# Palestinian Coalition for Women's Health

## Management of Menopausal Women at the Primary Health Care Level

## A Curriculum for the Training of Physicians

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# Management of Menopausal Women

# A Training Module for Physicians working at the Primary Health Care level

## Components

I. a. Definition and approach to an alternative understanding of menopause, medical, social and cultural
b. Physiological changes during menopause
c. Socio-cultural aspects

II. a. History taking
b. Physical examination, including vaginal exams
c. Laboratory tests: hemoglobin, complete blood count, urine analysis, mammography, pap smear, wet smear
d. Differential diagnosis
e. Identification of risks/complications and referral in the following cases:

i. Abnormal pap smear
ii Breast discharge
iii Any bleeding in the post menopausal period (one year after complete cessation of menstruation)
iv. Urinary incontinence
v Prolapse, stages two and three
vi. Serious psychological problems and depression
vii Any tumor in the vulva
viii Moderate or severe anemia (hemoglobin level less than 10g/dcl)

III. Management and follow up

a. Referral
b. Nutrition
c. Medication
d. Counselling

e. Support groups
f. Additional regular tests: pap smear and breast exam

IV. Health education and promotion: communication component, physiology, menopause as a normal stage in a woman's life cycle:
i. Positive and negative aspects
ii. Premenstrual tension
iii. Hot flushes
iv. Depression, loss of purpose

V. Follow up

i. Medical

a. Prolapse
b. Urinary incontinence
c. Fibroids
d. Vaginal dryness and sexual intercourse
e. Vaginal infections, *Candida albicans,* bacterial
f. Urinary tract infections
g. Osteoporosis
h. Bleeding

ii. Psychosocial

a. Psychological changes
b. Mood changes
c. Depression
d. Marital problems
e. Social support systems

# Module Objectives

**By the end of this course, participating physicians will be able to:**

**1. Identify the process of menopausal change and its impact on women.**

**2. Demonstrate skill in history taking of menopausal women.**

**3. Appreciate both cultural and individual variations in the way menopause is experienced, as well as the importance of open communication and support to women during this period.**

**4. Explain the physiological changes of menopause to women experiencing this change.**

**5. Demonstrate competence in conducting physical and pelvic examinations, including the examination of the breast, pap smear and wet smear testing.**

**6. Demonstrate skill in the management of the symptoms and complications of menopause.**

**7. Counsel menopausal women about the importance of a proper diet, exercise and general well being in assisting them to go through this period with minimal untoward effects.**

# Part One

- **Definition**

There are several ways to define the term 'menopause'. Literally, the word menopause means the cessation of menstruation, or the ending of a woman's 'periods'. Menopause is a medical term which refers to the ending of menstrual cycles, and ovulation as well. Menopause is a natural process in human development, and may be viewed as a natural phase in a women life cycle.

- **Cause**

Menopause is caused by the slowing down of the ovaries and the termination of ovulation. The ovaries cease to produce the female hormones, estrogen and progesterone, although estrogens continue to be produced in other parts of the body in small quantities.

In Arabic, the term **Sin al-Ya's**, a heavily culturally laden, biased and unacceptable, is used to denote menopause. **Sin al-Ya's** denotes the end of the social and productive life of women, merely because they can no longer reproduce. This reflects the negative connotations associated with the cessation of menstruation rather than scientifically and objectively expressing a biological event.

**Menopause does not negate the active participation of women in all aspects of Palestinian life.**

- **Course**

The transition from reproductive years to menopause is gradual and is called **climacteric.** Usually, the climacteric period starts around the mid forties with a gradual decline in ovarian function and irregular menstruation. It ends with the cessation of menstruation. During the climacteric period a woman might notice that her periods are no longer regular and the intervals between periods might be as far as six months. Menstrual flow can be heavy or spotty at times.

**Menopause is a natural phase in a woman's life cycle. Psychological changes during this phase are often linked to the socio-cultural context.**

Reactions to menopause vary considerably from woman to woman. Some may find the transition without major symptoms or pains. Others will experience irregular periods, hot flashes and flushes, vaginal dryness, thinning of bone density, dryness of the skin and wrinkles. Emotionally, women may experience biologically and socially linked anxiety, irritability, mood swings and even depression.

Many of the symptoms faced by women during the menopausal period are not only due to biological reasons, but also by the psychosocial pressures imposed on them by society's negative view of this normal phase in a woman's life cycle.

- **Factors that influence the onset of menopause**

Most women experience menopause between the ages of 45 -52 years. However, there is a great deal of variation among women with genetic, psychological, environmental and nutritional factors all influencing the onset and the course of menopause. Some women continue regular menstruation during their 50's. Others stop to menstruate in their early 40's. Heredity influences the time women begin the process of change. Often daughters follow menstrual patters similar to their mothers. However, research has suggested:

- that an improved nutritional status leads to prolonged biological productive years.
- that women who live at higher altitudes experience menopause earlier than women who live at low altitudes.
- that non-smoking women experience menopause later than women who smoke.
- that obese women tend to reach menopause later than thin women.

The age at which a woman stops menstruating does not seem to be related to the number of children she has conceived. There is also no evidence to indicate that the use of birth control pills is linked to early menopause. The age of reaching menarche does not seem to have a relationship to the age of reaching menopause.

