

Women's Health at Menopause

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Menopause is caused by the cessation of ovulation which marks the end of reproductive life of a woman. There will be drastic reduction in the production of the female hormone estrogen. The average age of female menopause is about 50. The typical symptoms in the short term are menstrual irregularities and vasomotor symptoms, e.g. hot flushes, night sweating, irritability and insomnia. The medium and long-term symptoms are related to urogenital atrophy, osteoporosis and increase incidence of cardiovascular accidents.

Menstrual irregularities usually present as oligomenorrhoea and hypomenorrhoea. Cycles become more and more infrequent until total cessation in one or two years. Sometimes patients may present with polymenorrhoea and menorrhagia. Careful examinations and investigations had to be performed to exclude uterine pathology before starting hormonal treatment. The incidence of vasomotor symptoms varies with countries and it is less common in Chinese and Japanese communities. In some patients, it is the feeling of unwell and lethargy that drive them to seek treatment. It has been reported these complaints are direct results of loss of REM sleep during the attacks of hot flushes at night time. These vasomotor symptoms are easily correctable with hormonal replacement therapy (HRT).

Estrogen withdrawal gives rise to generalized atrophy of the urogenital system. This will predispose the woman to atrophic vulvitis, vaginitis and endometritis. This will cause dyspareunia and loss of libido. Urinary urgency and incontinence are also common complaints of the female climacteric. These symptoms are also amendable with hormonal replacement.

Long-term problems with menopause are the risks of osteoporosis and cardiovascular accidents. Reduction of estrogen leads to increase bone resorption and puts menopause women at risk of osteoporotic fractures. All clinical studies showed that osteoporosis could easily be prevented by HRT. However, patients should be reminded that there are other potentially modifiable factors like smoking, physical inactivity, low dietary calcium, alcohol and caffeine abuse. Avoidance of these factors can also prevent osteoporosis.

Prevention of cardiovascular accidents with HRT remains controversial. Meta-analysis studies and large scale observational studies showed a protective effect on primary prevention. Randomized Controlled Trials (RCT) for primary prevention are on the way and results will only be available until 2006. Some recent RCT results showed no beneficial effects on secondary prevention, that is, in women with previous heart

attacks or strokes. The recent recommendation for these high-risk patients by the American Heart Association is: 'Don't start and don't stop' approach.

Classical HRT is replacement with estrogens, either by the oral or transdermal route. If there is an intact uterus in the woman, either sequential or continuous progestagen has to be added to protect the endometrium. Other choices of treatment include tibolone, a 'Tissue Specific Receptor Agent' or raloxifene, a 'Selective Estrogen Receptor Modulator'. The selection of an appropriate form of therapy for our patients will involve consideration of the route of administration, the regimen (continuous or sequential), the nature of the progestagen and the most important of all, the patients' choice. This of course include her wish to receive or not to receive medications after careful explanations