SIGMA CANADIAN MENOPAUSE SOCIETY

MENOPAUSE

Frequently Asked Questions

*Talk to me, **I can help.***

sigma
Canadian
Menopause Society

TABLE OF CONTENTS

WHEN DOES MENOPAUSE USUALLY HAPPEN?

Menopause can occur at various ages, but the age range that most women experience menopause is between ages 45 and 55, with the average age around 51. Early menopause occurs between ages 40 and 45 and late menopause between ages 55 and 60. 1-2% of women develop premature menopause before age 40. The time at which a woman reaches menopause depends on a number of factors. Smokers reach menopause on average 2 years earlier than nonsmokers. The best predictor of menopause age is the age at which mothers and sisters reach menopause.

Natural menopause is a spontaneous, ending of menstruation not caused by disease or intervention. With increased life expectancy, most North American women now live at least one-third of their lives after menopause.

Surgical menopause. Menopause occurs immediately if both ovaries are surgically removed (bilateral oophorectomy). Surgery to remove the uterus (hysterectomy) does not cause menopause if the ovaries are left in place, although menses will stop. Women who have had hysterectomy on average will start menopause 2-3 years earlier than women who have not. This will be heralded by hot flushing and night sweats for most women. Chemotherapy and pelvic radiation therapy may predispose a woman to have an earlier menopause. With chemotherapy or radiotherapy, these symptoms may be temporary and return of normal function of the ovaries (and menstruation) may occur.

Premature menopause, whether natural or induced, occurs before age 40. The major cause (40%) is unknown. 30% of cases are autoimmune with antibodies destroying ovarian egg cells. Investigations for coexisting autoimmune conditions (thyroiditis, rheumatoid arthritis, lupus, etc.) should be done. Less common causes include destruction of ovarian tissues secondary to surgery, radiation and chemotherapy. Rare causes include genetics and chromosomal abnormalities. Terminology for this condition includes premature menopause, premature ovarian failure (POF) and premature ovarian insufficiency. Women with premature menopause should discuss hormone therapy with their health care provider to help prevent certain age-related diseases.

WHAT ABOUT MOOD SWINGS, MEMORY LOSS AND DEPRESSION?

Many women often experience irritability, tearfulness, anxiety, difficulty concentrating, lack of energy, poor concentration and mood swings as they go through menopause. But, are all of these things caused by menopause?

Mood swings vs. depression: Mood swings related to menopause and depression are two separate things. Menopause does not cause depression nor are there higher rates of depression among menopausal women. However, sleep disorders and hot flushes (flashes) are common, and these can contribute to feeling irritable and moody.

Memory and menopause: What about memory problems? Many women report difficulties with their memory and with concentration during the transition to menopause. Studies that attempted to measure memory changes in this group tend to be small in size, and the memory tests that are used in these studies may not reflect the kinds of memory-related tasks women do in real life. Many authors also point out that the way we see ourselves ("I have a poor memory!") does not always match with objective tests that demonstrate our abilities (e.g. You scored well on a memory recall test; or you could remember all the words to a song you just heard). Given these shortcomings, it is difficult to assess whether menopause and memory loss are correlated.

Menopause is just one of many challenges that women face. Mid-life is full of stressors that impact our mental health. Dealing with adolescent children, facing an empty nest, increased career demands, financial challenges, and care of aging parents can influence a woman's perception of stress and distress in her personal environment. With the arrival of menopause, with sleep disturbances and hot flushing, the situation may seem unmanageable.

THE TAKEAWAY MESSAGE: Try to relieve the important factors in daily life that are likely contributing to changes in mood and stress.

Please talk to your health care provider if you are concerned about your mental health.

WILL MY SEX LIFE CHANGE AFTER MENOPAUSE?

A healthy and active sex life prior to menopause is likely to remain healthy and active after menopause. Unfortunately, sexual dysfunction can happen at any age—from adolescence to post-menopause.

