menopause

presenting a positive outlook

answers to some commonly asked questions about the menopause and hormone therapy

2011 Update

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This book has been written by Dr Alastair MacLennan, Professor and Head of the Discipline of Obstetrics and Gynaecology, The University of Adelaide and Dr Alice MacLennan, GP and Clinical Senior Lecturer at the University of Adelaide. Both are past Presidents of The Australasian Menopause Society.

It contains advice based on their clinical expertise and practice and represents their independent views.

Video available

The Menopause. Evidence-based answers to your questions.

This video answers the most common questions asked about the menopause. It also gives a better understanding of how to assess the quality of the evidence supporting the many putative managements of the menopause.

A group of friends invites three experts on the menopause to lunch. Over the meal they obtain accurate information to help them decide how they should manage the menopause and help them maintain quality of life as they age. This video has been produced independently by the authors of this booklet.

Copies are available from:

‘MENOPAUSE VIDEO’,
The University of Adelaide,
Department of Obstetrics and Gynaecology
at the Women’s and Children’s Hospital,
72 King William Rd,
North Adelaide, SA 5006.

The price is A$99 including postage and handling.
Cheques payable to ‘Menopause Video Account’.
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Your years between 45 and 55 can be the best of your life. You should now be able to do the things you enjoy.

These years are also usually the time when you reach the menopause. With the right treatment, however, menopause will barely interfere with your life.

This booklet has been put together to answer your questions about the menopause. It also outlines ways in which you can reduce, and even eliminate, the effects of menopausal symptoms, so you can maintain an active, vibrant lifestyle after the menopause.

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(19th edition)

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1 What is it? Why is it? When does it happen?

The menopause literally means ‘the pause in menstruation’ and relates to the time a woman has her last period. For most women, this is between the ages of 45 and 55 years, but sometimes, though rarely, occurs as early as 30 years. However, the end of periods is only one sign of many changes happening in the body both before and after this time. Symptoms such as hot flushes, tiredness, joint and muscle pains, depression and an irregular cycle may occur years before your periods stop.

The menopause and all its associated changes are due to the ovaries ceasing to function. It is not known why this happens, but, as the ovaries produce hormones vital to the health of many body tissues, the replacement of these hormones can help you avoid the more serious side effects of the menopause, such as osteoporosis.

The three most important hormones produced by the ovaries are oestrogen, progesterone and testosterone. After the menopause, oestrogen and progesterone are no longer produced by the ovaries, although a small amount of oestrogen may still be produced by fat tissue. Many of the body’s tissues need oestrogen to stay healthy. Now that women are living much longer (e.g. 30 to 40 years after the menopause), long-term oestrogen deficiency problems such as hip fracture, dowager’s hump, discomfort at intercourse and incontinence are becoming more common towards the end of life. Such problems obviously reduce quality of life but may be preventable.

2 How can I assess the quality and relevance of medical studies about the menopause?

Not all studies are equal! Results from medical studies can sometimes be conflicting. It is important to understand the strength of the results and whether

they are likely to apply to you.

Level 1 studies have the strongest design and they try to eliminate factors that might give false results. These studies are described as **double-blind, randomised, placebo-controlled trials.** The 'double-blind' means that neither the investigator assessing the results nor the volunteer were aware whether they took a placebo (dummy) therapy or the real therapy being investigated. The random allocation of these therapies helps to improve the chance that the groups being studied were similar. Such trials can usually only study one or two regimens and the results best apply to the type of volunteers studied. The US Women's Health Initiative study of postmenopausal hormone therapies was a Level 1 study of women initiating oral combined oestrogen and progestogen mostly many years after menopause. It is discussed later in this booklet.

Level 2 studies are called **observational studies** and are not randomised, double-blind or placebo-controlled. Users and non-users of therapies are compared to each other but there is the potential for many biases. Therefore, associations seen in observational studies require confirmation in Level 1 studies.

Level 3 studies are the **weakest** and are usually anecdotal reports of treated cases without control groups or accurate understanding of the influences that might have affected the results.

3 What are the signs of the menopause?

There are five groups of oestrogen deficiency symptoms. You may experience any or all of them around the time of the menopause.

