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Managing Menopause

This clinical practice guideline has been prepared by the Menopause and Osteoporosis Working Group, reviewed by the Clinical Practice Gynaecology and Family Physician Advisory Committees, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To provide updated guidelines for health care providers on the management of menopause in asymptomatic healthy women as well as in women presenting with vasomotor or urogenital symptoms and on considerations related to cardiovascular disease, breast cancer, urogynaecology, and sexuality.

Outcomes: Lifestyle interventions, prescription medications, and complementary and alternative therapies are presented according to their efficacy in the treatment of menopausal symptoms. Counselling and therapeutic strategies for sexuality concerns in the peri- and postmenopausal years are reviewed. Approaches to the identification and evaluation of women at high risk of osteoporosis, along with options for prevention and treatment, are presented in the companion osteoporosis guideline.

Evidence: Published literature was retrieved through searches of PubMed and The Cochrane Library in August and September 2012 with the use of appropriate controlled vocabulary (e.g., hormone therapy, menopause, cardiovascular diseases, and sexual function) and key words (e.g., hormone therapy, perimenopause, heart disease, and sexuality). Results were restricted to clinical practice guidelines, systematic reviews, randomized control trials/controlled clinical trials, and observational studies. Results were limited to publication dates of 2009 onwards and to material in English or French. Searches were updated on a regular basis and incorporated in the guideline until January 5, 2013. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology assessment-related agencies, national and international medical specialty societies, and clinical practice guideline collections.

Key Words: Menopause, estrogen, vasomotor symptoms, urogenital symptoms, mood, memory, cardiovascular diseases, breast cancer, lifestyle, nutrition, exercise, estrogen therapy, complementary therapies, progestin, androgen, menopausal hormone therapy, hormones, estrogen, testosterone, menopause, depression, antidepressants, sexuality

Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

Values: The quality of the evidence in this document was rated using the criteria described by the Report of the Canadian Task Force on Preventive Health Care (Table).

SUMMARY STATEMENTS AND RECOMMENDATIONS

Chapter 1: Assessment and Risk Management of Menopausal Women

Recommendations for Patients

1. Women aged 51 to 70 should consume 7 servings of vegetables and fruits, 6 of grain products, 3 of milk and alternatives, and 2 of meat and alternatives daily. (III-A)
2. A diet low in sodium and simple sugars, with substitution of unsaturated fats for saturated and trans fats, as well as increased consumption of fruits, vegetables, and fibre, is recommended. (I-A)
3. Routine vitamin D supplementation and calcium intake for all Canadian adults year round is recommended. (I-A)
4. Achieving and maintaining a healthy weight throughout life is recommended. (I-A)
5. Women aged 18 to 64 should accumulate at least 150 minutes of moderate to vigorous aerobic physical activity per week in bouts of 10 minutes or more. (I-A)

Recommendations for Health Care Providers

1. A waist circumference ≥ 88 cm (35 in) for women is associated with an increased risk of health problems such as diabetes, heart disease, and hypertension and should be part of the initial assessment to identify risk. (II-2A)
2. Tobacco-use status should be updated for all patients on a regular basis, (I-A) health care providers should clearly advise patients to quit, (I-C) the willingness of patients to begin treatment to achieve abstinence (quitting) should be assessed, (I-C) and every tobacco user who expresses the willingness to begin treatment to quit should be offered assistance. (I-A)
3. Blood pressure should be assessed and controlled as women go through menopause. (II-2B) If the systolic blood pressure is ≥ 140 mmHg and/or the diastolic blood pressure is ≥ 90 mmHg, a specific visit should be scheduled for the assessment of hypertension. (III-A)
4. Women ≥ 50 years of age or postmenopausal and those with additional risk factors, such as current cigarette smoking, diabetes, and arterial hypertension, should have lipid-profile screening done. (II-2A)
5. A cardiovascular risk assessment using the Framingham Risk Score should be completed every 3 to 5 years for women aged 50 to 75. (II-2A)
6. A history of past pregnancy complications (preeclampsia, gestational hypertension, gestational diabetes, placental abruption, idiopathic preterm delivery, and/or fetal growth restriction) should be elicited since it can often predict an increased risk for premature cardiovascular disease and cardiovascular death and may inform decisions about the need for screening. (II-2B)

Chapter 2: Cardiovascular Disease

Recommendations

1. Health care providers should not initiate hormone therapy for the sole purpose of preventing cardiovascular disease (coronary artery disease and stroke) in older postmenopausal women since there are no data to support this indication for hormone therapy. (I-A)
2. The risk of venous thromboembolism increases with age and obesity, in carriers of a factor V Leiden mutation, and in women with a history of deep vein thrombosis. Transdermal therapy is associated with a lower risk of deep vein thrombosis than oral therapy and should be considered only if the benefits outweigh the risks. (III-C) Health care providers should abstain from prescribing oral hormone therapy for women at high risk of venous thromboembolism. (I-A)
3. Health care providers should initiate other evidence-based therapies and interventions to effectively reduce the risk of cardiovascular disease events in women with or without vascular disease. (I-A)

