Improving Menopausal Care: General Concepts, Harnessing the Annual Wellness Exam, and Symptom Treatment

Executive Summary

In the United States alone, 6000 women each day or 2 million women each year reach menopause.[1-3] Around 75% of these women experience symptoms that can be embarrassing, uncomfortable, or even debilitating, including vasomotor symptoms, urinary incontinence, joint and muscle pains, or depression.[4-5] Many of these women are uncomfortable seeking medical help for their symptoms and may even turn to unregulated and untested treatments.[4] Clinicians are well-positioned to help ensure women receive tested and effective treatments for menopause symptoms. Unfortunately, many clinicians are uncomfortable with basic key concepts related to menopause,[1, 4, 6-7] do not prioritize menopausal care during annual wellness visits,[5, 8-9] and are not familiar with available hormonal and non-hormonal treatments. Clinicians require more extensive training about menopause to improve patient care and increase the use of evidence-based treatments.[4] The proposed educational initiative will provide an expert-led review and evaluation of key concepts related to menopause, discuss how the annual wellness exam can be harnessed to improve menopausal care, and review treatments to combat menopause symptoms. This information will help clinicians better understand menopause and how to provide more effective menopausal care.

Practice Gaps and Learning Objectives

Background

Women entering menopause represent the fastest-growing and largest population in the United States.[2-3] In fact, United States census estimates that there will be over 50 million postmenopausal women by the year 2020.[2-3] Many of these women experience symptoms caused by hormonal changes for up to a decade, including depression, urinary incontinence, vulvovaginal atrophy, vasomotor symptoms, disrupted sleep, mood changes, or short-term memory impairment.[4-5]

New educational and training programs are therefore required to maintain the health of the growing number of menopausal and postmenopausal women. Unfortunately, recent surveys report that that the majority of clinicians are not confident in basic key concepts surrounding menopause and associated symptoms. Clinicians are uncomfortable with their knowledgebase in areas like symptom pathophysiology, bone health, breast health, or cardiovascular disease.[1, 4, 6-7] Improving education in these and other key areas could help clinicians provide more effective menopausal care.

Meanwhile, several studies suggest that the majority of women will not initiate conversations with their doctor about menopause or seek medical help for their symptoms.[5, 8-9] Many patients are uncomfortable talking about sensitive subject areas surrounding menopause or believe that their clinician will not take symptoms seriously. Therefore, many women turn to unsafe and untested alternative medications for symptom managment.[4] Since patients will not seek help on their own, the annual

wellness exam could be the ideal time for clinicians to initiate dialogs about menopause. Talking to patients about possible menopause symptoms before their onset may invite patients to seek medical help when the need arises. Educating clinicians about different routes to initiate and maintain these conversations could ultimately ensure more patients receive tested and effective treatments for menopause symptoms.[5, 8-9]

Finally, evidence suggests that clinicians are not aware of the breadth of treatments available for menopause symptoms.[4] This contributes to a growing number of patients turning to unsafe and untested treatments to manage menopause. Education about hormone therapy (estrogen alone or in combination with progestin or progesterone), and therapy with estrogen receptor agonist-antagonists (eg, conjugated estrogens/bazedoxifene and ospemifene) can help clinicians provide evidence-backed treatment options to patients. Additionally, there is some evidence that the off-label use of certain medications can help relieve menopause symptoms, including some medications for seizures, anxiety, and depression.[10] Non-pharmacological treatments are also recommended in guidelines and position statements for some patients, including clinical hypnosis, mindfulness-based stress reduction, and weight loss. Education about the full breadth of treatment options can encourage clinicians to work with patients to select the most effective treatment for each unique situation.[11-13]

Practice Gap #1: Clinicians are largely uncomfortable with basic concepts necessary for the effective management of menopause patients.