- Changes in the normal working of the blood vessels may produce; hot flushes, night sweats, headaches, palpitations, sleeplessness, excessive tiredness and crawling sensations under the skin.
- Psychological symptoms may also be felt –

anxiety, depression, mood changes, loss of memory and a feeling of being unappreciated or unloved.
- Dryness of tissues such as the vagina can occur, making intercourse uncomfortable. The bladder can also be affected, leading to a desire to urinate more often.
- Loss of interest in intercourse.
- Loss of strength in the body's supporting tissues and thinning of the bone produce backache, joint and muscle pains and, later in life, fractures due to thinning of the bones, known as osteoporosis.

4 What is osteoporosis?

From the time of the menopause, a gradual thinning of the bone (about 1-2% every year) can lead to fractures. Without preventative therapy, about one third of women will experience a fracture by the age of 75 and one half by the age of 85, with hip and spine fractures often causing ongoing incapacity. Early oestrogen replacement therapy can prevent osteoporosis.

5 Who is more likely to develop osteoporosis?

This condition is seen more often in women:
- who have had premature menopause (before age 45)
- with a family history of osteoporosis
- of thin build
- who have had few regular periods during menstrual life
- with diabetes
- taking corticosteroids (e.g. cortisone for asthma)
- who have many of the oestrogen deficiency symptoms listed under question 3
- whose lifestyle may accelerate bone loss through smoking, excessive alcohol and caffeine, poor calcium intake and little weight-bearing exercise.

A bone density test is the best way to assess your risk of developing osteoporosis.

6 In what other ways can the menopause affect me?

The incidence of heart disease and stroke increases in women after the menopause. Prior to the menopause, women are partially protected by their oestrogen levels.

Hormone replacement therapy (HRT) does not appear to reverse established cardiovascular disease when given for the first time after a heart attack. At this time, HRT is not recommended for prevention or treatment of heart disease.

HRT in younger women in observational studies suggest a beneficial effect in the reduction of heart disease. A reduction in adverse cardiac events in women commencing HRT near menopause has also been shown recently when all the results from all Level 1 randomised, controlled clinical trials to date were pooled. This beneficial effect was not seen when HRT was commenced many years after menopause and about a 1% increase in cardiac events was reported in the first year of combined HRT. This has led to the hypothesis that there may be a therapeutic window of opportunity to reduce the risk of heart disease when HRT is initiated within a few years of menopause. This will be a difficult hypothesis to test in a long-term randomised trial that would have to begin at menopause and go on for up to 30 years.

It is important to reduce non-hormonal risk factors for heart disease, e.g. avoid smoking, reduce obesity (through exercise and diet), reduce blood pressure and use cholesterol lowering agents, etc when advised by a doctor.

Dementia (of the Alzheimer's type) may also be related to low oestrogen levels in later life. Short-term verbal memory, reaction times (e.g. preventing falls) and clarity of thinking have been improved in some but not all trials of HRT use in younger postmenopausal women. The effect on future risk of dementia may differ with the timing and length of use of HRT. Observational studies suggest a reduction in dementia if used long-term from early menopause. In a large controlled trial involving women started on

HRT in late menopause (65-79 years of age) this effect was not seen and the risk of dementia increased by about 0.23% per year. However, a 2010 large observational study has shown a 26% reduction in dementia risk when HRT is used in mid-life i.e. started around the age of menopause. These findings give further support to the likelihood that there is a critical window of therapeutic benefit if HRT is commenced and used during mid-life.

7 If I have had a hysterectomy, but still have my ovaries, how do I know I have reached the menopause?

The onset of oestrogen deficiency symptoms, as assessed in Table 2 (page 28), often indicates that you may have reached the menopause.

You should seek advice around the age of 50, or at any time you feel you could be experiencing oestrogen deficiency symptoms. A full history and physical examination (blood pressure, breast and pelvic examination), cervical (cancer) smear and possibly blood tests will determine your menopausal status. Blood tests do not accurately predict your fertility or your menopausal status and are usually unnecessary. The symptom score chart (Table 2) best predicts your hormonal status.

8 What is hormone replacement therapy (HRT or HT) and what are its advantages?

Strictly speaking HRT is when hormones are replaced around menopause to alleviate oestrogen deficiency symptoms which are common at that time. Hormone Therapy (HT) is when hormones are used in women without symptoms to prevent or treat longer term diseases such as osteoporosis. For simplicity we shall use HRT throughout this discussion. HRT does not try to replace all the hormones produced by the ovaries before menopause. Only small maintenance doses of oestrogen, and where necessary progestogen and testosterone are usually given to

help the function of some tissues and reduce menopausal symptoms.