4. Risk factors for stroke (obesity, hypertension, elevated cholesterol levels, diabetes, and cigarette smoking) should be addressed in all postmenopausal women. (I-A)
5. If prescribing hormone therapy to older postmenopausal women, health care providers should address cardiovascular risk factors; low- or ultralow-dose estrogen therapy is preferred. (I-B)
6. Health care providers may prescribe hormone therapy to diabetic women for the relief of menopausal symptoms. (I-A)

Chapter 3: Menopausal Hormone Therapy and Breast Cancer

Recommendations

1. Health care providers should periodically review the risks and benefits of prescribing hormone therapy to a menopausal woman in light of the association between duration of use and breast cancer risk. (I-A)
2. Health care providers may prescribe hormone therapy for menopausal symptoms in women at increased risk of breast cancer with appropriate counselling and surveillance. (I-A)
3. Health care providers should clearly discuss the uncertainty of risks associated with systemic hormone therapy after a diagnosis of breast cancer in women seeking treatment for distressing symptoms (vasomotor symptoms or vulvovaginal atrophy). (I-B)

Chapter 4: Vasomotor Symptoms

Recommendations

1. Lifestyle modifications, including reducing core body temperature, regular exercise, weight management, smoking cessation, and avoidance of known triggers such as hot drinks and alcohol, may be recommended to reduce mild vasomotor symptoms. (I-C)
2. Health care providers should offer hormone therapy, estrogen alone or combined with a progestin, as the most effective therapy for the medical management of menopausal symptoms. (I-A)
3. Progestins alone or low-dose oral contraceptives can be offered as alternatives for the relief of menopausal symptoms during the menopausal transition. (I-A)
4. Non-hormonal prescription therapies, including certain antidepressant agents, gabapentin, and clonidine, may afford some relief from hot flashes but have their own side effects. These alternatives can be considered when hormone therapy is contraindicated or not desired. (I-B)
5. There is limited evidence of benefit for most complementary and alternative approaches to the management of hot flashes. Without good evidence for effectiveness, and in the face of minimal data on safety, these approaches should not be recommended. Women should be advised that, until January 2004, most natural health products were introduced into Canada as “food products” and did not fall under the regulatory requirements for pharmaceutical products. As such, most have not been rigorously tested for the treatment of moderate to severe hot flashes, and many lack evidence of efficacy and safety. (I-B)
6. Estrogen therapy can be offered to women who have undergone surgical menopause for the treatment of endometriosis. (I-A)

Chapter 5: Urogenital Health

Recommendations

1. Conjugated estrogen cream, an intravaginal sustained-release estradiol ring, and low-dose estradiol vaginal tablets are recommended as effective treatment for vaginal atrophy. (I-A)
2. Routine progestin co-therapy is not required for endometrial protection in women receiving vaginal estrogen therapy in an appropriate dose. (III-C)
3. Vaginal lubricants may be recommended for subjective symptom improvement of dyspareunia. (II-2B)
4. Because systemic absorption of vaginal estrogen is minimal, its use is not contraindicated in women with contraindications to systemic estrogen therapy, including recent stroke and thromboembolic disease. (III-C) However, there are currently insufficient data to recommend its use in women with breast cancer who are receiving aromatase inhibitors (where the goal of adjuvant therapy is a complete absence of estrogen at the tissue level). Its use in this circumstance needs to be dictated by quality-of-life concerns after discussion of possible risks. (III-C)
5. Systemic estrogen therapy should not be recommended for the treatment of postmenopausal urge or stress urinary incontinence given the lack of evidence of therapeutic benefit. (I-A) Vaginal estrogen may, however, be recommended, particularly for the management of urinary urge incontinence. (II-1A)
6. As part of the management of stress incontinence, women should be encouraged to try non-surgical options, including weight loss (in obese women). (I-A) Pelvic floor physiotherapy, with or without biofeedback, (II-1B) weighted vaginal cones, (II-2B) functional electrical stimulation, (I-B) and/or intravaginal pessaries (II-2B) can also be recommended.
7. Behavioural modification, (II-2B) functional electrical stimulation (II-1B), and antimuscarinic therapy (I-A) are recommended for the treatment of urge urinary incontinence.
8. Vaginal estrogen therapy can be recommended for the prevention of recurrent urinary tract infections in postmenopausal women. (I-B)

Chapter 6: Prescription Therapeutic Agents

No recommendations

Chapter 7: Ongoing Management of the Menopausal Woman and Those With Special Considerations

Recommendations

1. Any unexpected vaginal bleeding that occurs after 12 months of amenorrhea is considered postmenopausal bleeding and should be investigated. (I-A)
2. Cyclic (at least 12 days per month) or continuous progestogen therapy should be added to estrogen therapy if women have an intact uterus; physicians should monitor adherence to the progestogen therapy. (I-A)
3. Hormone therapy should be offered to women with premature ovarian failure or early menopause, (I-A) and its use until the natural age of menopause should be recommended. (III-B)
4. Estrogen therapy can be offered to women who have undergone surgical menopause for the treatment of endometriosis. (I-A)