- **How is menopause viewed in different cultures**

There is no doubt that menopause is a challenge for most women. The challenge is better met with the support of families and society. There are cultures, such as Palestinian traditional which confer respect to older women. In those cultures menopause does not de-value the position of women. With age, women may gain social status and might enjoy privileges which are seldom given to younger women, for example easier access to public life, improved freedom of movement etc. However, there is a growing tendency in Palestinian culture to visualize menopause in negative terms, primarily because women at this stage can no longer pro-create. This undue emphasis on biological reproduction has caused many women substantial pain and anxiety. Thus at this stage, women might feel threatened by younger women; they might be fearing the loss of their husband as a result of their loss of the ability to reproduce; they might be anxious about their husband marrying another woman; and they might be troubled by the idea that they are losing their sex appeal.

**Although it might be expected that menopausal women are no longer interested in sex, in fact, menopause does not affect a woman's sexual or emotional needs.**

- **Factors influencing women's experiences during menopause**

During menopause, women tend to be sensitive to outside stimuli. Familial and social support is important for the general well being of women. An understanding husband, supportive children, strong extended family support and friends, are all factors which help women navigate easily through this period.

There are many factors that influence the way women experience menopause:

- General physical and psychological well being.
- Women's social status.
- Lifestyle, including women's workload and level of stress, involvement in work outside the house and the degree of community involvement.
- Social and familial support, especially support from husband, children and friends.
- Cultural perceptions about menopausal women.
- Adequate medical/health management, including counselling, preventive health and health education.
- Genetic factors.
- Health status.
- Nutritional status.

**A good physician is the physician who is aware of the socio-cultural conditions surrounding women, so that s/he can adequately manage this phase of life.**

- **Types of menopause**

- **Premature menopause**: medically, premature menopause is defined as reaching menopause before the age of forty years. Premature menopause is rate and the physician should conduct a thorough investigation to eliminate the possibility of pregnancy, severe malnutrition, or other illnesses. Hormonal replacement is often recommended to women who experience

menopause early, in their thirties, in order to avoid bone and cardio-vascular problems.

- **Late menopause**: Some women continue having regular periods after the age of fifty three years. Some physicians associate late menopause with an increased risk of uterine cancer. Vaginal bleeding might be caused by other abnormalities in the uterus.

- **Surgical menopause**: Surgical menopause is caused by the removal of the ovaries. when both ovaries and uterus are removed - total hysterectomy - a menopausal condition results. Surgical menopause in women usually results in triggering the severe symptoms of menopause, such as hot flashes, dryness of the vagina et. Removal of the uterus causes the cessation of regular bleeding. However, it does not precipitate menopause, as the ovaries continue to produce female hormones.

- **Artificial menopause**: all forms of radiation to the ovaries may result in cases of artificial menopause. Pelvic x-ray and chemotherapy can also cause temporary and sometimes permanent amenorrhea. In young females, this form of artificial menopause disappears after chemotherapy is terminated.

- **Physiological changes during menopause**

There is a general tendency to blame many physiological as well as psychological problems on menopause or 'the change of life'. When a mature woman complains of depression because of family sickness or death, people tend to blame this on the 'change of life'. In reality, there are a few symptoms associated with menopause:

- Irregular periods are often the first sign. As a result some women might start complaining of bloated stomachs and /or sluggishness. Irregular periods may mean lighter or heavier menstrual flows, either shorter or longer intervals between menses, or even spotting. Some women continue to have regular periods and then their menstrual flow suddenly stops.
- Hot flashes may or may not be present. They are caused by hormonal changes, especially the drop in the level of estrogen. Most hot flashes cease after one or two years. The frequency and severity of hot flashes vary from one woman to another.

Hot flashes are the most problematic symptom for women. A woman described the sensation as:

> '... Feeling hot in the face, upper body... feeling dizzy, flushed, your heart pounds, and you sweat all over'. The sensation might last a few seconds, or five minutes, leaving a woman restless or exhausted.

Hot flashes occur during the day or at night. Many women experience hot flashes at night, which disturbs and interrupts their sleep. A woman might feel the need to have less bed covers. Synthetic clothing might cause discomfort and add to the feeling of being 'hot and sweaty'.

- Other symptoms and sensations might include:
  * Headaches.
  * Joint pain.
  * Palpitations.
  * Numbness and tingling in the hands and feet.
  * Vaginal atrophy.
  * Dryness of the vagina.
  * Thinning of the labia.
  * Changes in the skin including wrinkle formation and general skin dryness.
  * Increase in the frequency of urination and incontinence.
  * Loss of bone density and fractures.
  * Weight gain.
  * Nervous tension and anxiety.
  * Insomnia.
  * Depression, irritability and mood changes.

**Women experience menopause differently.**
**Not all symptoms occur at the same time.**
**Severity varies from person to person and from episode to episode.**
**Up to 10-15% of women do not experience any symptoms.**

# Part Two

## History-Taking for Menopausal Women

In many cultures, women may suffer from the symptoms of menopause in silence. The role of the physician is to be sensitive to the possible presence of these symptoms, and to deal with history taking in a gentle and understanding way.

The first step in physical assessment is taking a good history, including both present and past health problems and experiences. History taking should include an assessment of the social conditions within which women live. A physician cannot make an accurate diagnosis without spending time listening and asking probing questions.

**Good history taking begins with the respect of women's descriptions and feelings, combined with good listening skills and ability to raise probing questions**.

Most physicians are able to diagnose menopause by asking questions about the woman's age and regularity of menses. Generally speaking, the older the woman, and the longer the duration between periods, the more the likelihood that the woman might be experiencing menopause.

**Make sure to explain to women why you are asking questions. And... remember to insist on not seeing more than 20 patients during a six hour working day. A doctor cannot diagnose and adequately manage a patient in less than 15 minutes.**

History taking includes asking questions about:

- Present health status, main complaints or symptoms felt by the woman, including current illnesses.