Despite the growing number of women experiencing menopausal symptoms, many clinicians remain uncomfortable providing menopausal care. In a survey of 100 internal medicine residents in the United States, half of respondents indicated a low comfort level managing menopausal women, over a third reported not receiving clinical experience in menopausal care in the last 6 months, and three quarters felt that more training opportunities in this area were needed.[4, 6]

A more recent survey of medical residents found that over 66% of respondents indicated they needed to know more about key menopause issues and only 20.8% of respondents belonged to a program that had formal menopause training in the curriculum. Respondents reported lacking knowledge in key areas of menopausal care, including the pathophysiology of menopause symptoms (67.1%), bone health (66.1%), cardiovascular disease (71.7%), and metabolic syndrome (69.5%).[7]

Patients may also detect clinician discomfort with menopause symptoms and treatment. In an international survey of over 1400 menopausal patients, over half of respondents felt their family doctor did not acknowledge the seriousness of menopause.[14] “Our findings suggest that we, as health professionals, continue to let our patients down with poor provision of information, inaccurate or wrong information, or access to the right care,” the study’s authors concluded. “The cost of this is women living with preventable sequelae associated with the menopausal transition with a consequent adverse impact

on health and the health economy."[14]

However, educational programs detailing basic issues related to menopause can help build clinician confidence. One study examined the comfort level of medical residents with menopausal care before and after a 2-year curriculum on menopause issues. Key topics discussed included menopause physiology, breast health, and bone health, autoimmune disease, and cardiovascular disease. Before the program, over three quarters of residents reported low comfort levels with menopausal care. However, over 85% of respondents felt comfortable after the curriculum, and over 95% of residents indicated the educational program provided useful training. Indeed, the test scores after the conclusion of the program were significantly higher when compared to the pretest scores.[1] A similar study found a significant improvement in test scores before and after medical residents completed a rotation in a clinic for menopausal women, attended lectures on menopause, and participated in a commercial menopausal education program.[15]

Collectively, these findings suggest that an educational program discussing basic concepts in areas like menopause and symptom pathophysiology, bone health, breast health, and cardiovascular disease could help improve clinician comfort in providing menopausal care. This could lead to better management of menopause patients.

Learning Objective #1: Review basic concepts and issues associated with menopause, including pathophysiology, bone health, breast health, and cardiovascular disease.

Practice Gap #2: Clinicians do not understand the importance of prioritizing menopausal care during the annual wellness visit.

Women reportedly do not seek medical help for symptoms related to menopause.[8] For example, one study found that almost a third of surveyed patients with vulvovaginal symptoms related to menopause never sought out a provider and an additional 28% waited over a year before seeking help.[8, 16] Another study similarly found that a mere 30% of women reported seeking medical help for their menopausal symptoms within the year of the conducted survey.[8]

The annual wellness visit can therefore be an ideal time for clinicians to discuss menopause, symptoms related to menopause, and available treatments. However, even during these annual visits, both clinicians and patients often prioritize other conditions over menopause.[5] This is also compounded by a discomfort from both the patient and the clinician to discuss some of the sensitive areas that surround menopause, like sexual health or urinary incontinence.[5, 8] In one study, roughly half of respondents felt it was taboo for postmenopausal women to admit to having vulvovaginal symptoms. Furthermore, older women were significantly less likely to talk to their provider, friend, or even partner about their sexual health.[8-9]

Fewer studies have examined provider comfort with discussing menopause symptoms. However, one study found that 44% of surveyed women experiencing dyspareunia had to initiate a conversation about sexual health themselves when talking to their clinician while only 10% reported that the clinician initiated the conversation.[8-9]

Clinicians need to understand the importance of prioritizing menopause and its symptoms during the annual wellness visit since few women will seek medical help on their own. Treating wellness visits as an opportunity to educate patients about menopause and associated symptoms may also increase patient comfort with sensitive medical topics and encourage them to actively seek help outside of the annual exam.

