Canadian Family Medicine Clinical Card

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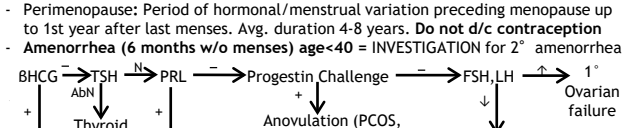
Menopause

Diagnosis of Menopause

- Clinical retrospective diagnosis of 12 months without menses in women above 40. Average age: 52. ***Remember to R/O pregnancy***.
- Perimenopause: Period of hormonal/menstrual variation preceding menopause up to 1st year after last menses. Avg. duration 4-8 years. **Do not d/c contraception**
- **Amenorrhea (6 months w/o menses) age<40** = INVESTIGATION for 2° amenorrhea



Common Concerns in Menopause

Vasomotor Symptoms/ Sleep Disturbances

Sx: Hot flashes, sweating, palpitations, night sweats, insomnia

Management: Treatment based on patient preference

1. **Lifestyle**: Sleep hygiene, exercise, wt loss (if obese), smoking cessation, trigger avoidance (EtOH, hot drinks, warm ambient temp)
2. **Hormonal Replacement Therapy HRT**
   - **Oral**: Conjugated estrogens 0.3mg/d (starting dose)
   - **Transdermal**: 0.5 mcg/day 17 β-Estradiol patch (starting dose)
   - Add progestin if pt has intact uterus
   - Contraindications to HRT: VTE, CAD, pregnancy, severe liver dz, undiagnosed vaginal bleeding, breast or uterine cancer.
3. **Non-Hormonal Rx:** SSRIs/SNRIs, clonidine, gabapentin, zoplicone

Bleeding

Anovulatory (irregular) bleeding may be expected in perimenopause.
Act on prolonged/heavy/intermenstrual bleed. If ↓BP↑HR: ABCs+activate EMS

Inv: CBC (if prolonged bleeding), **U/S** (for anatomical cause e.g. fibroids, hyperplasia). **Biopsy** if Endometrial CA risk (age>40 , nulliparity, PCOS unopposed estrogen, or BMI>30)

Initial Mgmt:
Non Hormonal (during menses): NSAIDS, Tranexamic acid.
Hormonal: combined OCP, Levonorgestrel-releasing IUD

Urogenital Atrophy

Sx: Vaginal dryness, dyspareunia, dysuria, frequent UTI

DDX: Lichen sclerosis (thin white lesions, intense pruritis, burning → biopsy)

Management: Vaginal Moisturizers e.g. Replens™, lubricants for intercourse. **Vaginal Estrogen** (progestin not required) – Vaginal Tablet (e.g Vagifem™), Cream (e.g. Premarin™), Vaginal Ring (e.g. Estring™)

Bone Health

Assessment: Canadian FRAX score for 10 year hip fracture risk: use FRAX tool to stratify into low (<10%), moderate (10%-20%) or high risk (>20%) (Web search for "FRAX tool", make sure to select Canadian version)

Management: All risk groups: Exercise (wt. bearing, balance and strength), smoking cessation, caffeine reduction, Ca^{2+} >1500mg/day, Vit D >800IU/day. **Low risk:** reassess in 5 years. **Moderate risk:** TL spine x-ray if concerns for vertebral fracture. If fracture or other risk factor, treat as high risk. Otherwise repeat BMD in 1-3 years. **High risk:** Along with general mgmt: 1. Bisphosphonates 2.SERMs 3.HRT if pt has vasomotor Sx

Incontinence

General Management of Incontinence: Wt. loss, physiotherapy (bladder training, pelvic muscle exercises, biofeedback), trigger avoidance (EtOH, caffeine, excessive fluids), absorptive pads.

Stress Incont. (i.e. with ↑pelvic pressure): Consider pessaries, surgery

Urge Incont.(i.e. spontaneous): Consider antimuscarinics, e.g. oxybutinin

Key References: Papaioannou A, et al. 2010 clinical practice guidelines for the diagnosis and management of osteoporosis: summary. *CMAJ*. 2010;182(17):1864-73. Brockie J, et al. EMAS position statement: Menopause for medical students. *Maturitas*. 2014;78(1):67-9. Reid R, et al. Menopause and Osteoporosis Update 2009. *J Obstet Gynaecol Can*. 2009;31(1):S1-S3.