- Surgical history. This should include obtaining information about types and dates of operations, if any.
- Gynecological history. This should include questions about:

- Age of menarche.
- Menstrual history.
- Regularity of periods- interval between periods.
- Duration of periods.
- Amount of blood produced during a period ( light, normal or heavy).
- Date of the last menses.
- History of abnormal genital bleeding.
- History of ovarian disease.

- Obstetrical history, including total pregnancies, parity and infant deaths.
- Family history (especially in relation to cancer, osteoporosis, and heart problems.
- Medical history. This section should include questions about:

- Cardio-vascular disease (heart disease, including congenital, thromboembolic disease and hypertension).
- Osteoporosis.
- Kidney disease, acute and chronic.
- Liver disease (including tumors, acute and chronic hepatitis).

- Bladder disease, including incontinence.
- Diabetes mellitus.
- Breast and/or genital neoplasms.
- Hot flashes and sweating.
- Smoking.
- Discomfort during intercourse - vaginal dryness.
- Exercise.
- Depression, irritability and anxiety.
- Nutrition and dietary history. This includes asking questions about: number of meals eaten daily, size of meals, consumption of between meal snacks, frequency of eating dairy products, animal protein, cereals, vegetables and fruits.
- Pain of any sort.

**The role of the physician is vital in identifying women who suffer from menopausal symptoms without recognizing them.**

## Symptoms of Menopause

The following three categories of symptoms have been known to be associated with menopause. Remember.. these symptoms do not occur in all women at all times.

I. **Autonomic** ( involuntary symptoms)

- Hot flushes and flashes.
- Cold chills.
- Palpitation of the heart.
- Night sweats.
- Increased perspiration.

II. **Physical and metabolic changes**

- Menstrual changes. Those include changes in cycle (shorter or longer) and changes in the amount of flow (increased or decreased).
- Breast size decrease/atrophy.
- Skin thinning and wrinkling.
- Vaginal atrophy (dryness, burning, itching), discharge and occasional bleeding, dyspareunia (painful intercourse) contracting and scarring of tissues.
- Vaginal relaxation with prolapsing.
- Increased facial, chest and abdominal hair.
- Bladder dysfunction, including frequency of urination, dysuria, increased bladder infection symptoms without infection.
- Osteoporosis, degeneration of bone joints, and fractures, leading to pain.
- Increased muscular weakness, leading to pain.
- Increased cardiovascular disease (heart attacks and strokes).

III. **Psychogenic**

- Apathy.
- Apprehension.
- Decline in libido.
- Depression.
- Fatigue.
- Forgetfulness.
- Formication (feeling like ants under the skin--- skin crawling).
- Numbness.
- Weight gain.
- Headaches.
- Insomnia.
- Irritability.
- Mood changes.

**Remember... these symptoms do not occur in all women all the time**.

# Part Three

## Physical Examination

It is important to begin a physical examination by ensuring that women have

comfort and privacy. A woman should undress in private and have a clean cloth or disposable sheet under her as well as covering her.

## Make sure to use sterile instruments and clean or disposable gloves when conducting the physical examination.

- **Instruments and supplies needed for the physical examination**

- Examination table.
- Speculum.
- Forceps.
- Stethoscope and blood pressure cuff.
- Microscope.
- Good lighting.
- Disposable gloves.
- Spatula (fish tail) for pap smear.
- Slides for wet and pap smear.
- Alcohol, 70%, for fixation.
- Culture tubes.
- Scales.
- Thermometer.
- Sanitary pads.
- Gauze and cotton wool.
- Light antiseptic solution.
- Normal saline for the pap smear.
- Lubricant (if available) or use Savlon or warm water.

## Make sure to wash your hands before the physical examination

- **Procedures**

- Take the weight of the woman.
- Measure her blood pressure/count the pulse, and take the body temperature, if needed.
- **Head exam:** carefully observe hair, eyes, and face (note hair thinness, increased facial hair, skin dryness, wrinkles).
- **Neck exam**: ask the woman to sit then stand behind the woman and place fingers flat on either side of the neck. Start palpating from the base of the ears down. Note the presence of masses. Make sure to observe and palpate

the thyroid.

- Examine the body for mass, skin lesions, lymph nodes. Palpate the abdomen, liver and spleen for abdominal masses.
- **Chest exam:** listen to the heart and identify any abnormal heart sounds and murmurs**.**
- **Breast exam:** the main objective of the exam is to discover breast masses as part of the cancer detection activities, and to t**each women methods of self examination.**

- **Procedures**

i. Examine the chest for breast size, check contour for shadows, including 'dimpling' or masses. Examine nipples for shape, color or discharge.
ii. The woman should be in a sitting position with arms at the sides. Later the woman is asked to have her arms over the head.
iii. While the woman is in a sitting position, palpate the breast systematically so that all the areas are covered, including the nipples and axilla. Repeat the palpation after the woman is asked to lie down flat on the back. If breasts are very large, ask the woman to lie slightly to the side to facilitate a thorough palpation.
iv. Use the pads of the fingers, **not the tips or the palms of the hands** to feel large areas of the breast against the chest wall. Examine breast tissues between both hands.
v. Gently squeeze the nipples to determine the presence of discharge, for example, milk or blood.
vi. Feel the area over the clavicles, at the base of the neck and the axilla for any lymph node enlargement.

