POSTMENOPAUSAL PROBLEMS AND EASY SOLUTIONS

IN EVERY DAY PRACTICE

Dr Uma Marthi
GPsW
Castleton Health Centre
01/102016
Age UK Statistics

- 11.6 million people aged 65 or over in UK
- **Life expectancy at birth for women 82.8 years**
- 3 million people above 80 years old
- There are more people >60 years and above than there are under 18 years old.
- Out of 11 million people 3.8 million live alone and 70% these are women
- 1 in 3 older women above 65 years experience incontinence
Natural process

- Age. Hormone levels fall
- Change in BMI
- Medical problems
- Family circumstances
- Job/ Financial
- Relationship problems
- ++++Menopausal symptoms
Menopause

Menopause in women who have

- Not had a period for at least 12 months and are not using hormonal contraception.

- Symptoms in women without a uterus
Common Menopausal problems

- Hotflushes - vasomotor symptoms
- Psychological symptoms
- Urinary symptoms
- Local symptoms - vulval irritation, vaginal dryness etc
- Loss of libido
- Some worry about contraception!
Lack of Oestrogen

- Fat distribution changes
- LDL Increases/ HDL decreases
- Increased triglycerides
- Skin
- Bone
- Muscles/ collagen/ epithelium
- Heart- CVD risk
- Cognitive function
- Changes in mood and Memory
Common clinical cases

- A 52-year-old lady presented with hot flushes, night sweats, insomnia and mood changes affecting her work and family life.

- A 58-year-old presented with low mood and was very tearful. Going through relationship problems related to loss of libido and vaginal dryness.

- A 70-year-old lady with multiple medical problems brought by her daughter with a history of recurrent UTI and vaginal soreness symptom.
Treatments already tried....

- Soya, red clover - phyto oestrogens
- Herbal remedies
  - Black cohosh, Ginkgo biloba
  - Dong quai, evening primrose oil
  - Ginseng, liquorice root, valerian root, St. John’s wort, Yams... So on

Oestrogen is for .... Oestrogen
Vaginal atrophy

- Very common - 50% of women have some symptoms
- Dyspareunia
- Vaginal discharge
- Vulval irritation
- Urinary problems

Unlike vasomotor symptoms, which abate over time, vaginal atrophy is typically progressive and unlikely to resolve on its own
Sexual health

- Sexual issues generally increase with aging;
- Distressing sexual complaints peak during midlife (ages 45-64) and are lowest from age 65 onward
- Decreased estrogen causes a decline in vaginal lubrication and elasticity
- Decreased testosterone may contribute to a decline in sexual desire and sensation
- An active sex life, lubricants and moisturizers, and local vaginal estrogen help maintain vaginal health
ATROPHIC CHANGES IN VAGINA
Why are we less confident in prescribing HRT?

Why do patients hesitate to start HRT?
Multiple reasons

- Too many studies.. Too little evidence
- Confusing data
- Press.. / Media
- Other medical problems
- Cancers – eg: Breast
- Family history of any cancers
- What are the types available? What route is best?
To avoid blood test in women above 45 years and to consider HRT if they are symptomatic

To offer women HRT after discussing with the tem the short term and longer term benefits and risks.

To offer vaginal oestrogens for women as long as needed to relieve symptoms.

Consider testosterone supplements for menopausal women with low sexual desire if HRT alone is not effective
NICE guidelines - 2015

Understanding risks-
Breast Cancer - Per 1000 women aged 50-59

Cases normally diagnosed - 23
Additional 4 with Combined HRT
Additional 5 if women who drink Alcohol
Additional 3 who are current smokers
Additional 24 in women who are overweight or obese (BMI > 30)

FOUR FEWER in women who are on oestrogen therapy
UTERUS INTACT

LMP < 1 YEAR

SEQUENTIAL HRT
Oral (E&P cyclically)

Patches - Sequential patches
Or Oestrogen patches + oral progesterone

IUS + oestrogen oral or patches

LMP > 1 YEAR

COMBINED CONTINUOUS HRT
Oral - tablets containing E+P

Patches containing E+P

Transdermal Oestrogen - gel or patch + IUS

Tibolone
POST HYSTERECTOMY

ONLY OESTROGEN THERAPY

-OESTROGEN GEL

--ORAL TABLETS – 0.5mg, 0.625mg, 1.25mg

-Oestrogen patches - 25mcg, 50mcg, 100mcg changed TWICE weekly
Non hormonal lubricants

