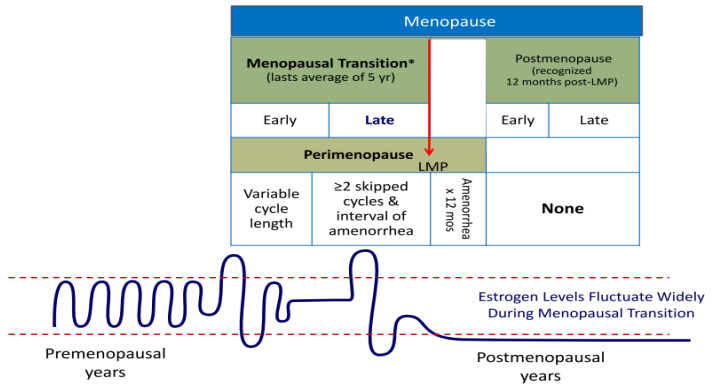
MENOPAUSE:

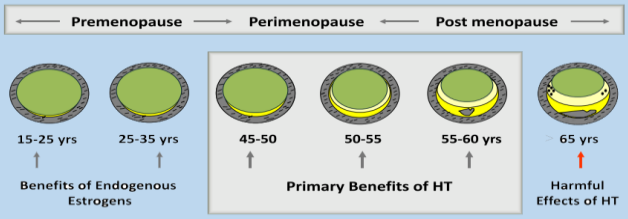


WHAT WE KNOW FOR SURE:

- Women have a LOT of hot flushes:
  - 50s: 60-80% 60s: 12-15% 70s: 9%
  - Hot flushes lasting > 1 year: 80% > 15 years: 15%
- **HRT is the most efficacious therapy for VMS**
  - 75% reduction in frequency for any HRT
  - Significant reduction in hot flash severity
  - Combination of E+P slightly more effective than E alone

SUMMARY OF HRTs:

- Custom compounded hormones are not recommended
- Hormone testing is not recommended
- Breast and hormone therapy is a complex issue with multiple factors
  - Counseling is key
  - Confounding factors need to be addressed
- HRT should not be initiated with the sole purpose of cardiac prevention
- Landmark trials show timing of starting HT is vital
  - Younger than 60 and within 10 years of menopause



NON-HORMONAL TREATMENT FOR VMS:

Recommended	Further studies	Insufficient, conflicting, possible harm*
• SSRI/SNRI • Gabapentinoids • Clonidine • CBT • Hypnosis	• Weight loss • Soy isoflavones • Mindfulness based stress reduction • Stellate ganglion block	• Exercise/yoga • Cooling techniques • Avoid triggers • Paced respiration • OTC supplements or herbs • Acupuncture

* although may have healthy benefits, may be unlikely to help VMS = delay appropriate treatment

- SSRI/SNRI – MOA unclear, but may balance serotonin and decrease NE
  - Venlafaxine 37.5 – 75 mg
  - Paroxetine 20 mg
- Gabapentin – MOA unclear, hypothalamic receptors/cooling
  - 300-900 mg daily divided doses
- Clonidine – MOA possibly by altering sweating threshold or widening thermoneutral zone (decreases NE); vascular reactivity
  - 25 mcg – 75 mcg BID

TISSUE SELECTIVE ESTROGEN COMPLEX (TSEC) SUMMARY:

- CE/bazedpxifene: alleviate VMS & vulvovaginal atrophy, prevent postmenopausal bone loss WHILE ALSO having a favorable safety profile with respect to breast & endometrium
- Obviates need for progestin co-therapy if using systemic estrogen

GENITOURINARY SYNDROME OF MENOPAUSE (GSM):

Vaginal atrophy	• Vaginal dryness • Vaginal irritation/discharge • Dyspareunia • Post-coital spotting
Lower urinary tract dysfunction	• Recurrent UTI • LUTS (urgency, frequency, dysuria)
Sexual dysfunction	• Desire or arousal disorder

PATHOPHYSIOLOGY

- Deterioration in structure & function of urogenital tissues d/t:
  - Tissue aging
  - Estrogen deficiency

TREATMENT:

- Water & silicone lubricants prn primarily for intercourse
- Moisturizers containing polycarbophil for temporary sx relief
  - Ex// Replens
- Tissue repair agents hyaluronic acid on a regular or semi-regular basis
  - Mucoadhesive polymers that retains large amounts of water (up to 1000x its own weight) and forms a non-greasy water and light permeable film on tissue
  - Ex// RepaGyn
- Vaginal estrogen on a regular basis
  - Increased vaginal blood flow and lubrication
  - Increase elasticity (more rugosity)
  - Clinically:
    - Improves dyspareunia
    - Decrease arousal disorder
    - Improve desire
    - Less secondary sexual & relationship dysfunction

KEY LEARNING POINTS:

- GSM encompasses both vaginal & urinary sx of menopause
- GSM is a common, chronic condition that can have a significant effect on a woman's quality of life
- Women suffer in silence, are reluctant to initiate a dialogue about their symptoms, and are unaware that effective treatments are available
- Physicians need to routinely discuss and effectively manage the symptoms of GSM in post-menopausal women

SUMMARY OF HORMONE THERAPY AGENTS:

	Dosage forms	Decisions
Oral	• CEE • E2	• Specific needs • Individualizaiton of therapy
	• MP • MPA	• Generally only cost
Trans-dermal	• E2 patches • E2 gel • E2 combos	• Lifestyle: shift working, swimming, etc • Ease of use
Vaginal	• CEE • Estrone • E2	• Lifestyle • Dosing regime, schedule • Age

SUMMARY:

- Women have undergone great uncertainty when it comes to hormone therapy, and we need to ensure we pass along EVIDENCE BASED MEDICINE to them
  - Does it work?
  - Is it safe?
  - What would you do?