## Always conduct the breast exam in the presence of an assistant.

- **Teaching breast self exam**

A physician should ensure to describe clearly to women why and how to conduct a breast self exam. This should be done while the physician is examining the breast. General guidelines include the following:

a. Explain the importance of examining the breasts.
b. Reassure the woman that not all lumps are cancerous. However, if a lump is found, the woman should contact the physician immediately.
c. A woman should be told to examine the breasts for lumps which are harder than the rest of the breast.
d. A breast self exam is best done standing in front of a mirror and lying down.
e. For a post-menopausal woman, the breasts should be examined the first day of every

month. For menstruating women, the breast exam should be done 7-10 days after menstruation.

**Stage one:** examining the breasts in front of a mirror

The breasts should be examined for contour, shape, color and texture of the skin and nipples. Any discharge should be reported to the physician immediately.

1. A woman should undress the upper part of her body.
2. Stand with arms at the side.
3. Move the hands to the hips and continue to examine the breasts.
4. The arms should be moved overhead, and observation continues.
5. The nipples should be gently squeezed between the thumb and the index finger **only once monthly.**

**Stage two:** lying down

1. A pillow or a folded towel should be placed under the left shoulder. One hand should be placed behi

lumps of the breast tissue.

## It is important to examine both breasts systematically.

2. The woman should examine the entire breast using circular movements.
3. Move the towel to the other shoulder and continue to examine the right breast using the left hand.
4. Remind the woman that a clinical breast exam is recommended every one or two years, starting at age forty.

**Instruct women in the following:**

**If a woman is less than 40 years old:**
***** Examine breasts monthly.
* Have a breast exam by doctor at least every three years.
**If a woman is between 40 and 49 years old:**
* Examine breasts monthly.
* Have a breast exam by doctor every year.
**If a woman is 50 years old and over:**
* Examine breasts monthly.
* Have a breast exam by doctor every year.
* Have a mammogram every 1-2 years.

** These recommendations are intended for women who have no breast symptoms.*

## Perform pap smear every one or two years, if all is normal.

- **Mammograms**

➢ A mammogram is a breast X-ray which helps find very small breast tumors or changes in breast tissue, which cannot be detected in a breast self exam or clinical breast exam. It helps differentiate between types of breast disease and detects cancerous lumps before they can be felt with the fingers. Many lives have been saved because lumps were found early and breast cancer treatment started in a timely fashion.

➢ In mammography, each breast is squeezed in turn between two flat surfaces, one of which contains the X-ray film. This is done twice for each breast, once holding the breast horizontally and once vertically. The procedure can be uncomfortable or even painful if the breasts are tender.

➢ Opinions vary about the need for mammograms before the age of fifty. In the USA, the national Cancer Institute recommends mammograms to women 50 years and older and for younger females who are at high risk of breast cancer, because a mother or sister has had the disease. In general terms, mammograms are recommended every one or two years. Screening is especially important if a woman:

1. Is on hormonal therapy.

2. Has a history of breast disease.
3. Has had a mastectomy.
4. Has a history of breast cancer in mother or sister.

- Size of tumors detected by mammography

Average size lump found by getting regular mammogram
Average size lump found by first mammogram
Average size lump found by women practicing regular breast self exam
Average size lump found by women practicing occasional breast self exam
Average size lump found by women untrained in breast self exam

- **Risk factors for breast cancer**

**- Family history (mother, sister) of breast cancer before menopause, especially if family member had cancer in both breasts*.**
**- Previous breast cancer*.**
**- Certain fibrocystic breast conditions.**
**- High fat diet.**
**- First period before age 12.**
**- Late menopause.**
**- No pregnancies.**

**** Highest risk***.

- **Pelvic exam**

## ➢ Preparation

i. Inspect the examination facility (room).
ii. Make sure that the necessary equipment and instruments are available and functioning before the start of the examination.
iii. Necessary antiseptic measures should be taken.
iv. Oversee cleaning of all surfaces in examination room with 5% Chlorox solution and soap.

### ➢ Examination procedures

a. Wash your hands thoroughly before the examination.
b. Give special care to women having their pelvic examination. Be reassuring.
c. Have the woman empty her bladder (if this has not been done before).
d. Introduce yourself to the woman if the previous steps of medical assessment have been taken care of by someone else.
e. Explain the procedure and tell the woman what she may feel.
f. Be as gentle as possible. Lack of lubrication might make a pelvic examination very uncomfortable.

If a woman gets tense during the examination, **stop and reassure her before proceeding.**

**A pelvic examination should not be painful**.

## ➢ Examination steps

### I. Inspection

a. Put on examination gloves and seat yourself comfortably.
b. Inspect the external genitalia. With your gloved hands separate the labia and inspect with both hands:
i. The labia minora.

ii. The clitoris.
iii. The urethral orifice.
iv. The vaginal opening.
c. Note any inflammation, ulceration, discharge or swelling.
d. Assess the support of the vaginal outlet. Ask the woman to strain down. Note any bulging of the vaginal walls.

II. **Speculum examination**

**Avoid using lubricants other than warm water when conducting speculum examinations, because lubricants interfere and affect the reading of smears.**

a. Select a speculum of appropriate size and shape.
b. Lubricate and warm the speculum with water. Other lubricants can be used if cytological or bacteriological studies are not planned.
c. Place two fingers just inside or at the introitus - vaginal opening - and gently press down on the perineal body.
d. With your other hand introduce the **closed** speculum past your fingers at a 45 degree angle downward. The blades should be held obliquely and the pressure exerted towards the posterior vaginal wall in order to avoid the more sensitive anterior wall and urethra.
e. Be careful not to pull on the pubic hair nor to pinch the labia with the speculum.
f. Rotate the blades of the speculum into a horizontal position, maintaining the pressure posteriorly.
g. Open the blades after full insertion and maneuver the speculum so that the cervix comes into full view.
h. Under good light, inspect the cervix.
i. Obtain a culture or pap smear, when needed or if you observe abnormal discharge or symptoms.
j. Inspect the vaginal mucosa by gently rotating the speculum several degrees in both directions, and after loosening the screws.
k. Withdraw the closed speculum slowly.