Local Hormonal Preparations
Vaginal discharge

Common symptom in Post Menopausal Women
Causes of Vaginal discharge

- Atrophic vaginitis
- Foreign bodies - ring pessaries, shelf pessaries and toilet tissues
- Recurrent thrush - diabetes
- STIs
- Urethral caruncle
- Prolapse
- Associated vulval conditions
- Rare causes - fistulae
Urethral caruncle

- A urethral caruncle is a benign polypoid mass of the urethral meatus, most commonly found in postmenopausal women.
- Soft smooth red fleshy lesion or red ring of urethral mucosa protruding through the urethral orifice.
- It may appear to be polypoid (sessile or pedunculated).
- They may (rarely) thrombose and turn purple or black.
- Often asymptomatic but sometimes they are painful.
- Can cause dysuria, discharge and occasionally they may bleed.
STIs

- Clinicians should not assume that peri- and postmenopausal women are not at risk for STIs.

- Vaginal atrophy increases the risk for contracting an STI.

- Older women may not be as knowledgeable as younger women about infection risks or steps to take to reduce those risks.
Management of vaginal discharge

- Hesitation to seek help
- Social factors: dependency
- Drug interactions
- Difficulty in using applicators for local preparations
- Persistent local factors (irritants/ pads)
Treatment of vaginal discharge

Routine treatment of vaginal discharge

?? Suitable for elderly

Drug interactions

- Warfarin (more elderly women on warfarin- increased diagnosis of AF/ increased valve replacement surgeries).
- Oral Metronidazole in treating anaerobic infections
- Oral Fluconazole – for candidal infection

BOTH SIGNIFICANTLY INTERACT WITH WARFARIN
Treatment for vaginal discharge

- Review of medical problems – diabetic control
- Treating atrophic changes- liberal use of local oestrogen therapy.
- Use of local antibiotic preparations clindamycin or Metronidazole
- Co-amoxiclav as an alternative to Metronidazole (if women are on warfarin)
- Vulval hygiene- do’s and don’t’s (clear instructions to nursing staff or carers)
- Maintaining a register or to have a recall system for change of pessaries (ring/Gellhorn/shelf) or documentation in their care plan.
- If no better or symptoms recur – Needs reassessment and referral to specialists
Challenging Clinical cases

Case -1

74 year old women who had hysterectomy at the age of 52 years referred by our local GP with history of persistent vaginal discharge – tried antibiotics/thrush treatment on numerous occasions / local oestrogen treatment for few months – NO better

Case-2

82 year old lady presented with recurrent offensive vaginal discharge / had swabs x6 times HAD all possible treatments but was NO better.
Clinical cases

Case I - Persistent discharge - yellow to brown? Doubted faecal matter. So referred her to gynaecologist and found to have fistula colo–vaginal fistula.

Case II – In view of her symptoms / bloated feeling and discharge – did TV scan there was a bright echogenic area in uterus? Blood but it turned out to be air - diagnosed with colo-uterine fistula.

**BOTH WOMEN HAD SEVERE DIVERTICULOSIS with FISTULA**
Vulval conditions

- Vulval candidiasis or intertrigo in groins
- Lichen sclerosis
- Atrophic changes
- Contact / Irritant dermatitis due to over washing, urinary and faecal incontinence.
- Lichen simplex chronicus
- Lichen planus
- Paget’s disease
- Squamous cell carcinoma more common in elderly
Vulval conditions

Reasons

- Vulva is more sensitive to irritants
- Age and lack of oestrogen make it more susceptible
- Vulva is in close proximity to rectum and its pathogens (poor self care)
- Mechanically damaged by constant use of panty liners and pads
- Exposed to Ammonia due to urinary incontinence
Lichen sclerosis

- Porcelain white plaques in figure of ‘8’ distribution around vulva, perineum and perianal areas
- Skin texture – described as ‘parchment’
- Fissuring and erosions are common.
- Loss of architecture is common with LS – loss of labia minora or fusion of clitorial hood/intertotial narrowing.
- **Followed up in primary care regularly 6/12**

Advice patients to report if they notice any changes

Having a register or recall system for patients with Lichen sclerosis is very helpful.
Vulval cancers

- Primary disease in elderly women
- If diagnosed early prognosis is better

5 year survival rate
- 8 of 10 with early cancers survive
- 13% survive with metastatic disease

Age of presentation is reducing due to increased incidence in VIN.
Management of vulval symptoms

- Removal of irritating agent
- Use of soap substitute /EMOLLIENTS
- Treat the condition – candidiasis, Lichen sclerosis,…
- To stop itch and scratch cycle – antihistamine (interaction with other sedating medication should be reviewed)
- Any doubt about the vulval lesions – not sure about the condition or not responding to treatment – REFERRAL TO SPECIALIST
Recurrent UTI

Recurrent urinary tract infection (UTI) refers to ≥2 infections in six months or ≥3 infections in one year.