For some women, menopause **does affect their sex life**. Here are a few common conditions:

Low sexual desire, also known as hyposexual desire disorder (HSDD), includes the absence of sexual fantasies or desire for any form of sexual activity. This absence of desire is often distressing to the woman, and may cause difficulties in her sexual relationship. Women who have had their ovaries surgically removed (i.e. have undergone surgical menopause) are more likely to experience HSDD than women who experience natural menopause.

Sexual pain disorders are the result of the thinning of the vulva, vagina and urinary tract over time. Known as vulvovaginal atrophy, or VVA for short, this thinning occurs with the loss of estrogen production during menopause. In addition, a loss of vaginal elasticity can make sexual intercourse uncomfortable and result in tears of delicate tissue. There is also an increased risk of vaginal infections and reactive spasms of vaginal muscle secondary to painful intercourse. Simple solutions such as using vaginal lubricants and moisturizers can help; your doctor may prescribe estrogen creams, tablets or rings in more severe cases. All patients with sexual pain should be assessed for gynecological conditions.

There are also situations related to menopause that in turn affect sexual desire: Although not directly caused by menopause, depression is common in women. The average lifetime prevalence of major depression in women is approximately 20% and can dampen sex drive and affect the global sexual response cycle. Some antidepressants particularly selective serotonin reuptake inhibitors (SSRIs) can also lessen sexual desire.

Relationship issues. Menopause can be a challenging time; when a woman is unhappy, angry or disappointed with her partner, her sex life may suffer too. Research has shown that relationship issues can be a factor in lack of sexual desire, more so than hormone levels.

THE TAKEAWAY MESSAGE: Menopause does ***not*** *signal the end of a healthy and active sex life! Do not be afraid to talk to your health care provider. With appropriate evaluation, possible treatment, counseling, and involvement of your partner, you can resolve many issues and continue to have an enjoyable sex life well beyond menopause.*

WHAT CAN I DO ABOUT HOT FLUSHES?

While hot flushes (flashes) are fairly common, they are not universal. In North America, about 75% of women experience hot flushes as they go through menopause. Hot flushes start at menopause transition, and are most prominent in the first two years of menopause. While the cause of hot flushes is not fully understood, it is known that a decrease in estrogen levels plays an important role. Unlike vaginal dryness that only worsens with time, hot flushes usually disappear after 7 years in 60% of menopausal women, although up to 15% of women still report hot flushes for 10 years or more.

Most hot flushes are mild to moderate. Severe hot flushes that disrupt quality of life happen to about 10% of women. Mild flushes can usually be managed with lifestyle modifications such as keeping yourself cool, regular exercise, weight control, smoke cessation and avoidance of triggers (e.g. hot and spicy food, caffeinated beverages and alcohol).

Hormone therapy remains the most effective treatment to relieve hot flushes in menopausal women. If you are unable to use hormone therapy, your doctor can prescribe you a non-hormonal treatment. If you are thinking of taking a complementary and alternative medicine (herbal preparation, soy, or other botanical) it is worth knowing that many of these treatments have been shown to have little benefit. What's more, most have no safety data.

THE TAKEAWAY MESSAGE: *Hot flushes are common but they are manageable, both with lifestyle modifications and with hormone therapy.*

DOES HORMONE THERAPY CAUSE BREAST CANCER?

Research has shown a link between hormone therapy and breast cancer: it is uncertain whether estrogen causes breast cancer or promotes the growth of pre-existing tumors. Current research points to estrogen as NOT causing breast cancer.

In 2002, the Women's Health Initiative (WHI), the largest study of women and hormone therapy, reported that increased estrogen and progestin use in women with a uterus was associated with a small increased risk of breast cancer at 5 years. In 2004 the Women's Health Initiative Estrogen only arm (women without a uterus) did not show an increased risk of breast cancer after 6.8 years on estrogen only.

Other studies have shown that the longer the use and the greater the dose of estrogen, the higher the risk of breast cancer. This is why many healthcare practitioners prescribe HRT at "the lowest effective dose for the shortest time."

