

Editorial

Menopause

Menopause is the time that marks the end of the menstrual cycle and is diagnosed when a woman has not had a period for one year. Average age of menopause in Bangladesh is 51 years. World Health Organization (WHO) define natural menopause as the “permanent cessation of menstruation resulting from loss of ovarian follicular activity” and no other biological or physiological cause can be identified. Menopause is prompted by decline in oestrogen and progesterone production, and rising follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels. But the hormonal changes and clinical symptoms occur over a period of time both proceeding to and also following menopause; this period is frequently termed as menopausal transition (MT) or climacteric. During the menopausal transition, women often experience a range of symptoms like hot flushes (most common), insomnia, weight gain and bloating, mood changes, irregular menses, breast pain, depression, headache and is associated with an accelerated loss of bone mineral density (BMD), which increases the risk of osteoporosis and bone fractures. BMD loss starts before the final menstrual period, and continues throughout the menopausal transition. This fast decline in BMD can be associated with irreversible disruption of bone microarchitecture and a greater risk of spine and hip fractures .

Menopausal symptoms are often misunderstood, ridiculed and underestimated. However they may severely affect a woman's health and quality of life. Hot flushes and sweats can sometimes be so bad which constantly interrupt sleep. Menopause also lead to low mood, osteoporosis and urogenital changes that can cause vaginal dryness, urinary tract infections, and adversely affect a woman's sexual life. We have to adopt an individualized approach to the management of menopause. We need to give information to menopausal women and their family members which should include – explanation of the symptoms of menopause, lifestyle changes and interventions that could maintain general health and wellbeing and if needed benefits and risks of medical treatments for menopausal symptoms with long-term health implications. This management system is termed as menopausal replacement therapy (MRT)

Treatment options for menopausal symptoms include lifestyle changes, hormonal and non-hormonal medications. One need to eat low salt, low fat, low sugar and high fiber diet which are present in variety of fruits and vegetables. Menopause friendly foods are broccoli, carrot, legumes (beans, peas, peanuts), orange, dairy products, soya (tofu, soya milk). To avoid hot flush first step is to cut out caffeine, alcohol and spicy food. An exercise program that includes walking or weight training for 30 minutes per day can help reduce the risk of osteoporosis.

Hormone replacement therapy (HRT) was once recommended to women almost universally for both short and long term use but since 2002 when research pointed out to an increase risk of cardiovascular disease and breast cancer for some women, recommendation have changed significantly². It is now recommended that HRT be used at the lowest possible dose for the shortest possible time and only for women experiencing moderate to severe menopausal symptoms in spite of life style changes. Short term (up to 5 years) HRT is generally considered safe but each woman need to discuss her individual situation with her attending physician to see whether she has got any contraindications for HRT. Complete history and physical examination should be done. Some related investigations like OGTT, pap smear, mammogram, TVS (if irregular per vaginal bleeding) bone density scan (if indicated) should be done.

The choice of HRT for an individual depends on an overall balance of indication, risk-benefit profile, side effects and convenience. HRT mainly include oestrogen which is available in oral, transdermal and subcutaneous (patch) form. The other associated drugs are progestogens, \pm -adrenergic drugs (clonidine), gabapentin, SSRI (venlafaxine and paroxetine), tibolone, herbal(black cohosh, wild yam) and bio-identical. HRT should be started at a low dose especially in older women and increased if symptoms persist after a few months.

Regarding the adverse effects it is observed that HRT with oestrogen alone is associated with little or no change in the risk of breast cancer. HRT with

oestrogen and progestogen can be associated with an increase risk of breast cancer and it is related with treatment duration and reduces after stopping HRT¹. But micronised progesterone and dydrogesterone may be associated with lower risk of breast cancer and venous thrombosis compared to other progestogens¹. Transdermal administration of estradiol is associated with lower risk of venous thrombosis or stroke than the oral users. Patches deliver a more steady level of hormone which can also be helpful in conditions triggered by fluctuating levels e.g. migraine. HRT does not increase cardiovascular disease risk when started in women under 60 years. Presence of cardio vascular risk factors is not a contra indication to HRT as long as they are optimally managed¹. HRT (either orally or transdermally) is not associated with an increased risk of developing neither type 2 diabetes nor an adverse effect on blood glucose control. HRT should be considered for menopausal symptoms in women with type 2 diabetes after taking comorbidities into account and seeking specialist advice if needed¹. Tibolone is a synthetic steroidal compound with oestrogenic, progestogenic, and androgenic activity. It is an option for postmenopausal women where progestin-containing therapy is not appropriate (e.g. progestogenic adverse effects).

Review of HRT treatment is done 3 months after commencement and annually thereafter once settled on treatment. Endometrial thickness is not monitored routinely in follow up. However any unscheduled per vaginal bleeding should be reported for evaluation. Women with POI should use HRT at least until the average age of menopause. If HRT is to be used in women over 60 years of age, lower doses should be started, preferably with a transdermal route of estradiol administration.

The decision whether to use HRT should be made by each woman having been given sufficient accurate information to make a fully informed choice.

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