Most recurrences are thought to represent reinfection rather than relapse, although occasionally a persistent focus can produce relapsing infection.
Recurrent UTI

DIFFICULTIES
- Poor history
- Asymptomatic bacteria is common in elderly
- Specimen collection
- Other associated conditions (vulval lesions)
- Drug resistance
- Drug interaction
Recurrent UTI

- Symptoms
  Dysuria, frequency, suprapubic tenderness, urgency
  polyuria and haematuria (3 out of 6)

- Management
  - correction of dehydration
  - Avoid treating asymptomatic bacteruia
  - selection of antibiotic (resistance)
  - Drug interactions & electrolyte balance

- Recurrent UTIs / Persistent microscopic haematuria with negative cultures-
  Refer to urologist? underlying malignancy
Recurrent UTI

Almost 50% reduction with use of local oestrogen therapy

ATROPHIC VAGINA = ATROPHIC URETHRA
INCONTINENCE HOT LINE

PLEASE HOLD!
Urinary Incontinence problems

- Involuntary urine loss – has significant impact on personal and social life of women
- 20% women > 40 years
- 35% women > 80 years

‘Under-diagnosed’

How to find them?????

Opportunistic questioning when they come for smear, any gynae problem or any medical problem... Or even depression.....Well Women Clinics...
Definitions - Types of Incontinence

- Stress UI is involuntary urine leakage on effort or exertion or on sneezing or coughing.

- Urgency UI is involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to delay).

- **Mixed UI** is involuntary urine leakage associated with both urgency and exertion, effort, sneezing or coughing.
Incontinence in women

- Stress incontinence
  - Obesity
  - Trauma
  - Post menopause
  - Family history
  - Infection
  - Constipation
  - Lifting
  - Poor pelvic tone
  - Prolapse

- Urge incontinence/ frequency overactive bladder
  - Infection
  - Diabetes
  - Drugs
  - Caffeine etc
  - Vaginal atrophy
  - Prolapse
Post menopausal Women presenting with urgency
Nice Guidelines

- Women Centred Care
- Good communication - supported by Evidence based Information
- Appropriate treatment, care and Information
- Initial assessment should categorize the condition
- Bladder diaries - 3 days
- Urodynamic studies NOT recommended before conservative Treatment
NICE/SIGN Guidelines - Assessment

- BMI and Blood pressure check
- Abdominal examination
- Speculum examination - Dorsal/ Left lateral
- Bimanual/ Assessment of pelvic floor
- Rectal examination (if neurological condition suspected)
- Urine dipstick/ Bladder diary/ Bladder scan (in voiding problems)
BMI

Yes 22%
No 78%
Examination

- Yes: 39%
- No: 61%
Recommendations

- Lifestyle advice; Caffeine, Weight, Fluid Intake
- Physical Therapies; Bladder Retraining and Pelvic floor muscle training
- Refer to bladder and Bowel team
- Anti-Muscarinics
Identified causes

Patients at CHC said resolving this issue helped most
Medical Management- Anticholinergics (NICE guidelines)

- Do not offer oxybutynin (immediate release) to frail older women
- Oxybutynin (slow release), or
- Tolterodine (immediate release), or
- Darifenacin (once daily preparation)
- If the first treatment for OAB or mixed UI is not effective or well-tolerated, offer another drug with the lowest acquisition cost[^9]
- Offer a transdermal OAB drug to women unable to tolerate oral medication.

Follow guidance on Mirabegron for treating symptoms of overactive bladder,
Before prescribing anticholinergics

Prescriptions should be individualised

- Cognitive impairment (any risk of dementia)
- MEDICATION REVIEW: To AVOID anticholinergic load
- Lifestyle of the patient
- To rule out: Patient has history of acute angle Glaucoma
- Discuss side effects in detail
- Consider: Drugs that don’t cross Blood Brain Barrier (Trospium and Fesosterodine) in women with dementia
PROLAPSE

Common presenting symptoms

- Dragging sensation
- ‘I think my womb is falling’
- ‘something down below’
- ‘something not right’
- urinary incontinence
Incidence

- It is not always reported so difficult to know the exact incidence of the problem.
- 50% of parous women have some degree of prolapse.
- 60% are more than 60 years old
- 10-20% symptomatic
- Post hysterectomy prolapse 1% after 3 years and 5% at 17 years after a hysterectomy.
- Congenital or Nulliparous prolapse -2%
Terminology

Prolapse is classified according to which organ has herniated into vagina.