THE TAKEAWAY MESSAGE: Menopausal women (aged 50-60) who are suffering hot flushes should know that short term use of hormone therapy will have very little impact on their personal breast cancer risk. If women are at a high risk, they need to discuss their personal benefit/risk situation with their physician to make a decision.

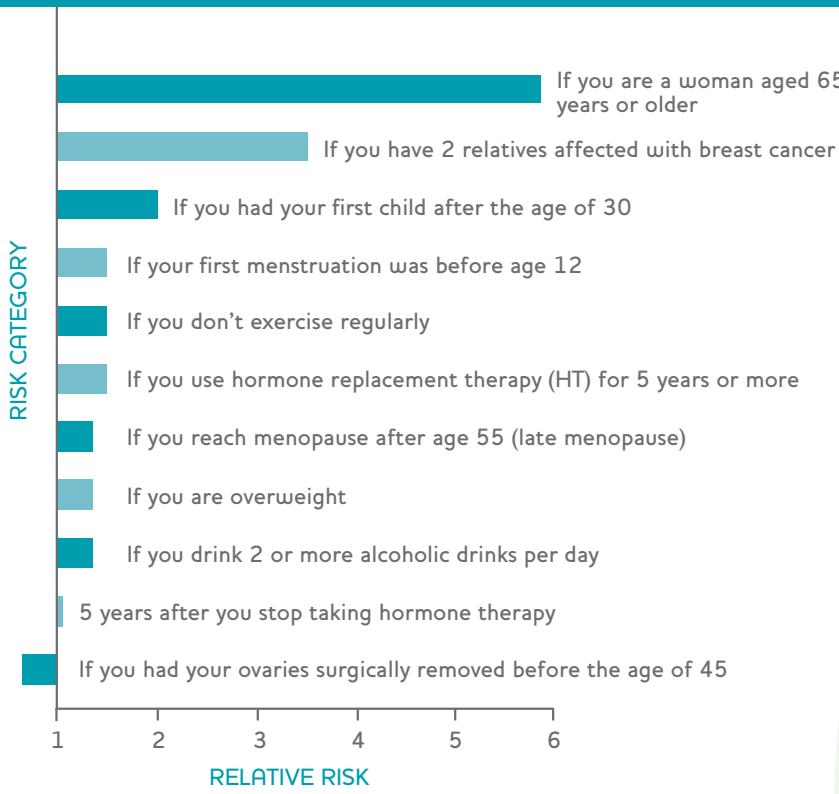
Know your personal risks of developing breast cancer:

MAJOR RISK FACTORS INCLUDE: age (risk increases significantly after age 55); family history; previous breast biopsy that showed abnormal cells; increased breast density on mammography; never having children (or having first child after age 30).

LIFESTYLE CHOICES THAT IMPACT YOUR RISK INCLUDE: lack of exercise; excessive alcohol intake (more than 2 drinks per day); obesity and weight gain after menopause; smoking; not breast feeding.

DID YOU KNOW? Early diagnosis of breast cancer has been shown to reduce mortality risk by approximately one-third in women aged 50-69. At present, the only proven strategy to reduce breast cancer deaths is early detection through mammography in women over 50.

RISK FACTORS FOR BREAST CANCER



It may surprise you, but lifestyle factors such as lack of exercise, alcohol intake and weight gain after menopause also have an impact on your risk of developing breast cancer similar to or greater than the use of hormone therapy!

THE TAKEAWAY MESSAGE: *When post menopausal women (age 50-60) experience distressing vasomotor symptoms (hot flushes), they should know that* ***SHORT TERM USE*** *of hormone therapy will have little effect on their personal breast cancer risk, yet will afford them excellent symptom control and quality of life. Longer use of hormone therapy* ***DOES*** *increase breast cancer risk, similar to lifestyle risks.*

DOES HORMONE THERAPY CAUSE HEART ATTACKS?

Heart disease is the number one killer of women in Canada. Hormone therapy alone does NOT increase the risk of heart attack. The single most important factor for heart disease is AGE; being premenopausal is protective and the risk is low, but after menopause as the woman grows older, the risks of heart disease increase.