**It is best to obtain a high vaginal swab (HVS) from the cervical os and/or the posterior vaginal fornix.**

III. **Digital examination**

i. Using the right index finger, guarded with a rubber glove and well lubricated, palpate the vaginal walls. Note any growth, cyst, or a foreign body.
ii. Then examine the fornices. Note whether they are obliterated or made to bulge by swellings inside the pelvis. Bands of scar tissue of traumatic origin may be found passing across the vault of the vagina.
iii. Next examine the cervix. Note its direction, size and shape. Its surface may be smooth or irregular. The external os may be small, as is usual in nullipara or large and patulous, admitting the tip of the finger. The digitation does not as a rule extend to the internal os, unless there is something inside the uterus which is trying to extrude. The cervix may be torn on one or both sides, and the lips of the cervix may be averted. The cervix may be ulcerated and the site of a malignant growth evident. Or there may be a polyp growing from it or coming through it. Occasionally, the cervix can be reached only with difficulty as when it is pushed upwards by a tumor in the recto-vaginal pouch.

IV. **Bimanual examination**

a. From a standing position, introduce the index and middle finger of your gloved and lubricated hand into the vagina, again exerting pressure primarily posteriorly. Your thumb should be abducted, your ring and little fingers flexed into your palm.
b. Identify the cervix, noting its position, shape, consistency, regularity, mobility and tenderness.
c. To palpate the uterus, place both examining fingers in the anterior fornix above the cervix and sweep abdomina hand forward over the abdomen, pulling the uterine fundus forward between the hands as possible. Determine the position, size, consistency, any tenderness or abnormality. A retroverted uterus may not be felt. In such cases, put the examining fingers in the posterior fornix and repeat the process.
d. Palpate the right adnexa by placing examining fingers in the right fornix and the abdominal hand in the area of the iliac fossa. Bring the hands together and move them centrally towards the pubic bone. During the examination, note any excessive pain or masses. Repeat the procedure for the left side.
e. Withdraw your fingers from the vagina and ask the woman to return to a sitting position.
f. Explain the results of the examination and answer any questions raised by the woman.

Remember that a definitive diagnosis of menopause is made by measuring the follicle stimulating hormone (FSH) level in the blood stream. However, this test should be conducted only when indicated and not routinely. With menopause, while the ovaries lose their ability to respond to FSH, the brain continues to produce the hormone, and as a result, the levels of FSH in blood rise.

V. **Risk factors for endometrial cancer**

| |
|---|
| **- Diabetes.**<br>**- High blood pressure.**<br>**- Infrequent ovulation, due to hormonal imbalance.**<br>**- Use of estrogen, other than in birth control pills *.**<br><br>***Some studies show that using birth control pills actually reduces the risk of endometrial and ovarian cancer**. |

- # Screening

The following laboratory tests should be performed on a regular basis:

| **Test** | **Frequency** |
|---|---|

| | |
|---|---|
| - Pap smear | Yearly: after three normal annual exams in a row, it may be done less often. |
| - Mammogram | Baseline at age 35-40. Yearly after age 50. |
| - Cholesterol | If normal, every five years. |
| - Screening for colon cancer | Every three to five years after two normal annual exams in a row. |
| - Thyroid function | Every five years. |

# Part Four

## General Management

Management of all menopausal women entails not only the relief of symptoms and the prevention of complications, but also the broader, more positive aim of achieving a healthy maturity normally. Thus good management entails:

- Through positive measures, the reduction of the occurrence of 'natural

ailments' such as arthritis, obesity, cardiovascular disease and cancer.

- Enabling women to maintain the confidence, zest for life and strength of character needed to maintain a normal and healthy life.
- The encouragement of women to keep physically and mentally fit, so as to be better able to enjoy a full and happy life, even in older age.

Managing women during menopause entails several possible options:

I. Providing support, education and counselling, including about how to manage menopause with changes in lifestyle.
II. Dietary management.
III. Medications.
IV. Referrals.

In general terms, management options should be discussed with the woman. Depending on her family history, obstetric history and present symptoms, a doctor can then chose which one or more of the options to take.

**To manage women during menopause, doctors must be patient, listen and explain the benefits and burdens of each management option, and try to reach a conclusion with women's informed consent, not alone.**

### I. Providing support, education and counselling

In Palestinian culture, menopausal women react to this stage in their lives differently, and depending on their context, economic and health status, especially the support system around them. Some in fact feel relieved that they can no longer get pregnant. They are also relieved by the cessation of menstrual flow. Some are at a stage in their lives where they begin to assume more power within the family, less work responsibilities and more decision making ability at home.

Others respond with sadness at the end of their abilities to reproduce, as so much value is attached to the function of reproduction as the primary role that women play, forming an important part of their identity. Social pressure, loss of the sense of purpose and self worth, compounded by menopausal symptoms all require special counselling and medical management attention.