HRT may give four potential advantages:

- an increase in the quality of life when the symptoms of the menopause respond to oestrogen therapy. Without treatment, these symptoms can persist for 10 years after the menopause (and sometimes for the rest of life) in 40% of women (see Table 2). In particular hot flushes, night sweats, sleeplessness, sexuality, joint pains and vaginal dryness respond very well to this therapy
- long-term oestrogen therapy prevents loss of bone and osteoporosis and reduces fractures in later life
- combined HRT has been associated with a reduction in lower bowel (colorectal) cancer and diabetes
- genitourinary problems in old age are reduced, e.g. urinary and vaginal infections, bowel and urinary urge incontinence and vaginal dryness and discomfort may improve with local vaginal oestrogen or HRT.

9 Will HRT cause bleeding?

There are three main types of HRT:

a) Women who do not have a uterus will not bleed and usually they receive oestrogen only, as progestogens are given only to stop or reduce uterine bleeding and help prevent uterine (endometrial) cancer.

b) If you have a uterus and are still menstruating, or if it is only a few months from your last menstrual period, it is usual to add a cyclical progestogen to the oestrogen. This gives a predictable bleeding cycle or period at the end of each treatment phase. These periods are usually lighter than normal periods and often diminish over time. When it can be assumed that your natural periods (ovarian cycle) have stopped, i.e. two to four years later, you have the option of moving on to another type of regimen (c), which leads to no bleeding after a few months of therapy.

c) In women who are clearly postmenopausal, i.e. at least one year since their last natural period, it is usual and appropriate to give an HRT containing continuous oestrogen and progestogen, i.e. the same HRT each day. The advantage is that after several months no further bleeding occurs.
It is important to note that it is common on many oestrogen/ progestogen regimens for irregular bleeding and spotting to occur in the first few months of therapy. This is normal. Bleeding should diminish gradually but spotting can take up to 12 months to stop. See your doctor if it does not stop or if it is troublesome.

10 Are there any disadvantages to HRT?

Yes there are. Some women can experience side effects. There are some common minor side effects such as temporary, irregular start-up bleeding in women whose periods had stopped as just discussed, and a few women experience breast tenderness or symptoms similar to premenstrual syndrome. These can usually be alleviated by adjustment of the HRT. Skin patches can produce local skin irritation in up to 15% of women. If any of these occur, speak to your doctor who may adjust the type or dosage of your HRT to overcome most of these start-up side effects. Each woman is an individual and your doctor will select an appropriate therapy for you.

There may be a small increase in the incidence of gallstones and a possible increase in the size of uterine fibroids with HRT therapy.

There is also evidence of a small (absolute) increase in the incidence of thromboembolism (clotting) when HRT is taken by mouth **but not with skin patches or gels**. An annual increase of about 1 for every 500 women using oral HRT has been described in some studies. This overall risk can be more or less depending on an individual's personal details which may increase thrombosis risk e.g. increasing age, hereditary clotting disorders, obesity, etc. If you are in these risk groups a non-oral route of HRT is advised

HRT has been associated with an increase in stroke and heart attack in women who have previously had such problems prior to HRT or who are at high risk of blood vessel thickening (atherosclerosis). As discussed in question 6, HRT is not recommended for the treatment of women with possible heart disease or who have risk factors for heart disease.

11 Will I gain weight?

For all men and women around the age of 50, weight gain is a common problem. Nature tends to redistribute body fat to the lower parts of the body. 70% of women around menopause put on weight and **this gain is no different between users and non-users of HRT** when compared in double-blind, placebo-controlled trials.

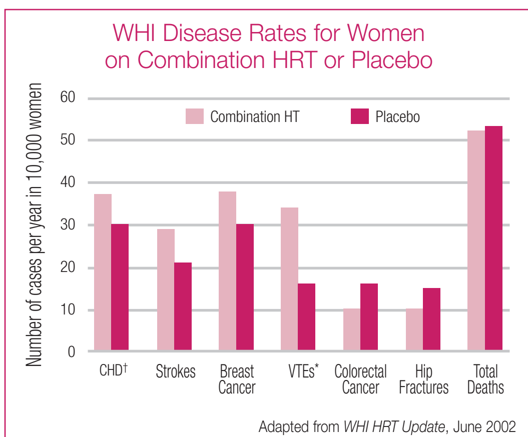
12 Will HRT change my risk of developing cancer?

