Managing Menopausal Symptoms – Hormonal Therapy and Beyond

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I have no disclosures.
Off label uses of FDA approved products are noted.

Objectives

- Identify the most common symptoms associated with menopause.
- List options for management of systemic treatment, indications and contraindications.
- List options for management of vaginal symptoms.

Q: I currently prescribe systemic hormone therapy for menopausal symptoms.

1. YES
2. NO
3. I only refill existing prescriptions; do not write new prescriptions.

Case 1

- Anne is a 53 year old female with complaints of hot flashes
- LMP was about 18 months ago
- She reports hot flashes, about 5-10 per day
- She is also waking at night with flushes, affecting her sleep
- She complains of fatigue and mood disturbance
- Went to the Magic Hormone Clinic and was told all her hormone levels were low—but treatment options were too expensive at the MHC.
- Wants you to prescribe hormone treatment.

Q: Is Anne a candidate for systemic hormonal therapy (HT) to manage her menopausal symptoms?

1. Yes
2. No
3. Unsure

Women's Health Initiative Findings

- Conjugated equine estrogen (CEE) plus medroxyprogesterone
  - *Increased risks of:*
    - Coronary heart disease
    - Stroke
    - DVT
    - Breast cancer
    - Morbidity and Mortality (Global index)
    - Dementia in women 65+
  - *Decreased risks of:*
    - Hip fracture
    - Colon cancer
    - Diabetes
    - Hot flashes/night sweats
  - No improvement in mood/depression/cognition

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Women's Health Initiative Findings

- Conjugated equine estrogen (CEE) only
  - *Increased risks of:*
    - Coronary heart disease in women in 70s
    - Stroke
    - DVT/VTE
    - Morbidity and Mortality in women in 70s
    - Dementia in women 65+
  - *Decreased risks of:*
    - Hip fracture
    - Diabetes
    - Hot flashes/night sweats
    - Coronary heart disease in women in 50s
    - Morbidity and Mortality in women in 50s
  - Breast and colon CA risk neutral in this arm

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Risk Assessment for HT

- Absolute contraindications to HT:
  - Medical history of DVT/VTE, stroke, MI
  - Medical history of hormone sensitive cancer (breast, uterine)
  - Known thrombogenic condition
  - Unexplained abnormal uterine bleeding

- Relative contraindications to HT:
  - Current personal risk factors for cardiovascular disease
    - Diabetes, hypertension, obesity, smoking
  - Family history of early CVD/ stroke/ DVT
  - Family history of breast cancer

What are benefits of HT?

- Reduction of hot flashes and night sweats
  - May improve fatigue, overall well being
- Decrease in vaginal dryness
  - May improve sexual function
- Any prevention benefits?
  - Decreased risk of fracture
  - CVD—verdict unclear and likely age dependent

Anne #1

- PMH: No major medical problems
- BMI 27
- Gyn history: G2P2, no history of abnormal bleeding
- Family history: NO FH of breast CA or early CVD/MI or stroke
- SH: Non smoker
- Screening: Recent normal lipids and fasting glucose, BP, mammography, and colonoscopy

- ** I would consider this Anne a HT candidate!

HT Systemic Options

- With intact uterus, need estrogen and progestin!

- Types of estrogen:
  - CEE
  - Estradiol (“bioidentical”)

- Types of progestin:
  - Medroxyprogesterone, norethindrone, norgestrel
  - Progesterone (”bioidentical”)

- Modes of delivery
  - Oral
  - Transdermal (Patches/ ring (FemRing)/ creams)
  - IUD for progestin?
  - Compounded progestin treatments (buccal/transdermal)

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Q: Should we get hormone levels to determine dosing?

1. YES
2. NO
3. UNSURE/ It depends.

Dosing HT

- Current best practice:
  - Lowest dose to manage symptoms
  - Shortest period of time—year to year
  - Consider up to 5 years as optimal
  - Not guided by hormone levels

Anne #1 Treatment

- Estradiol 0.5 mg tablet or Estradiol patch
- Micronized progesterone 100 mg daily (Prometrium)
- Could also consider levonorgestrel IUD? (off label)

Anne #2

- PMH: Hypertension—on medication
- BMI 35
- Current BP today 145/90
- Gyn history: G2P2, no history of abnormal bleeding
- Family history: NO FH of breast CA or early CVD/MI or stroke
- SH: Smoker
- Screening: Recent normal lipids, mammography, and colonoscopy

- ** This Anne is NOT an ideal candidate for HT

Non-Hormonal Options for Menopausal Vasomotor Symptoms

- SSRIs/SNRIs
  - Paroxitine 7.5 mg daily, FDA approved
  - Venlafaxine 37.5-75 mg daily—off label
  - Desvenlafaxine 100 mg daily---off label
- Clonidine (alpha-2 agonist)—0.1 mg daily---off label
- Gabapentin --300-900 mg daily---off label

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Non-Hormonal Options for Menopausal Vasomotor Symptoms

- Complementary/Natural Products
  - Phytoestrogens
  - Herbals (Black Cohosh, Dong quai, Ginkgo, Ginseng, St. Johns Wort)
    - No clear evidence of benefit
  - Acupuncture
- Other strategies
  - Layered dressing, room temperature
  - Avoidance of triggers (alcohol, caffeine, stress)

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Anne #2 Treatment

- Usually start with trial of SSRI or SNRI
- Could try gabapentin first if nighttime symptoms are more prominent
- Review lifestyle changes

Case 2

- Sarah is a 60 year old female complaining of pain with intercourse
- This has been getting worse over the past 5 years, now avoiding IC
- Tried OTC lubricant without relief (KY Jelly)
- Also notes decreased libido

Q: What is the best option for management?

1. Vaginal hormone therapy
2. Systemic hormone therapy
3. Neither of these options.

Vaginal HT

- Vaginal HT
  - Generally very effective at treating atrophy associated with menopause and associated symptoms (dysuria, dyspareunia, dryness)
  - Must have adequate exam to exclude other comorbid conditions

Vaginal HT Options

- Vaginal creams
  - CEE (Premarin), Estradiol (Estrace)
- Vaginal ring
  - Estring--3 months
- Vaginal tablet
  - Vagifem 10 mcg daily or less frequently

•**CAUTION in ER+ cancer patients

Other Options

- Lubricants for IC
  - Water or silicone based
    - Astroglide, Slippery Stuff, Millenium, KY Liquid
  - Natural oils
    - Coconut, olive oil
- Vaginal moisturizers
  - Replens, KY Liquibeads

•**Review vulvar hygiene practices

Q: Should Testosterone therapy be considered?

1. YES
2. NO
3. UNSURE/It depends

Testosterone

- Significant side effects and likely significant risks
- Did show some increase in # of satisfying sexual events in Cochrane review
- Never used without systemic estrogen
- Never used in higher risk patients

- Should strongly consider other interventions prior to use
    - Sexual health counseling

Sarah Treatment

- Start with estrace cream 0.5 g nightly x 1-2 months.
- Transition to less frequent cream or alternative product (tablets, ring)
- If using cream or tablets, can use 2-3 times per week once symptoms are improved.
- Will need long term maintenance therapy.
- Discuss best lubricant options.

Questions?


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