**Physicians must gain the confidence of women so that information exchange, discussion, and counselling could be achieved successfully, and according to the level of understanding of women.**

- **Coping with menopausal symptoms**

i. **Hot flashes**

1. Drink lots of water and juice.
2. Wear layers of clothing and remove layers when experiencing a hot flash.
3. Avoid drinking coffee, tea and colas.
4. Avoid warm areas and tight clothing.
5. Wash your face and take a shower when experiencing a hot flash.
6. Exercise regularly. It helps with insomnia.
7. Avoid heavy covers and over-dressing.

ii. **Vaginal dryness**

As the cervix ceases to secrete mucous, vaginal dryness and/or itching can occur. Intercourse can become painful or at least uncomfortable. If dryness is a problem, women should be advised to **use a water soluble lubricant such as xylene, and not a petroleum-based product such as vaseline**.

iii. **Mood changes**

1. Reassure the woman that these symptoms are due to hormonal imbalance in their body.
2. Encourage women to discuss these symptoms with other women in her community who are experiencing or have experienced similar symptoms and feelings.
3. If needed, encourage frequent follow up visits.

**Give women time to allow them to express their feelings and worries.**

iv. **Skin changes**

Another area of concern for women who are experiencing menopause are notable changes in the skin especially dryness or wrinkles. Dryness is caused by the decrease in the fat under the skin. These changes are often gradual and are more noticeable in smokers and lighter skinned women who have exposed their skin to excessive sunlight. For dryness of the skin, women should be advised to:

1. Use skin creams and moisturizers, and avoid excessive exposure to sunlight.
2. Increase their intake of foods which are rich in vitamin A.. Physicians might recommend squash, yellow and red fruits, pepper and leafy vegetables.

v. **Bones and menopause**

- Humans lose bone mass as they get older, past their thirties. Osteoporosis is the progressive thinning of bones, making bones more susceptible to fracture. Menopause is often associated with the process of decreased bone density. Inactive females whose lives lack exercise, who suffer from nutritional problems, and smokers, are at a high risk of developing osteoporosis. Healthy eating habits and exercise are the best answers to this condition.

**Risk Factors for Osteoporosis**

| | |
|---|---|
| * **Family history.** | * **Diet consistently low in calcium.** |
| * **Age.** | * **Sedentary lifestyle.** |
| * **Caucasian.** | * **Smoking.** |
| * **Small boned.** | * **High caffeine intake.** |
| * **Fair skinned.** | * **High protein diet.** |
| * **Early menopause- natural or surgical.** | * **Low body weight.** |
| | * **Constant dieting.** |
| * **Certain diseases, such as liver and kidney disease, some thyroid diseases and inflamatory bowel disease.** | * **Diet low in vitamin D.** |
| * **Regular use of steroids.** | |

- Premenopausal women should be advised to increase their dietary intake of calcium. Milk, cheese, nuts, seafood, turnip, figs and raisins can bee good sources of calcium. the recommended daily allowance (RDA) for non-pregnant and non-menopausal women is 800 milligrams. For women experiencing menopause, daily calcium intake should be between 1000 to 1500 milligrams. The following are foods which are particularly high in calcium:

| | | | | |
|---|---|---|---|---|
| **Cheese** | **Milk** | **Fish** | **Yogurt** | **Sardines** |
| **Labana** | **Lettuce** | **Tahineh** | **Almonds** | |

**Prevention against osteoporosis should take place as early as possible. All post-menopausal women should participate in a prevention programme consisting of regular exercise, balanced diet, adequate dietary calcium and vitamin intake, or supplementation.**

- Generally, calcium supplement is not indicated, except in specific circumstances, such as patients who have been identified as having a high risk of developing osteoporosis. This is because calcium supplement without estrogen has little impact on trabecular bone. If using hormones, calcium may have an effect. **Ideally and in non-high risk women, diet high in calcium is usually sufficient**.

I. **Dietary management**

Good nutrition and exercise are two key factors in promoting and maintaining post-menopausal health. A physician should extend the following advice:

1. Decrease fat intake, especially that of animal origin and use olive oil instead, but sparingly.
2. Increase consumption of vegetables and fruits.
3. Increase intake of fibers and foods which have calcium, such as whole wheat bread.
4. Carbohydrates should make at least 60% of daily caloric intake.
5. Proteins should not make more than 15% of total caloric intake.
6. Increase consumption of water to replace fluids lost in sweating during hot flashes.
7. Decrease caffeine consumption. Avoid smoking.
8. Cut down on sugar and sweets.
9. Decrease salt intake.

**Post menopausal women should concentrate on eating whole grains, beans, vegetables, fruits and non-fat or low**

## fat milk products.

Exercise is an important part of controlling weight gain. Exercise also helps in preventing calcium leakage from bone. Walking and maintaining an active lifestyle is key to staying in shape and in dealing with bone problems.

III. **Medications**

- **Hormone replacement therapy**

♦ In Hormone Replacement Therapy, natural or synthetic (artificial) hormones are used to relieve the short-term symptoms of menopause and reduces some long term risks associated with lower estrogen levels in the body, especially osteoporosis. At first, when only estrogen was used, the treatment was called Estrogen Replacement Therapy (ERT). Hormone Replace Therapy (HRT) refers to treatment combining estrogens and progesterone.

♦ There are three hormonal regimens that are commonly used by most physicians:

1. Estrogen alone, ERT, or unopposed estrogen.
2. Sequential treatment, where a period of estrogen use is followed by a shorter period of combined estrogen and progesterone therapy. This method mimics the menstrual cycle. This method is referred to as HRT.
3. Continuous combined therapy, with both estrogen and progesterone, given simultaneously.

The choice of natural or synthetic estrogen is usually primarily made on the basis of cost, as no differences were found between the natural and the synthetic hormones in terms of effectiveness and when administered in equipotent doses.