Until 2002 all long-term studies of HRT had compared women who had chosen to use HRT and women who had chosen not to use HRT. These so-called observational studies were open to other factors, possibly biasing the results. However, they had shown a major risk of endometrial (lining of the uterus) cancer, if a woman with a uterus used oestrogen without a balancing progestogen over many years. Nowadays, added progestogen therapy is advocated for any woman with a uterus and thus stops any increase in cancer of the uterine endometrium. The same observational studies had suggested that HRT was associated with a small decrease in bowel cancer and a similar increase in detected breast cancer.

In July 2002, the United States Women's Health Initiative (WHI) reported that its long-term study on combined oestrogen and progestogen therapy had been stopped because an increase in detected breast cancer of 8 per 10,000 women per annum had been seen, after five years of use. This was smaller than the expected rate from the previous observational studies

for this regimen and the increased rate of breast cancer was matched by a similar decrease in other major cancers, particularly bowel and uterine cancers. The population studied was aged 50 to 79 (average age 63) when therapy commenced and had many risk factors for heart and blood vessel disease and it is not known if this was the reason that a small increase in heart

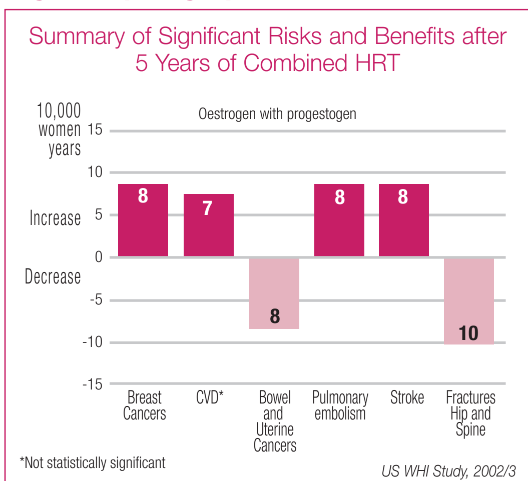
Figure 1



† CHD = coronary heart disease (heart disease caused by thickening of blood vessels, including angina, heart attack and heart failure)

* VTE = venous thromboembolism (clotting)

Figure 2 (all ages)

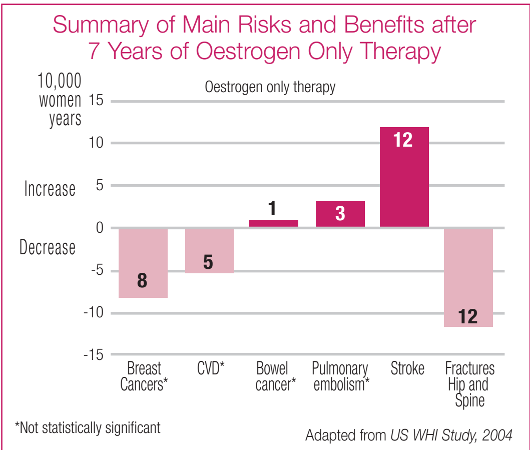


attack and stroke was reported in this study group. In contrast, a reduction in spine and hip fractures was seen in the women taking combined therapy.

It is not easy to weigh mixed risks and benefits of any therapy. It is helpful to understand the normal background incidence of the above diseases. Figure 1 shows the rates of the diseases measured in the US WHI in both the combined HRT group and those not taking hormones (the placebo group). Figure 2 shows a summary of the significant overall increases and decreases in major disease risk in all women commencing combined oestrogen and progestogen between age 50 -79 years. As discussed earlier when the results were analysed by age, women initiating therapy near the age of menopause did not show an increase in adverse cardiac events. Theoretically oestrogen may prevent thickening of the arteries but it does not reverse this disease process if it is established.

The oestrogen only treatment arm of the US WHI trial ceased in 2004 after nearly seven years of therapy. In contrast to combined oestrogen and

Figure 3 (all ages)



progestogen **no increase in breast cancer was seen with oestrogen only HRT**. A summary of the main results of the WHI oestrogen only arm is shown in Figure 3. This regimen is appropriate for women who have had a hysterectomy.

The risks and benefits for HRT in the US WHI study shown in figures 2 and 3 were for all women in that study commencing HRT between the ages of 50-79.