Chapter 8: Sexuality and Menopause

Summary Statements

1. Sexuality is multifactorial, biopsychological, and affected by psychological, relationship, physical, social, and cultural factors, as well as aging and hormonal decline. (II-2)

2. Although desire, arousal, orgasm, and satisfaction decline with menopause and age, the potential for sexual satisfaction still exists. (II-2)
3. Decreased desire is the most common sexual problem in middle-aged women, occurring in up to 40%. However, only 12% of menopausal women are personally distressed by the problem. (II-2)
4. As women age, their sexual function is affected by the presence or absence of a partner and the partner's health and sexual function. (II-2)
5. Surgically menopausal women have a higher prevalence of decreased libido and distress than naturally menopausal women. (II-2)
6. Satisfying sexual contact improves quality of life as women age. (II-2)
7. Medical and psychological illnesses and their treatment can affect sexuality. (II-2)
8. Women may be reluctant to discuss their sexuality with physicians. (II-2)

Recommendations

1. Health care providers should acknowledge that aging women are sexual and have sexual needs but may be unwilling to initiate a discussion about problems. (III-A)
2. Health care providers should be sensitive to changes in sexuality in women as they age or illnesses develop. (III-A)
3. Women and their partners should be educated about the changes affecting sexuality that occur as women age. (III-A)
4. If women have decreased sexual desire and are not distressed, no therapy is necessary. (III-B)

FEMALE SEXUAL DYSFUNCTIONS

Summary Statements

1. Determinants of sexual function involve central and peripheral mechanisms. (II-2)
2. Both testosterone and estrogen have effects on sexual function. (I)
3. The serum testosterone level is not a useful marker for the diagnosis of sexual dysfunction. (II-1)
4. Estrogen's primary action is on maintenance of vaginal and vulvar health. (II-2)

Recommendations

1. Vulvovaginal atrophy should be addressed in all middle-aged women who complain of sexual dysfunction. (I-A)
2. Serum androgen measurements should not be used in the assessment of female sexual dysfunction. (I-A)

EVALUATION AND TREATMENT

Summary Statements

1. Taking a brief sexual history is part of the evaluation of the menopausal woman. (III)
2. Female dysfunction can be categorized into desire, arousal, pain, and orgasm problems. These categories often overlap. (II-2)
3. Low desire with distress is most common in mid-life women. (II-2)
4. Vaginal atrophy occurs in 50% of women within 3 years of menopause and is a common cause of sexual pain in menopausal women. (II-1)
5. Sexual pain results in a cascade of detrimental sexual symptoms. (II-1)
6. The treatment of sexual dysfunctions involves a multifaceted approach addressing medical, psychological, and relationship issues. (III)
7. Transdermal testosterone therapy has been shown to increase desire, arousal, and frequency of satisfactory sexual events and to decrease personal distress for women with surgical and also natural menopause, but there are no approved products for this indication in Canada. (I)

Recommendations

1. Health care providers should include a short sexual screening history as part of a medical history of menopausal women. Interventions should be undertaken only if the patient is distressed about the problem. (III-A)
2. The patient's problem should be categorized according to desire, arousal, pain, or orgasm problems in order to facilitate treatment and triage care. (III-A)
3. Vaginal estrogen therapy should be prescribed for postmenopausal women with vulvovaginal atrophy and sexual dysfunction. (I-A)
4. For women with decreased sexual desire the current best options include management of vaginal atrophy, addressing treatable contributing factors, and sexual counselling. (I-A)
5. For women with signs or symptoms of vulvovaginal atrophy who cannot use estrogens, vaginal dilators, lubricants, and moisturizers should be offered. (III-B)
6. Clinicians should endorse the benefits of alternative forms of sexual contact for patients unable to have penetration. (III-A)

SPECIAL CLINICAL SITUATIONS

Summary Statements

1. Sexual dysfunction is common in depressed patients and those taking selective serotonin reuptake inhibitors. (I)
2. Premature loss of ovarian function may be attended by sexual dysfunction related to loss of both ovarian estrogen and androgen production at a time of life when sexual activity is normally heightened. (II-1)
3. Survivors of breast cancer using aromatase inhibitors have more sexual dysfunction due to vulvovaginal atrophy than do women using tamoxifen or control subjects. (II-1)

Recommendations

1. Patients using selective serotonin reuptake inhibitors should be educated about the effects of these medications on sexuality and informed that these effects are reversible when the medications are stopped. (III-B)
2. Patients with premature ovarian failure should be asked about their sexual health. (III-B)
3. Patients with breast cancer using aromatase inhibitors should be advised that these medications may have sexual effects. (II-2B) The decision to use intravaginal estrogen therapy for severe vulvovaginal atrophy in such women needs to be based on quality-of-life considerations and should be made only after a discussion of the uncertain effects on breast cancer recurrence. (III-I)

Chapter 9: Complementary and Alternative Medicine

Summary Statement

1. Health Canada's Licensed Natural Health Products Database lists products approved for use in women with menopausal symptoms that have been evaluated for safety, efficacy, and quality. (III)

Recommendation

1. Health care providers may offer identified complementary and alternative medicine with demonstrated efficacy for mild menopausal symptoms. (I-B)

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