## Not every woman needs hormonal therapy.

♦ **Unopposed estrogen (ERT)**

ERT is usually prescribed only for women who have had a hysterectomy, since ERT increases the risk of endometrial cancer. Women with a uterus who take

ERT need regular checkups for uterine lining changes.

### ♦ Sequential treatment (HRT)

HRT is usually prescribed only for women who have a uterus. In sequential therapy, estrogen is usually taken for two weeks, then progesterone is added on the 15th day of the cycle for ten days. On the 25th day, a menstrual-like flow occurs. The classic regimen is a daily .625 milligram dose conjugated estrogens - such as Premarin - from day one to day 25, with a daily 10 milligram dose of medroxyprogesterone acetate - such as Provera, added day 15 for ten days. Beginning the medication on the first day of the month makes it easier to keep track of which pills to take each day.

### ♦ Continuous combined therapy

Many women do not like the fact that sequential treatment leads to having periods. Thus, continuous combined therapy is the most commonly used regimen, because it partially solves the problem of continued periods. However, initially women will have irregular bleeding. It may last for months. A common daily regimen is 0.625 of conjugated estrogens (Premarin), and 2.5 milligrams of medroxyprogesterone acetate (Provera). The lower dose is thought to diminish some of the pre-menstrual symptoms like symptoms associated with the quantities of progesterone used on the sequential schedule. The continuous method is relatively new, so it has not been widely studied, especially for untoward and side effects.

It should be noted that hormone therapy reduces some health risks and increases others. Hormone therapy reduced some of the discomforts caused by menopausal symptoms. Physicians should carefully assess the pros and cons of using hormone treatment. Factors that should be taken into consideration before opting for hormonal treatment include:

1. The climacteric period which preceded menopause is gradual.
2. Postmenopausal women continue to make varying yet smaller amounts of estrogens.
3. Hot flashes do not last forever, and can be treated with simple measures.
4. Women who have heart disease or at a high risk of developing heart disease, or osteoporosis, are likely to benefit from hormonal treatment.
5. women who have cancer or at a high risk of cancer should not be given hormonal treatment. Studies have shown a link between long term use of estrogen and breast cancer.
6. Hormonal treatment does not stop the aging process.
7. The best approach to deal with menopause is to exercise, eat more nutritious and less fatty foods, avoid stress and maintain a positive attitude towards life.

**Ultimately, the decision whether to use hormonal therapy or not rests with the informed consent of the women, and her willingness to take the risks of treatment.**

## ♦ Benefits of hormonal therapy

Hormonal replacement therapy has several proven benefits, including:

1. **Hot flashes**: HRT provides rapid relief from hot flashes. When prescribed only to treat flashes, the lowest doses that work should be given, such as 0.3 milligrams conjugated estrogens - Premarin - which can be obtained by dividing the 0.625 milligram tablet. Depo-Provera is not generally recommended for use in the treatment of hot flashes, except in situations where women cannot take estrogens. Depo-provera is less effective that estrogens and carries more health risks.

**2.** **Vaginal changes**: HRT can help reverse the painful thinning of the vaginal walls together with the decreased lubrication sometimes caused by menopause. Although the reversal sometimes lasts for months, it is not permanent. Therefore some women can take hormones for a few months and then be off them for months or even a year. Estrogen for vaginal changes is often prescribed in the form of vaginal cream. **Many do not realize that the hormone in the cream is absorbed into the blood stream just as pills are and have the same side effects. If estrogen cream is prescribed for more than one month, progesterone pills for the last ten days of the cycle must also be prescribed, as if estrogen is being taken by mouth**. This is to reduce the risk of endometrial cancer. Progesterone itself has no effect on vaginal changes.

3. **Osteoporosis**: growing evidence shows that estrogen prevents the bone changes of osteoporosis, by decreasing bone breakdown (resorption). When combined with calcium and an exercise programme, HRT may even increase bone mass. HRT does seem to relieve some of the bone pain of osteoporosis. There is much debate about how exactly the hormones act to prevent bone loss. It should be remembered that as long as treatment continues, bone loss slows down. However, once treatment is stopped, bone loss resumes, and may actually accelerate. **Taking calcium with estrogen probably increases its effectiveness and may decrease the dose of estrogen needed.** Progesterone alone does not seem to have the same protective effect on bone as estrogen, except at un-acceptably high doses.

4. **Heart disease**: ERT reduces a woman's risk of heart disease by increasing the High Density Lipoprotein (HDL).

## ♦ Risks of hormonal therapy

In weighing the decision to use any kind of medication, take two kinds of side effects into account: **dangerous complications and effects which are a nuisance but not dangerous.** If major complications occur, hormonal therapy must be stopped. If minor side effects are experiences, the physician in consultation with the woman, must decide about the continuation of treatment.

### 1. Nuisance side effects of hormonal therapy

- **Withdrawal bleeding:** this happens when the woman goes off the hormones, between day 26-30. Withdrawal bleeding is not a dangerous sign. In fact, it is advantageous because it allows the endometrium to thin out. Usually, it stops after a few months or a year of treatment. The amount of bleeding is associated with the amount of estrogen taken: the less the dose the less the bleeding. If estrogens and progesterone are taken, the bleeding with often occur monthly, like a light period.