In addition, there are various techniques and tools that clinics can incorporate into their practice to improve conversations about menopause during the annual wellness exam. For example, several studies have looked at effective communication techniques to make patients more comfortable talking about sensitive subject matter.[8] Additionally, one study provided an electronic toolkit to patients aged 45-64 years to help compensate for the lack of priority on menopausal care during appointments. The toolkit included a 35-item questionnaire that patients could complete at their convenience in the home to help identify menopause symptoms. The toolkit could then provide information to the patient and provider based on responses to support communication and shared clinical decision-making. The toolkit resulted in a 72.2% increase in diagnosis of menopause-related conditions during the annual well woman visit.[5]

Educating clinicians about the importance of prioritizing menopause discussions during annual visits can help ensure that patients receive effective treatments for their symptoms.

Learning Objective #2: Discuss the importance of prioritizing menopausal care during the annual wellness visit and highlight avenues care systems can take to harness the annual exam to improve menopausal care.

Practice Gap #3: Clinicians are unfamiliar with the breadth of treatments available to treat menopause symptoms.

There are an increasing number of hormonal and non-hormonal treatments to help manage menopausal symptoms, including vascomotor symptoms, genitourinary syndrome, osteopenia, and osteoporosis.[4-5, 17] However, an increasing body of evidence suggests clinicians are not equipped to help patients select appropriate treatments to manage menopause symptoms.[4-5, 17]

Consequently, more patients are turning to alternative treatments that are often not clinically tested or regulated by the Food and Drug Administration (FDA), including custom-compounded hormone products. Some of these alternative treatments may not

be safe or efficacious and could have dramatically inconsistent doses or even contaminated product.[11, 13, 18] For example, a recent survey of 3725 postmenopausal women found that 35% of respondents on hormonal therapy were taking compounded products.[18]

"Reluctance to treat menopausal symptoms has derailed and fragmented the clinical care of midlife women, creating a large and unnecessary burden of suffering," Drs. JoAnn E. Manson and Andrew M. Kaunitz reflected in a recent editorial. "Clinicians who stay current regarding hormonal and nonhormonal treatments can put menopause management back on track by helping women make informed treatment choices."[4]

Hormone therapy is widely regarded in guidelines and position statements as the most effective treatment to manage menopause symptoms.[11, 13] The benefits of hormone treatments are widely recognized to outweigh risks for most patients.[11, 13-14] Estrogen therapy alone or in combination with progestin or progesterone is widely regarded as the gold standard for treating vasomotor symptoms and can also help with osteopenia and osteoporosis. Women with an intact uterus are usually prescribed estrogen with progestin since estrogen alone increases the risk of endometrial cancer. Meanwhile, women who have had a hysterectomy are generally given estrogen alone.[17, 19] However, these therapies can be accompanied by vaginal bleeding, breast tenderness, endometrial proliferation, and can increase the risk of breast cancer in some patients.[6] Estrogen receptor agonist-antagonists (ERAAs) are another class of effective treatments that provide many of same benefits while reducing adverse effects.

For example, Conjugated estrogens/bazedoxifene can be very effective against moderate to severe vasomotor symptoms and can help prevent postmenopausal osteoporosis in women with an intact uterus. A series of double-blind, placebo-controlled phase 3 trials showed the treatment significantly reduced hot flashes in improved bone density compared to placebo.[17, 20] The treatment is ideal for patients who want fewer of the side effects associated with hormone therapy, who are at a higher risk of osteoporosis, or who do not want to take progestin alongside estrogen.[17, 20] Other possible benefits of the treatment include relief of genitourinary syndrome of menopause and positive impacts on the uterus.[17] Meanwhile, ospemifene is approved for the treatment of genitourinary syndrome and acts as an estrogen agonist in the vaginal mucosa and an estrogen antagonist elsewhere.[17] The treatment can help women who find alternative mediations for genitourinary syndrome ineffective or inconvenient, including over-the-counter lubricants, vaginal estrogen, or systemic hormone therapy.[17]