The seven major factors which explain 94% of the risks of heart attacks have been identified as: smoking, abnormal lipid profile, hypertension, abdominal obesity, poor diet, excess alcohol and stress. The really good news is that these are ***modifiable*** – meaning you can do something about them.

The landmark 2002 Women's Health Initiative (WHI) study of women who started menopausal hormones between 50-80 yrs of age raised concerns about the relationship between hormonal therapy and heart attacks.

BUT there is more to the story that you may not know: The initial results were reported by popular media as causing 26% more heart attacks in post menopausal women (50-80 yrs old) taking estrogen + progestin (vs. those not taking hormone therapy) but failed to clarify what this meant. Those who started hormone therapy between 50-59 years of age were **less** likely to die from coronary artery disease (one less death per 1000 HT users). In a reanalysis of the WHI data and other studies, a clear outcome emerged: risks associated with postmenopausal hormonal therapy (estrogen/estrogen-progestin) are age-related. That is, prior to giving treatment with any hormone therapy, women in their 50's have half the CV risk of women in their 60's, and one quarter the risk of women in their 70's.

It is important for a physician to consider the age of a patient before prescribing hormone therapy. There is good evidence that women who start HT between 50-59 years of age are **not** at increased risk of cardiovascular disease, and may indeed experience **cardiovascular benefits** as a result of taking hormone therapy.

THE TAKEAWAY MESSAGE: *Women in the 50-59 year-old age group should feel reassured that taking hormone therapy is not harmful to their heart health. Women experiencing hot flushes and other symptoms should not hesitate to take HT for relief of their symptoms. However, caution is advised if hormone therapy is being considered for the older postmenopausal woman, as starting menopausal hormones after age 60, and particularly after age 70, could have adverse effects.*

THE FACTS:

Used at the right age, hormone therapy can be good for your heart

Studies have shown that starting hormone therapy in early menopause is safe, and may actually have beneficial qualities in protecting heart health. Currently the Society of Obstetricians and Gynecologists of Canada (SOGC), North American Menopause Society (NAMS) and International Menopause Society (IMS) recommend that hormone therapy should be used for the management of moderate to severe menopausal symptoms, and should not be prescribed solely to prevent heart disease.

DOES HORMONE THERAPY CAUSE STROKES?

Strokes are not uncommon in both Canadian men and women. They occur in one in five Canadian women, and are the third leading cause of death. Unlike heart disease, being premenopausal does not offer any protection from stroke. However, the incidence of stroke is very small for the younger women, between ages 50 to 59.

Even though stroke increases with age, the key to reducing stroke risk – regardless of whether or not you are on hormone therapy – is a healthy lifestyle. This should include an active exercise program, controlling blood pressure as well as weight and diabetes (if relevant), stopping smoking, and limiting alcohol intake.

What about the use of menopausal hormone therapy (MHT)?

The relationship between hormone therapy and ischemic strokes (a clogged blood vessel obstructing blood flow to the brain) is fraught with misinformation and fear. The results of studies looking at whether use of menopausal HT increases strokes are conflicting: many have shown no effect, some found a decrease, while others have shown an increase of strokes with HT.

Most recent studies have shown that lower doses of estrogen, the addition of micronized progesterone and most recently, the use of transdermal preparations (i.e. estrogen patches or gels), do not appear to increase stroke risk.

AM I TOO YOUNG TO WORRY ABOUT SOMETHING LIKE OSTEOPOROSIS?

Women lose bones more rapidly than men during the menopause transition when the estrogen level declines. A woman in her 50 has a 40% chance of developing hip, vertebral and wrist fractures in her lifetime. It is never too young to prevent osteoporosis.

RISK FACTORS FOR OSTEOPOROSIS.

Knowing your risk factors can help you determine what preventative measures you can take to reduce your risk of osteoporosis and fracture. You can take an online test for fracture risk developed by the World Health Organization called FRAX.