Figure 4

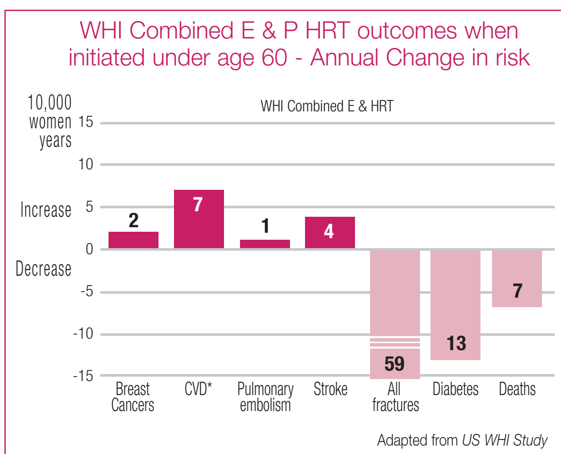
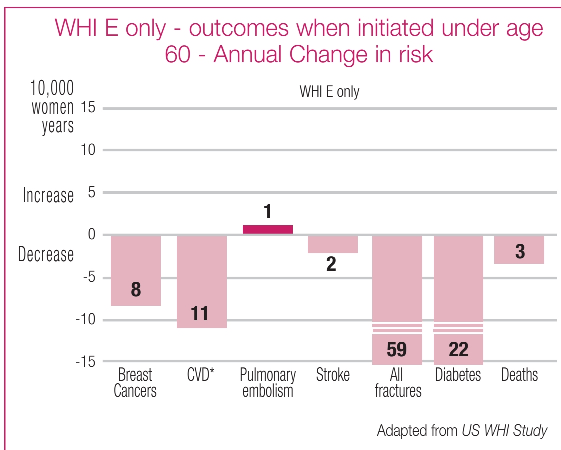


Figure 5



The women in that study averaged age 63 when they commenced HRT. This is not the normal age at which women start HRT for symptomatic relief.

There is now an understanding that women who commence HRT within 10 years of menopause have a better risk profile because oestrogen may help reduce thickening of the arteries and reduce the risk of heart disease.

Figures 4 and 5 show the decrease or increase in adverse outcomes seen in women in the US WHI study who commenced HRT under age 60.

It should be noted that this sub study of WHI did not have enough numbers of women to reach statistical significance. However, there were nearly 9,000 women under age 60 in both arms of the study and this is the best available data for women starting HRT under age 60. **Thus, Figure 4 is the most appropriate graph for women on combined HRT and Figure 5 is the most appropriate for women who have had a hysterectomy and take oestrogen only therapy starting under age 60.**

Until more quality trial results are available, all HRT combined oestrogen and progestogen regimens, by any route, must be assumed to have the same potential benefits and risks.

Unlike the findings from other studies, breast tumours reported in the WHI study in HRT users compared to non-users were slightly bigger and more advanced. Women on HRT have a greater tendency to have increased breast tissue density on routine mammography and an increase in subsequent investigations to diagnose or exclude cancer. Overall, **the combination of the progestogen with the oestrogen in the WHI study was associated after 5 years with an increase in breast cancer of nearly 0.1% per year.**

Despite the same degree of reduction in other major cancers seen in women on HRT, e.g. colorectal cancers, there is an understandable fear of an increase in breast cancer. Using the most pessimistic increase in detected breast cancers there could be one extra breast cancer per 100 women using HRT for more than 10 years.

To put this risk into perspective, it is approximately similar to the increased risk of breast cancer seen when a woman's alcohol consumption exceeds two glasses per day, or if a first pregnancy is delayed from 20 to 35 years, or if natural menopause does not occur until after 55 years of age.

Once a woman has considered her own need for therapy and understands the potential benefits and risks for her individual situation, then she must be the one to decide about therapy. A medical practitioner interested in women's health can help her decide and should review her particular circumstances annually.

All women, whether on HRT or not, should have regular breast examinations and, if possible, a mammogram every two years from the age of 50, or yearly from the age of 40 if her mother or sister had breast cancer.

13 Am I fertile on HRT?

At the menopause the ovary runs out of both eggs and hormones. HRT replaces only the hormones and does not make you fertile again. However, if you take HRT before the menopause, when you are still having spontaneous periods (or have recently had a natural period), then HRT cannot be relied on as a contraceptive.

HRT does not suppress ovulation and, therefore family planning methods should be considered. Non-smokers may successfully use a low dose pill as both a contraceptive and HRT in the years of irregular ovarian activity, before the menopause.