Additionally, ERAAs like tamoxifen and raloxifene can be effective at reducing the risk of breast cancer and have some potential additional benefits in menopausal care. Tamoxifen was originally approved for the treatment of metastatic breast cancer. However, it also received approval for cancer prevention after a series of clinical trials demonstrated that tamoxifen significantly reduced the incidence of estrogen receptor-positive breast cancer.[17] Other possible benefits of the treatment include reducing

cardiovascular risk and osteoporotic fractures, though these uses are not approved by the FDA.[17] Meanwhile, raloxifene is approved for the treatment and prevention of osteoporosis and can also reduce the risk of estrogen receptor-positive breast cancer in postmenopausal women at higher risk for the disease. One study also found that risk reduction for breast cancer may even persist after treatment is discontinued.[21] However, both of these treatments have also been reported to sometimes cause hot flashes or other menopausal symptoms.[22] Additionally, there is some evidence that the ERAA-like S-equol derivatives of soy isoflavones can be effective against menopausal symptoms, but the North American Menopausal Society recommends these with caution and notes that more studies are warrented.[10]

Sometimes a patient has medical contraindications or personal preferences that eliminate hormonal therapy as a treatment option. In these cases, prescription pharmacotherapies or lifestyle changes with non-pharmacotherapy options can be used to lesson symptoms. Clinicians need to be aware of the breadth of non-hormonal options to best serve all patients.

There are several non-hormonal options available for the management of vasomotor symptoms. The North American Menopause Society recommends FDA-approved paroxetine salt for the management of hot flashes associated with menopause. Additionally, medications approved by the FDA for depression, anxiety, or seizures may also effectively treat vasomotor symptoms, including venlafaxine, desvenlafaxine, gabapentin, pregabalin, paroxetine, fluoxetine, and citalopram.[10, 19, 23] Available guidelines recommend the off-label use of these treatments for some patient situations.[10, 19, 23]

Outside of pharmacotherapies, some studies suggest that simple changes in diet and lifestyle can also help reduce menopausal symptoms. Taking vitamin D, calcium, or even supplements that include these ingredients can help fight osteoporosis.[19] Exercise, yoga, weight loss, and relaxation methods may also be effective at reducing hot flashes.[10,19] Other studies suggest that cognitive-behavioral therapy and clinical hypnosis can also work well in some patients for managing vasomotor symptoms.[10] Additionally, vaginal moisturizers and lubricants can be effective against symptoms associated with genitourinary syndrome.[11] Clinicians need to be aware of all options to best serve the individual needs of each patient.

Learning Objective #3: Review available treatments for menopause, including hormone therapy, ERAAs, non-hormonal pharmacotherapies, and non-pharmacotherapy options.

<u>Proposed Agenda</u>

AGENDA

5 minutes	**Activity overview**
	Pre-activity assessment

20 minutes **Concepts and Issues in Menopause**

--Introduction to menopause

--Key issues and concepts related to menopause, including

--Menopause symptoms and pathophysiology

--Breast health

--Bone health

--Cardiovascular disease

15 minutes **Prioritizing Menopause during the Annual Wellness Exam**

--Why women do not seek help or treatment for symptoms

--Examples of

--Initiating dialog about symptoms before menopause

--Effective methods of communication about sensitive subjects

--Utilizing technology to educate and communicate with patients between appointments

15 minutes **Treating Menopause Patients**

--Available guidelines and position statements, including the North American Menopause Society, the International Menopause Society, and the Endocrine Society

--Hormone therapy

--ERAAs

--Non-hormonal pharmacotherapies

--Non-pharmacotherapies

5 minutes **Activity summary**

Post-activity assessment

References

1. Christianson MS, Washington CI, Stewart KI, Shen W. Effectiveness of a 2-year menopause medicine curriculum for obstetrics and gynecology residents. Menopause. 2016;23(3):275-9.
2. US Census Bureau. 2012 National Population Projections: Summary Tables (2012). www.census.gov/population/projections/data.
3. US Census Bureau. 2005 Population Estimates: National Tables (2005). www.census.gov/popest.
4. Manson JE, Kaunitz AM. Menopause Management--Getting Clinical Care Back onTrack. N Engl J Med. 2016;374(9):803-6. .
5. Silvestrin T, Steenrod A, Coyne K, et al. Outcomes of implementing the women's health assessment tool and clinical decision support toolkit. Womens Health (Lond). 2016;12(3):313-23. .

