symptoms persist despite adequate treatment, it may be time to investigate or refer to a menopause specialist.

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Specialist referral

Ideally a woman's own GP, who has knowledge of her past history and a good awareness of her family and social situation, is the best person to offer assistance at menopause. Also, the general medicine background of GPs enables them to manage the multiple systems of the body that are affected at menopause.

Some menopause patients have more complex problems, and it is reasonable to refer them to a menopause specialist. Menopause is an area of special interest for some GPs, some gynaecologists and some endocrinologists.

To tell a woman that this is a natural stage and she should just put up with it, which has been some women's experience, is unreasonable and poor patient care, given that symptoms can last for many years. Often an initial consultation with a menopause specialist can put a woman on the right track, and GP follow up is then appropriate.

Facilitating informed decision-making

I am often asked whether I 'believe in' HRT, as though treatment for menopause is a belief system rather than an evidence-based area of medicine. No one has ever asked me as a GP whether I 'believe in' treatment for diabetes or asthma! The GP's task, once the patient's agenda (her top three issues initially), check-ups and any possible contraindications have been reviewed, is to give the patient verbal and written information about options for treatment and allow her to make up her own mind. Checking what she was hoping to get out of her consultations with you and what her particular concerns are will help inform the discussion. This personalising of your advice creates a much more meaningful decision-making process.

Many women will have tried or want to try complementary and alternative medicines. As with any other area of medicine, it is important to stick to the evidence and steer people away from sometimes costly, often ineffective and sometimes risky therapies. The AMS information sheets *Complementary and herbal therapies for hot flushes* and *Bioidentical hormones for menopausal symptoms* can be of help in explaining to patients why you would not advise these forms of therapy.

Follow up – yearly review

All women taking HRT or any other therapy at menopause should have at least an annual follow-up consultation to update their medical history, determine any need for further investigations and generally review the treatment they are taking, taking into account the latest available evidence. There is no set minimum or maximum duration for using HRT. Every few years consider either reducing the dose of HRT to see whether a lower dose would still cover symptoms or ceasing the therapy if several years have passed since starting it. If symptoms return, discuss with the patient the HRT risks and benefits individualised for her updated personal and family history.

Conclusion

Menopause is a common presentation in general practice and can be challenging for both the GP and the woman experiencing the symptoms. Patients appreciate their GP taking time to listen to their particular experience of menopause and individually tailoring information and evidence-based options for treatment. GPs should plan menopause management over several consultations to give themselves time to manage the list of concerns and update routine check-ups and to give patients the time to digest information about options for treatment.

After a decade of confusion, new guidelines are available to assist in safely prescribing HRT again to healthy women at the time of menopause. Several nonhormonal prescribed medications are also effective at reducing symptoms. Patient expectations should include gradual reduction in symptoms and the need to tailor treatments over time. MT

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COMPETING INTERESTS: Dr Elliott has been a subinvestigator and principal investigator on clinical research trials for major pharmaceutical companies, and has received honoraria for chairing and presenting at medical education meetings.

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