Those who cannot stop smoking, have menopausal

symptoms, or are still menstruating and need contraception can use HRT and a non-hormonal form of contraception.

Your doctor can advise you when the menopause is likely to have occurred, after which contraception is unnecessary and HRT can be used alone.

14 Are there any women who cannot take HRT?

Very few. Those who may benefit from a different type or route of therapy are women with a history of liver disease, clotting problems or oestrogen dependent cancers. You should inform your doctor of your full medical history for an assessment of your needs. However there should be a clear indication to take HRT such as:

1. to improve quality of life by reducing menopausal symptoms and/or
2. to reduce the risk of osteoporotic fractures

15 How long will I need HRT?

In our practice, women on HRT have a yearly medical review and their treatment individualised. When considering cessation of HRT, it is reasonable to halve the dose over 1-2 months and assess your quality of life once HRT treatment has stopped. Sufficient menopausal symptoms may be experienced again by up to 40% of women, which may warrant consideration of a further course of HRT. When choosing longer-term HRT you should be aware of the currently known mixed risks and benefits explained in the answers to questions 8-12. In women who have been shown to be at risk of osteoporosis and have menopausal symptoms, longer-term therapy may be appropriate. For those at risk of osteoporosis who do not have menopausal symptoms, there are also non-hormonal treatment options called bisphosphonates and selective oestrogens (see question 23).

Finally, some women may choose to use long-term HRT by any route because they feel they experience a better quality of life on HRT than without it. They should do this knowing the risks and benefits described to date, which may in the future be better defined by long-term, randomised trials.

You should have your risk of these problems assessed. (See questions 5, 6 and the symptom score chart on page 28.)

16 Are there ways to take HRT other than orally?

Oestrogens can also be absorbed from:

- skin patches or gels, which can be applied to the buttock, thigh or abdomen
- skin sprays (not yet available in Australia)
- implants (pellets) placed under the skin (these last on average 6-12 months)
- vaginal pessaries, rings or creams, when local therapy is appropriate.

These non-oral methods may be considered for women with bowel or liver disorders and where oral therapy is not fully effective or tolerated.

17 Can I take calcium and vitamin D tablets instead of hormones?

After the menopause, the required calcium intake will not be fully absorbed unless oestrogen is taken along with it. Both are needed after the menopause to prevent osteoporosis in those at risk of this condition.

HRT increases the absorption of calcium. For women not on HRT calcium intake should increase from 800mg to 1300mg per day. Calcium supplementation on its own reduces fracture rates by about 20%.

Calcium is best taken naturally in your diet as milk, cheese, yoghurt or ice cream. Low fat dairy products containing more calcium are a good option if you need to reduce fat intake. If you cannot take three portions

of some of the above foods every day, you should seek medical advice on a suitable calcium supplement usually taken in the evening to enhance absorption.

Vitamin D is also needed for healthy bones and is formed when you are exposed to sunlight eg. at least 30 minutes a day. Those at risk of low levels of vitamin D can have a blood test and if low can take vitamin D supplements.

18 When should testosterone replacement therapy be considered?

When a major loss of libido, or sex drive is of concern and if the other therapies discussed below have not adequately helped then testosterone is a possible option.

Currently there are no testosterone products on the Australian market that have a registered indication for use in women. They are therefore prescribed at the discretion of your doctor and with your consent for "off label" indications.

Adequate oestrogen therapy may improve the sexual response and eliminate any discomfort of intercourse associated with a dry vagina. However, sexual difficulties can be due to many problems and sexual counselling may often be helpful. A gradual lowering of both libido and frequency of intercourse with ageing is normal in both men and women.

In some women, but not all, two to three-monthly injections of testosterone or a testosterone implant once or twice a year helps their sex drive. The doses used do not usually give any 'male' side effects such as facial hair. The long-term effects of testosterone therapy are not known.

Postmenopausal women may find that a compound called **tibolone**, which has some of the short-term benefits and side effects of HRT, may improve libido through an oestrogen, progesterone and testosterone-

like effect. This product is not associated with breast tenderness or increased breast density on mammography and did not increase breast cancer rates during trials upto 4 years. Its long-term effects on the breast are being assessed. It has not been associated with an increased risk of thrombosis.

19 What is the appropriate use of HRT?

HRT has been used for over 60 years in many countries.

The long-term risks and benefits of HRT are now better understood. HRT is only appropriate for those with recognised indications for HRT and who find a benefit from taking it. HRT is not indicated or advocated for all women.