6. Hsieh E, Nunez-Smith M, Henrich JB. Needs and priorities in women's health training: perspectives from an internal medicine residency program. J Womens Health (Larchmt). 2013 Aug;22(8):667-72. .
7. Christianson MS, Ducie JA, Altman K, Khafagy AM, Shen W. Menopause education: needs assessment of American obstetrics and gynecology residents. Menopause. 2013;20(11):1120-5.
8. Parish SJ, Nappi RE, Krychman ML, et al. Impact of vulvovaginal health on postmenopausal women: a review of surveys on symptoms of vulvovaginal atrophy. Int J Womens Health. 2013;5:437-47.
9. REVEAL W. Revealing vaginal effects at mid-life: Surveys of postmenopausal women and health care professionals who treat postmenopausal women. Madison, NJ: Wyeth; 2009. 2012.
10. Nonhormonal management of menopause-associated vasomotor symptoms: 2015 position statement of The North American Menopause Society. Menopause. 2015;22(11):1155-72; quiz 1173-4.
11. Stuenkel CA, Davis SR, Gompel A, et al. Treatment of Symptoms of the Menopause: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2015;100(11):3975-4011.
12. Stuenkel CA, Davis SR, Gompel A, Lumsden MA, Murad MH, Pinkerton JV, Santen RJ. Treatment of Symptoms of the Menopause: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2015;100(11):3975-4011.
13. Stuenkel CA, Santen RJ. An introduction to the Endocrine Society Clinical Practice Guideline on treatment of symptoms of the menopause. Post Reprod Health. 2016;22(1):6-8.
14. Cumming GP, Currie H, Morris E, Moncur R, Lee AJ. The need to do better - Are we still letting our patients down and at what cost? Post Reprod Health. 2015;21(2):56-62. .
15. Jiang X, Sab S, Diamen S, Schnatz PF. Menopausal medicine clinic: an innovative approach to enhancing the effectiveness of medical education. Menopause. 2012;19(10):1092-4.
16. Nappi RE, Kokot-Kierepa M. Vaginal Health: Insights, Views & Attitudes (VIVA) - results from an international survey. Climacteric. 2012;15(1):36-44.
17. Hirsch HD, Shih E, Thacker HL. ERAAs for menopause treatment: Welcome the 'designer estrogens'. Cleve Clin J Med. 2017;84(6):463-470.
18. Gass ML, Stuenkel CA, Utian WH, et al. Use of compounded hormone therapy in the United States: report of The North American Menopause Society Survey. Menopause. 2015;22(12):1276-84.
19. National Cancer Institute. Menopausal Hormone Therapy and Cancer. https://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/mht-fact-sheet. December 5, 2011. Accessed June 27, 2017.
20. Holmberg M. Duavee by Pfizer, Inc. http://www.pharmacytimes.com/publications/issue/2014/june2014/duavee-by-pfizer-inc-. June 16, 2014. Accessed June 26, 2017.

21. Vogel VG, Qu Y, Wong M, Mitchell B, Mershon JL. Incidence of invasive breast cancer in postmenopausal women after discontinuation of long-term raloxifene administration. Clin Breast Cancer. 2009;9(1):45-50.
22. Abedin S. Drugs help prevent breast cancer but pose risks too. http://www.cnn.com/2009/HEALTH/09/17/breast.cancer.drugs/. September 18, 2009. Accessed June 17, 2017.
23. Pachman DR, Jones JM, Loprinzi CL. Management of menopause-associated vasomotor symptoms: Current treatment options, challenges and future directions. Int J Womens Health. 2010;2:123-35.