- **Breast tenderness**: experienced particularly when high doses of estrogen are prescribed. Lowering the dose, for example, from 1.25 mg to 0.625 conjugated estrogens may eliminate the problem. Progesterone does not have any effect on breast tenderness.
- **Leg cramps**: some women experience leg cramps which can be a side effect of either estrogen or progesterone. Lowering the dose of hormones may decrease the cramps. **If the pain is in one leg only and accompanied by swelling and redness, the woman should be examined thoroughly to ensure that this is not caused by a blood clot.**
- **Increased body hair:** this is a possible side effect of testosterone, which is sometimes given together with estrogen.

### 2. Serious complications of hormonal therapy

- **Mid-cycle bleeding:** this type of bleeding occurs while the woman is taking estrogen. It is usually due to endometrial hyperplasia - an overgrowth of the cells of the lining of the uterus. **Mid-cycle vaginal bleeding can also be a sign of endometrial cancer.**
- **Endometrial cancer**: estrogen therapy alone greatly increases the risk of developing cancer of the endometrium. The higher the dosage, the greater the risk, and, the longer estrogen without progesterone is taken, the greater the risk. Taking progesterone for 10 days each month along with the estrogen reverses endometrial overgrowth - hyperplasia - and strong evidence suggests that it reduces the risk of developing endometrial cancer. However, this drug regimen - HRT as opposed to ERT, is still relatively new. As with the long term use of estrogen, women taking this regimen are part of an experiment the results of which are not yet known. T**he risk of endometrial cancer is increased for women who are overweight, who have high blood pressure, or endometrial hyperplasia, or those who have never had a baby.** Women with these risk factors need closer follow up than others with hormonal therapy.

- **Gallstones**: women who take HRT run a greater risk of developing gallstones. Estrogen taken in pill form passes through the liver and affects the function of both the liver and the gall bladder. Estrogen taken by other routes have much less effect because they are absorbed directly into the blood stream without going to the liver. **Women who are overweight are already at a higher risk of developing gallstones that others. This should be taken into account when considering HRT**.

- **Fibroids**: fibroids, benign tumors in the muscles of the uterus, depend on estrogen for their growth, and therefore, shrink after menopause. HRT re-introduces the estrogen and the possibility that the fibroids will grow again. With low doses of estrogen, this does not seem to be a problem.
- **Endometriosis**: although reports of HRT causing a recurrence of endometriosis are few, the Endometriosis Society of Canada suggests that women who had endometriosis before menopause avoid HRT.
- **High blood pressure**: the increased risk of developing high blood pressure with birth control pills has caused concern about the relationship between blood pressure and HRT. The risk of developing high blood pressure depends on the quantity of hormone taken: the lower estrogen doses used in HRT cause less of a problem. Nevertheless, many physicians try to avoid HRT in women with high blood pressure.
- **Breast cancer**: although it is an area of constant concern and study, there is presently no evidence that estrogen causes breast cancer. Certain types of breast cancer grow more quickly when stimulated by estrogen. If such a tumor develops, tumor growth will be increased by the added estrogen in HRT. This is a particular concern for women at high risk of developing breast cancer ( review box above).
- **Heart disease and stroke**: the increased risk of heart disease and stroke among women taking the birth control pill caused concern about HRT. Natural estrogens - Premarin - and very low doses of progesterone, appear not to increase the risk of developing heart disease and stroke. The amount of hormone in HRT is approximately 10 times less than that used in the average birth control pill, which may explain the difference in side effects. Synthetic estrogens and higher level of progesterone, such as those used in the birth control pill, alter the fats which circulate in the blood stream and increase the risk of heart disease and stroke.

**Increasing evidence shows that HRT with natural estrogens actually protects against heart disease, but not against blood clots and strokes.** Therefore, there is a tendency not to prescribe HRT to women who already have or once had either of these conditions.

- **Tranquilizers and anti-depressants**

- The widespread use of tranquilizers and anti-depressants has had an enormous effect on

the lives and health of women. Women are increasingly prescribed more mood altering drugs, especially during stressful times in their lives.

- Although tranquilizers and anti-depressants have a definite role in situations of acute anxiety, **they have long been used as medical band aids for social problems.** Women often seek and continue to take these drugs because without them their situations seem intolerable, and, because they are not supported or encouraged to find long term solutions to their problems.

- Tranquilizers produce serious side effects and can be addictive. When they are combined and therefore hidden, with other medications, physicians will have difficulty being aware of the possible side effects.

- Certain preparations of estrogen available for HRT contain tranquilizers. Often, women are not not told precisely what is prescribed for them, and the presence of a tranquilizer may not be evident from the medication label. **Except in specific and rare conditions, tranquilizer use in menopausal management is unacceptable management.**

## IV. **Referrals**

The following cases should be referred to appropriate health care facilities for further testing and investigations:

- Abnormal pap smear.
- Breast discharge or lumps, nipple or skin changes.
- Post menopausal discharge.
- Vulval irritation or itching.
- Dyspareunia or pain during intercourse.
- Any bleeding in the post menopausal period (one year after complete cessation of menstruation).
- Urinary incontinence and recurrent urinary tract infections.
- Prolapse, stages two and three.
- Tumors in the vulvae.
- Moderate anemia, with hemoglobin less than 10 gms/dcl.
- Serious psychological problems and depression.
- Repeated fractures.

# Conclusion

The life expectancy of women has increased and continues to increase. Many good years lie ahead after menopause. The physical changes that occur during menopause should not prevent women from enjoying this phase in their lives. To function at her best, remember to advise women to exercise, eat a balanced diet and maintain activity and social life. Also... remember that menopause is a natural event. Women can deal with it in their own ways. Adjusting to the changes of menopause can help women focus their attention where it belongs, **on a healthy life in the years ahead.**