However, the best treatment for oestrogen deficiency symptoms is still oestrogen, and it may be considered at any time that you experience menopausal symptoms.

20 Apart from HRT what else may help me?

A healthy lifestyle is very important. Stopping smoking is particularly helpful. Smokers have their menopause two years earlier on average and often have more severe menopausal symptoms. You should also avoid excessive alcohol (more than an average of one drink per day) and excessive caffeine. Weight-bearing exercise such as walking (half an hour every day) is very helpful, as is adequate calcium, preferably in your diet. You can also try to take on new interests and have fun!

21 Are so-called ‘natural’ or ‘herbal’ remedies helpful?

Unregistered products sold as health foods and promoted on the internet, in magazines and by word of mouth to be remedies or therapeutic medicines for curing or preventing menopausal problems should generally be avoided. They are no better than a placebo.

By claiming to be food they do not come under the full scrutiny of the Therapeutic Goods Administration. Scientific trials of their safety and effectiveness are usually lacking. Some herbal remedies have been shown to be toxic and may be quite dangerous. Advice from a qualified medical practitioner should be sought. There is early evidence that soy and some plant oestrogens may have weak beneficial effects but their long-term effectiveness and safety have not been studied. To date, double-blind, randomised, placebo-controlled trials (the gold standard of therapeutic trials) show that commercially produced extracts of plant oestrogens have no more effect on menopausal symptoms than a placebo (dummy tablet). This is in marked contrast to the clear efficacy of HRT in similar strictly controlled scientific clinical trials.

Look for the letters 'AUST R' rather than 'AUST L' on the label of a product. The former denotes the Government's registration of the product and shows acceptance of the product's effectiveness for its registered use and its safety. A product that is only listed (Aust L) and does not have the letters 'AUST R' has not had its effectiveness or long-term safety evaluated by the Government.

Unfortunately, non-registered, over-the-counter products can be promoted and sold in Australia as giving relief for menopausal symptoms, e.g. hot flushes and/or vaginal dryness, without having been subjected to rigorous scientific, controlled trials to see if they are helpful for these symptoms and that they do not have any adverse side effects. Such trials are the gold standards usually applied to registered drugs.

22 Progesterone creams – help or hype?

There is currently little valid scientific evidence to support the concept that women experience menopausal symptoms or long-term problems from progesterone deficiency. This concept appears to be commercially driven by those selling progesterone gels or by those who are associated with their promotion.

In Australia these unregistered concoctions have undergone no long-term safety or efficacy trials, undergo no independent quality control and the products usually contain no details of their supposed active constituents, details of their therapeutic effect, mechanism of action or side effects.

However, registered oral progestogens are available with all these legitimate details. It is usually advised that they be taken cyclically or continuously in women with a uterus who are on oestrogen therapy, to avoid or reduce both unnecessary uterine bleeding and the risk of endometrial cancer.

Unregistered progesterone creams have not been shown to give this protection and cannot yet be advocated for these reasons.

23 "Bioidentical" or so called "natural" Hormone Warning

Similarly there is no good evidence that so-called "bioidentical hormones", privately concocted by compounding pharmacists, are better or safer in any way than the same oestrogens in registered and tested products. These relatively expensive and untested mixtures give the buyer no proven advantage, are not approved by The Therapeutic Goods Administration, and do not protect against endometrial uterine cancer. There have been several reports of endometrial (uterine) cancer and masculising side effects following "biodentical hormone" use. Claims that "bioidentical hormones" can be tailored to suit each woman's hormonal needs by measuring hormones in their saliva are completely unsubstantiated, are pseudo-scientific and may lead to inappropriate prescription. We and major international scientific societies strongly advise against the use of these products. (The US Endocrine Society position statement on bioidentical hormones).

24 What are selective oestrogens?

New synthetic oestrogens are currently being developed which have the technical name Selective Oestrogen Receptor Modulators or SERMs for short. They have been designed to beneficially stimulate some tissues that normally respond to oestrogen, e.g. bone and lipid (cholesterol) levels but have an inhibitory effect in other tissues, e.g. breast and uterus. Thus, breast effects such as tenderness or uterine effects such as bleeding, are minimised.

Currently, these selective oestrogens only clearly benefit women with osteoporosis. They do not reduce menopausal symptoms (see Table 2) or have any beneficial effect on the bladder or the vagina. They will, however, be an option for women aged 55 to 85 who do not have menopausal symptoms but are at risk of osteoporotic fractures and have breast or uterine-related problems or concerns.