You could be at higher risk of developing osteoporosis if any of the following apply to you:

- Have suffered a previous fragility fracture
- Experienced loss of 1.5 inches or 3 cm in height
- Low body mass index
- Smoking, consumption of more than two alcoholic drinks per day
- History of corticosteroid use
- Family history of osteoporosis

One of the largest clinical studies of postmenopausal women – the Women's Health Initiatives (WHI) – demonstrated that even in a population of older postmenopausal women **not** at increased risk for fracture, the risk of hip fractures were reduced by taking hormone. Women with menopausal symptoms requiring estrogen may be reassured that this therapy is safe when initiated early after menopause and will also slow bone loss.

THE TAKEAWAY MESSAGE: *Menopause can put you at increased risk of developing osteoporosis – so talk to your doctor about what steps you should take to monitor and/or prevent bone loss. There are some HT treatments that are indicated for the prevention of osteoporosis – you and your doctor can decide if this treatment is right for you.*

WILL I GET BLOOD CLOTS IF I AM TAKING HORMONE THERAPY?

The majority of women taking hormone therapy do not experience blood clots in their legs (DVT: deep venous thrombosis) and or in their lungs (PE: pulmonary embolism). However, some women are at an increased risk of developing blood clots.

Based on Women's Health Initiative (WHI), oral estrogen (Premarin® 0.625 mg) and progestin (Provera® 2.5 mg) increased venous thromboembolism (VTE) two fold. With estrogen alone (Premarin® 0.625 mg), the VTE risk increased only slightly.

Recent data have suggested that with respect to hormone therapy and blood clots, the risk is greatest in the first 3 months of therapy, but then the risk decreases. ***Some data indicates that transdermal and lower-dose HT result in reduced risk of blood clots.***

Know your risk. *All women should know their personal risk for VTE before considering HT:*

- Age (risk increases with age)
- Weight (obesity and being overweight contribute to higher risk)
- Having a prior case of VTE
- Family history
- Smoking
- Pregnancy
- Being immobile (due to major surgery, especially bone and joint, abdominal, or pelvic surgery; or from suffering a fracture)
- Illness
- Injury or trauma
- Using oral contraceptives or HT

THE TAKEAWAY MESSAGE: *If you are considering HT, assess your risk of developing VTE and talk to your healthcare professional.* ***You may also want to consider reducing your risk of VTE using the following strategies:***

- Use a low dose of HT
- Use a transdermal ("patch or gel on the skin") form of HT
- Discontinue risky habits, such as smoking
- Keep an active lifestyle and practice weight control
- If you have a strong family history of VTEs or strokes, ask your doctor if you are a candidate for special tests for inherited risks for thrombophilia (i.e. a predisposition for blood clots)

AT THIS AGE, AM I AT INCREASED RISK FOR COLORECTAL CANCER (CRC)?

Menopause does not increase the risk for CRC, but growing older does. In fact, 93% of CRC cases occur in people over 50 years. Although it is not as well known as breast or ovarian cancer, CRC is the third most common cancer and affects both men and women equally. Screening for this cancer should be offered to all adults aged 50 to 74.

You can determine your risk for CRC using the simplified table below:

YOUR HISTORY (OVER 50 YEARS OLD	YOUR RISK	YOUR ACTION PLAN
• Showing no symptoms of CRC • No family or personal history of CRC or polyps	AVERAGE	Talk to your doctor about getting a fecal occult blood test (FOBT) done every 2 years
• Have two first-degree relatives (e.g. mother, sibling) with CRC or precancerous polyps at any age OR: • Have one first-degree relative with CRC or precancerous polyps BEFORE the age of 60	ABOVE AVERAGE	Talk to your doctor about getting a regularly scheduled colonoscopy
• Have a personal history of CRC, precancerous polyps, or inflammatory bowel disease	HIGH RISK	Ensure your doctor monitors your health regularly, as well as scheduling ongoing surveillance with colonoscopy

It's a good idea to talk to your doctor about your own personal risk of developing CRC.