- **Anterior vaginal wall prolapse:**
  - Prolapse into vagina of **urethra (urethrocele)**
  - Bladder (cystocele) or
  - Both - cystourethrocele.

- **Uterovaginal prolapse**

- **Posthysterectomy vault prolapse**

- **Posterior vaginal wall prolapse**
  - Rectocele – descent of the rectum
  - Enterocele - small bowel descent
Symptoms

- Symptoms common to all types of prolapse **are a feeling of dragging, or a lump in the vagina or something coming down**

- Specific symptoms
  - **Urinary symptoms** (frequency, urgency, stress incontinence, hesitancy, feeling of incomplete emptying)
  - **Bowel symptoms** (difficulty in defecation, incontinence, feeling of incomplete evacuation).
  - Sexual symptoms – dyspareunia, incontinence

- **Other local symptoms**
  - Blood stained and purulent discharge, low back pain eased with lying down and pain in the vagina
UTERUS PRESENT TO SUPPORT THE PESSARIES
UTERUS ABSENT – VAULT PROLAPSE/ CYSTOCELE / RECTOCELE
Post menopausal Bleeding (PMB)

- Bleeding from the genital tract following at least six months of continuous amenorrhoea in menopausal women not on HRT

- Break through bleeding in postmenopausal women receiving HRT

"to rule out any malignancies and the probability of cancer is age dependent
9% in their 50’s and 60% in their 80’s"
PMB - Causes

- Atrophic endometritis and vaginitis
- Endometrial carcinoma
- Endometrial or cervical polyps
- Endometrial hyperplasia
- Cervical carcinoma/ Vaginal carcinoma (very rare)
- Ring pessary
- Ovarian oestrogen secreting tumour (rare)
Guidelines

› Any patient presenting with symptoms suggestive of cancer should be referred

› Recognises PMB as a symptom of gynae cancer

› Recommends that all primary care health professional should undertake a full pelvic examination including a speculum exam of the cervix in these patients

› TV scan – Endometrial thickness more than 4mm is significant in Post Menopausal Women
Unscheduled bleeding on HRT

- Starting combined continuous HRT - advice women she might have irregular spotting for 3-4 months which is common

- If she starts bleeding after few months of ‘no spotting or bleeding’ – advise her to stop HRT and to make appointment ASAP

- Examination and referral
NOT to miss Ovarian Cancer

- Carry out tests in primary care if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis - particularly more than 12 times per month:
  - Persistent abdominal distension (women often refer to this as 'bloating')
  - Feeling full (early satiety) and/or loss of appetite
  - Pelvic or abdominal pain
  - Increased urinary urgency and/or frequency.

USE OF TV SCAN + CA125
PRESENTING SYMPTOMS

- Symptoms often non-specific and vague
- Difficulty eating and feeling full quickly
- Increased abdominal size and persistent bloating
- Persistent pelvic and abdominal pain
- Change of bowel habit
- Backache
- Urinary symptoms
PATIENT PRESENTED WITH DYSPEPSIA TREATED WITH PPIs

TRANSABDOMINAL SCAN - SHOWING PAPIILLAE died 4 months AFTER DIAGNOSIS
Take HOME points

- To ease the ‘fear’ in women who need HRT
- Liberal use of local HRT – to help vaginal and Urinary Symptoms
- PMB – Examination to rule out common causes
- Women keen to have HRT – but high BMI / smoker / medical problems as hypertension, diabetes, abnormal lipid profile
  - Encourage life style management
  - Transdermal preferred route or IUS+ transdermal
Take Home points

Local HRT

Oestrogen cream or vaginal tablets - Not absorbed systemically so no need to monitor uterine thickness

Only contraindication - women with breast cancer

Starting therapy – daily treatment for 10-14 days (in elderly 5-7 days is sometimes enough) followed by twice weekly as long as they need (can even reduce to once weekly).

Local treatment once or twice weekly can be continued for a long time if needed
OFFERING ....HOLISTIC CARE IS EASY

IF WE THINK OF

ESTROGENS!!!!
Thank you

umamarthi@nhs.net