25 Who can best tell me what would help me most around the menopause?

Most general practitioners interested in the menopause can advise you about your options to help maintain your health. In some cities there are both public and private menopause clinics. You can obtain addresses for clinics and doctors in your State from the Australasian Menopause Society home page on the internet at **www.menopause.org.au**

26 Are there any other sources of information about the menopause and its treatment?

Yes. Information about a comprehensive video on the menopause and treatments such as hormone replacement therapy is featured on the back page.

The Australasian Menopause Society's home page (**www.menopause.org.au**) lists many independent and scientifically valid references and other sources of information. For those wishing sophisticated reviews of the best medical evidence for a wide variety of

treatments visit the Cochrane Library at **http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME**

For women concerned about a premature menopause, visit **www.earlymenopause.com** on the internet. We also recommend the North American Menopause Society website: **www.menopause.org**, the Jean Hailes website: **www.jeanhailes.org.au** and the International Menopause Society website: **www.imsociety.org**

27 What are the best treatments for osteoporosis?

Adequate weight-bearing exercise and adequate calcium intake as previously discussed are essential for all women at risk of osteoporotic fractures (i.e. with low bone density). However, exercise and calcium alone are not fully effective and women with osteoporosis should have one of three proven medical therapies, namely, HRT, selective oestrogens (raloxifene) or bisphosphonates (alendronate, etidronate or risedronate). Parathyroid hormone and strontium ranelate are new options for some women. All have wider advantages and possible disadvantages and therapy should be individualised by your doctor or a specialist in this area. Vitamin D supplements can be added for those in institutional care and not often 'in the sun'. Avoidance of smoking, unnecessary steroids, loose carpets and poorly lit areas, and the wearing of hip pads all contribute to reducing the risk of osteoporotic fractures. Prevention of osteoporosis is the ideal but therapy will still reduce the risk of further fractures if instituted after an osteoporotic fracture.

A new, once a year for three years, 15 minute intravenous infusion of a bisphosphonate is also now available in Australia.

Your risk of developing osteoporosis

It would be helpful to know if you have any risk factors for the development of osteoporosis. To help with this, you may wish to answer the following questions (Table 1) and discuss them with your doctor. A bone density test of your wrist, hip or spine will be helpful to determine this risk more accurately.The value of ultrasound in predicting future risk of osteoporotic fractures is still unproven and more research is required before it can be recommended. X-rays may show an existing osteoporotic fracture but do not accurately measure bone density.

Table 1

Question	Yes	No
Are you underweight?	☐ Yes	☐ No
Have any of your elderly female relatives lost height, become stooped or had broken bones?	☐ Yes	☐ No
Did your periods stop before the age of 45?	☐ Yes	☐ No
Did you often miss menstrual periods during your life?	☐ Yes	☐ No
Did your ancestors come from Northern Europe or Asia?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Do you drink more than an average of one glass of alcoholic beverage a day?	☐ Yes	☐ No
Do you drink more than three cups of coffee or six cups of tea a day?	☐ Yes	☐ No
Do you take little regular exercise outside your normal duties?	☐ Yes	☐ No
Is your diet low in milk, cheese, yoghurt, ice cream?	☐ Yes	☐ No
Do you take fluid tablets (diuretics), antacids, steroids or phenytoin?	☐ Yes	☐ No

Assessing your menopausal symptoms

Although the symptoms listed opposite can individually be due to other problems, as a group they often appear around the menopause due to a reduction in oestrogen.

To best assess your level of oestrogen, all you need to do is fill in this questionnaire.

Simply rate each problem with a 0 (none), 1 (mild), 2 (moderate) or 3 (severe) depending on how dramatically it affects your life. For example, severe hot flushes might rate a 3 and mild headaches only a 1. Please include the symptom and its score even if you think there may be other reasons for it.

A total score of more than 15 before starting therapy usually means you have an oestrogen deficiency and may have reached the menopause.

The list of symptoms in Table 2 is not comprehensive. Many other symptoms have often been described around the menopause that may also be related to the end of ovarian function. Some of these symptoms are loss of memory, muddled thinking and palpitations (heart fluttering).

Table 2

Oestrogen deficiency symptoms	Before therapy	3 mths after starting	6 mths after starting
Hot flushes			
Light-headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under skin			
Fewer sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL SCORE			