Menopause 101: How to Initiate Treatment

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The mean age of natural menopause is 51 years and the majority of women will be postmenopausal for greater than one-third of their lives. 70-80% of postmenopausal women experience vasomotor symptoms (VMS), although the duration and severity of VMS vary for individual women. VMS are most prevalent in the late perimenopause and symptoms peak for approximately 1 year after menopause. Longitudinal data from a large U.S. study indicated that hot flashes persist longer than initially thought, with a median duration of 7.4 years. VMS are associated with decreased sleep, irritability, difficulty concentrating, reduced quality of life, poor health, and bone loss. They are also associated with an increased risk of cardiovascular disease and cognitive changes. Menopausal symptoms that go untreated are also associated with higher health care costs and loss of work productivity. Genitourinary syndrome of menopause (GSM), including dyspareunia, vulvar-vaginal atrophy (VVA) and urinary symptoms, affects approximately 30% to 50% of postmenopausal women. Whereas VMS are often transient, VVA symptoms are typically chronic and progressive and usually do not resolve without treatment. Bone loss and fracture risk can also accelerate during this time of estrogen decline but can be maintained if given hormone therapy (HT). Although HT is the most effective treatment for VMS and GSM, and can prevent menopausal bone loss and fracture risk, the use of systemic HT has decreased by at least 80% among U.S. women since the initial findings of the Women's Health Initiative (WHI) were published in 2002. This is despite the recent WHI 18 year cumulative follow up study which reported that HT was not associated with increased risk of all-cause, cardiovascular, or cancer mortality. In addition, guidelines from NAMS and other professional societies recommend HT for symptomatic women without contraindications, less than age 60 years, and within 10 years after the onset of menopause. HT is also recommended for women with early menopause or primary ovarian insufficiency, and should be used until at least the average age of menopause, 51 years. Systemic HT is FDA approved as first line therapy and remains the most effective treatment for the relief of menopausal VMS. HT can also reduce bone loss and fracture risk, and when given locally at lower doses, it can relieve symptoms of GSM. The decision to initiate or continue HT involves a careful assessment of the potential benefits and risks, but the majority of symptomatic healthy women will experience a significant quality of life benefit from the use of HT. The benefits of HT usually outweigh the risks for women without contraindications such as breast cancer, endometrial cancer, cardiovascular disease, active liver disease, and undiagnosed vaginal bleeding. Baseline risk of cardiovascular disease and breast cancer, and personalized risk assessment is helpful for an initial therapeutic recommendation. Before initiating therapy, a comprehensive past medical, gynecologic, surgical and family history is advised along with an updated physical exam, pertinent laboratory tests (liver function tests, lipids), and mammogram. Clinical decision support tools, such as the NAMS MenoPro free mobile app provides an algorithm to facilitate the individualized risk assessment required for counseling menopausal women regarding the benefits vs risks of HT. This decision support tool, can help identify appropriate candidates for HT, and includes information for both health care consumers and clinicians. MenoPro, has a separate mode for clinicians and patients, and facilitates shared decision making. For women with contraindications or choose not to use HT, it provides non-hormonal therapies and alternatives for GSM if this is her only symptom. The optimal duration of HT or alternate therapy varies for individual women. In the absence of contraindications, if on HT, women and clinicians should share in the decision of a preferred dose, formulation, and duration of use, with ongoing yearly reevaluation of the risks and benefits, and education about other alternatives.