THE WHI STUDY SHOWED THAT THERE MAY BE BENEFITS TO TAKING HT: IN THE TREATMENT GROUP TAKING ESTROGEN/PROGESTIN, 45 CASES OF COLON CANCER WERE OBSERVED, WHILE IN THE PLACEBO GROUP (PATIENTS TAKING "EMPTY" PILL), 67 CASES OF COLON CANCER WERE OBSERVED AFTER A 7-YEAR PERIOD.

ARE BIO-IDENTICAL HORMONES "NATURAL" AND SAFER THAN THE STANDARD HORMONE THERAPIES?

The term "bioidentical hormone" usually refers to estrogen and progesterone that are chemically identical to what our body produces. As such, it includes both government approved hormone therapy and custom-compounded hormone therapy. It refers to plant (soy and yam) hormones that are chemically altered to be similar to our body hormones.

There are many government approved hormone therapies that are produced from plants and are available as oral pills, gels, patches, and vaginal tablets. Speak to your doctors if you desire a plant-based government hormone therapy.

Custom-compounded hormone therapy refers to a hormone "recipe" made by a compounding pharmacist from a physician's prescription. The concern of custom-compounded hormone therapy is in its production. The production is not regulated and uniform standards for making these compounded products do not exist.

If custom-compounded hormone therapies are identical to the hormones in my body, aren't they safe and more effective?

There is no scientific evidence to back up the manufacturer's claims that custom-compounded hormone therapies are effective or safe because they have not gone through the vigorous process of testing by Health Canada.

THE TAKEAWAY MESSAGE: Similar to complementary therapies or natural remedies, it is "buyer beware": be careful when you decide to use a treatment that doesn't have important safety and dosing information. Beware of promises that seem too good to be true. And remember, if you want to take a bioidentical hormone therapy, there are a number of commercially available and approved pharmaceutical hormonal products that are bioidentical (including skin patches, gels, and oral pills). These have been widely tested for safety and effectiveness. Talk to your doctor about these options to see if they are appropriate for you personally.

ARE COMPLEMENTARY (OR "ALTERNATIVE") THERAPIES EFFECTIVE FOR MANAGING MENOPAUSE?

The thought of treating menopause "naturally" using herbal remedies is appealing to many women. Perhaps this is because many of us associate natural with harmless. Unfortunately, natural products are not always safe, and what's more, they are not necessarily as effective as advertised, when it comes to relieving menopause symptoms.

(HOT) FLUSH-IN-THE-PAN REMEDIES.

Many of the herbal remedy products currently on the market have been shown to have limited efficacy in relieving hot flushes. In a recent review, it was pointed out that although individual trials might suggest benefits from certain therapies, there is not enough conclusive evidence to show that complementary and alternative therapies are truly effective in managing menopausal symptoms. As well, without long-term safety and efficacy data, we cannot be sure that there is no harm. Side effects and drug interactions are not well known, but do occur.

THE TAKEAWAY MESSAGE: Again, it's "buyer beware" when it comes to buying natural remedies. Up until 2004, there were no limitations on product claims, leading many women to believe and buy products that promised more than they were able to deliver. This has been borne out of numerous consumer reports that have highlighted problems with inaccurate or false labelling. In the end, it is best to be wary of any herbal remedy product that promises relief from menopause symptoms.

Hormone therapy remains the best treatment for hot flushes.

ACKNOWLEDGEMENTS

EDITOR:

Dr. Chui Kin Yuen, MD, FRCS(C), FACOG, MBA

Dr. Denise Black, MD, FRCS(C)

REVIEWERS:

Dr. Christine Derzko, MD, FRCS(C)

Dr. Elaine Jolly, O.C., MD, FRCS(C)

Dr. David Kendler, MD, FRCP(C), ABIM

Dr. Brent Kvern, MD, CCFP, FCFP

Dr. Marla Shapiro, MDCM, CCFP, MHSc, FRCP(C), FCFP, NCMP

SIGMA Canadian Menopause Society
150-943 West Broadway, Vancouver, BC V5Z 4E1

Email: sigmamenopause@gmail.com
Phone: 604-263-3644 **Fax:** 604-263-3744

WWW.SIGMAMENOPAUSE.COM

This brochure was made possible through financial support by Merck Canada.