SOGC/CMS Menopause Guidelines

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Since the 2002 report from the Women's Health Initiative on combined (estrogen-progestin) menopausal hormone therapy,[1] the Society of Obstetricians and Gynaecologists of Canada's menopause guidelines have been published three times, most recently in 2014.[2] Each successive publication reflected returning confidence in the safety and effectiveness of hormone therapy in the management of menopausal symptoms and associated morbidity. The population of menopausal women continues to grow, and this demographic change—in Canada and elsewhere—mandates that health care providers remain aware of the needs of this population and how their needs can be met. Options for management of the symptoms and morbidity associated with menopause also continue to grow, and it is heartening that research in postmenopausal health has once again become a serious undertaking. Such basic questions as "What causes hot flashes?" and "Does menopause affect cognitive function?" are getting answers. With women increasingly remaining in the workforce and assuming positions of real authority, it is incumbent on us all to ensure that they can do so to the best of their ability.

The newly updated guidelines, which will be published across the October, November, and December issues of JOGC, are intended to provide strategies for improving the care of perimenopausal and postmenopausal women, and they are based on the most recent published evidence. To produce the guidelines, the PubMed, MEDLINE, and Cochrane Library databases were searched for relevant studies for the years 2002 to 2019. The content and recommendations were drafted and agreed upon by the principal authors and the boards of directors of the Society of Obstetricians and Gynaecologists of Canada and the Canadian Menopause Society. The quality of evidence was rated using the criteria described in the Grading of Recommendations Assessment, Development, and Evaluation methodology framework.[3] Each of the guidelines provides summary statements and recommendations, and we hope that these will provide a succinct basis for readers to update their approaches to management.

The first guideline (no. 422a), published in this issue, puts into perspective the most prevalent concerns of menopausal women, and it provides a systematic approach to the management of vasomotor symptoms in perimenopausal and postmenopausal women. The therapeutic options include hormonal and non-hormonal therapies; these therapies and their desirable and undesirable effects are discussed. Potentially effective lifestyle changes and complementary therapies are also documented. Guideline no. 422b discusses genitourinary health in the context of the genitourinary syndrome of menopause. The origins of genitourinary syndrome of menopause and options for management, including systemic and local treatments, are described. Guideline no. 422c reviews up-to-date information about validated changes in mood, sleep patterns, and cognitive function as they relate to perimenopausal and postmenopausal women. Potential strategies for responding to changes, including the role of hormone therapy, are reviewed and discussed.

In guideline no. 422d, the authors review sexuality in menopause, stressing that a brief sexual history should be included in the initial assessment of all menopausal women. Appropriate treatment options for sexual dysfunction, including approaches based on hormone therapy, physical therapy, and psychology, are reviewed. Guideline no. 422e deals with the topic of cardiovascular disease in women, the significance of which accelerates with menopause. The authors detail the information in this area that

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has appeared since publication of the 2014 guidelines, emphasizing once again that menopausal hormone therapy currently should not be prescribed for primary or secondary prevention of cardiovascular disease.

Guideline no. 422f is a discussion of the important topic of breast cancer. Primarily, the authors review the association between menopausal hormone therapy and breast cancer, but they also discuss the management of menopausal women with hereditary factors that increase their risk of breast cancer. The authors appropriately emphasize that the relationship between menopausal hormone therapy and breast cancer is complex and that women requiring hormone therapy expect to be prescribed a regimen with minimal associated risk.

The final instalment of the guidelines (no. 422g) deals with the identification and management of osteoporosis in menopausal women. The authors discuss the important role of menopausal hormone therapy and also describe the use of bone-specific therapies and potential adverse effects.

The intended users of these guidelines are physicians, including gynaecologists, obstetricians, family physicians, internists, and emergency medicine specialists; nurses, including registered nurses and nurse practitioners; medical trainees, including medical students, residents, and fellows; and other providers of health care for perimenopausal and postmenopausal women. Our target population for these guidelines is the population of adult women who undergo the menopausal transition, regardless of whether this is spontaneous or a result of surgery or other therapeutic intervention.

We trust that these menopause guidelines will be a source of practical advice in the management of the most prominent concerns of menopausal women. We are aware, nevertheless, that many fundamental questions remain unanswered, and only further research will provide answers. As always, we welcome readers' feedback as we strive to advance the health and well-being of menopausal women everywhere.

REFERENCES

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