

## NEGOTIATING THE MENOPAUSE TRANSITION:

Menopause is the final of the three “blood events” in women’s lives, following menarche (starting periods) and childbirth. Like these other defining thresholds, the menopause transition is surrounded by myth and apprehension in our culture. Add to that its entanglement with aging, and you have a recipe for confusion and fear in many women. This huge market for “answers” creates a profit motive that makes it harder to get straight answers based on solid data. Based on our annual trip to the North American Menopause Society meeting, review of the literature, and many years of listening to women negotiating the transition, here is the latest information available.

### **What will menopause feel like?**

Remember the girls that scared you about periods before you started yours, and told you horror stories about labor during your first pregnancy? The same thing happens with menopause – but in reality 80% of women surveyed after menopause feel that the transition was relatively easy, and the decade with the highest life satisfaction for women is the 50’s – so get ready to enjoy.

The Stages of Reproductive Aging Workshop (STRAW) has carefully looked at the stages of perimenopause to help women know where they are in the process.

“Early perimenopause” is defined by a consistent change in cycle length by 7 days or less. In this phase you are still ovulating, although not as efficiently. Periods are still fairly regular, but may be closer together and occasionally heavier. PMS can be more noticeable, including breast tenderness, bloating, shorter fuse etc. Hormonally, your progesterone levels are dropping, whereas estrogen is still fairly high.

“Mid-Perimenopause” In this phase you are ovulating less predictably, and may skip periods now and then. Estrogen levels are lower too now, leading to on and off hot flashes, sleep disturbance, and vaginal dryness may begin

“Late perimenopause” is characterized by at least one 60 day gap between periods. Ovulation is a rare event in this phase, leading to few periods and increased low estrogen symptoms. Once you go 12 months without bleeding, you’ve crossed the threshold – congratulations! You no longer need contraception, and your symptoms will gradually improve over the next year or two.

Notice that hormone levels, blood or otherwise, are not part of these definitions. Almost always, the diagnosis of perimenopause is “clinical”, meaning, based on your symptoms, not on lab tests.

Which symptoms in the 40’s and 50’s are hormone related and which are due to other factors, like aging, busy lifestyle, lack of exercise, and relationship issues? The ongoing Melbourne Women’s Midlife Health Project, in its 15<sup>th</sup> year, tells us that cycle changes, hot flashes, vaginal dryness, and breast tenderness are clearly from hormonal changes. Depression, libido changes, joint aches, fatigue, bloating, cognitive changes (“fuzzy brain”), anxiety, sleep disturbance (not those associated with night sweats) and weight gain are NOT “caused” by hormonal changes. They often occur in the same time period as hormone fluctuations, but have many other contributing factors that are more causative than hormones.

### **What if I do have symptoms that interfere with daily activities?**

First, get a thorough check up, including a good pelvic exam. Other health problems, such as thyroid imbalance, diabetes, sleep disorders, etc may be causing your symptoms. You may need an ultrasound of the pelvis or a sample taken from the lining of the uterus if you have pelvic symptoms, to be sure there are no abnormalities of the uterus or ovaries. Hormone levels are rarely of help due to great variation from day to day in the same individual, and between individuals. In special circumstances, they may be of use, for example, after hysterectomy or endometrial ablation, where the ovaries remain but there are no periods.

Next, start simple. Did you know that women who exercise 45 minutes daily have half the menopause complaints of nonexercisers? Black cohosh is very effective in up to 75% of women in placebo controlled trials for hot flashes and has been proven to work in the brain, where hot flashes start. Topical progesterone cream has also been studied in placebo controlled trials and found to be effective. Research at Bowman Grey University tells us that 30 - 40% of women break down oral soy to “equol”, and that these women have excellent response of hot flashes to soy supplements. The other 60 - 70% will have no benefit from soy. Start with 20 grams of soy protein from dietary sources (not pills or powders) per day and try it for 30 days to see if you are an equol producer. University of California research shows early promise for paced breathing techniques to reduce menopause symptoms.

If you are one of the 15% of women who are miserable despite conservative measures, you may need hormone therapy. In early perimenopause, progesterone alone may be effective to regulate periods and reduce flow. As estrogen drops and hot flashes begin, low dose estrogen can be added. These two hormones need to be balanced to feel good, and to protect the lining of the uterus from cancers that are increased in women who have a uterus and take estrogen alone.

Estrogen absorbed through the skin (topical cream, gel, vaginal ring, or patches) is safest, and helps keep testosterone levels as high as possible. Oral estrogen results in about a 50% reduction in bioavailable testosterone, which may contribute to low libido and energy. We can supplement testosterone in women with these symptoms to see if it helps. Some women have PMS type symptoms with oral progesterone, so this can be given vaginally or via a progesterone containing IUD if necessary.

### **What should I take and how long should I take it?**

For more than 25 years I have almost exclusively used estradiol and progesterone, the same hormones produced by your ovaries. It makes sense to me to use the same thing Mother Nature designed for the human female, although synthetics are also highly effective. In the past, there were few preparations commercially available (those you can pick up at Meijers and have your insurance cover) that contained these “bioidentical” medicines, so I worked closely with compounding pharmacies for many years. Since the early 1990s oral natural progesterone has become commercially available, and estradiol patches were introduced. They are “bioidentical” and commercially available – the best of all worlds for you. We also have natural testosterone gel currently, and soon, a natural testosterone patch for women. Occasionally women need these medicines in doses not available at your local drug store, and a reputable compounding pharmacy is a great

partner in your care, custom making a preparation for you with your doctor's prescription.

I prefer estrogen in patch or cream form rather than oral pills, as the risk of blood clots does not appear increased with transdermal delivery.

The lowest dose that solves your problems is the right dose for you. There is tremendous variation between women regarding "how much is enough", so I recommend starting low and adjusting up if necessary until you feel good. Balance the estrogen and progesterone, adding testosterone if necessary. Checking hormone levels is not usually helpful – we want you to feel good, not have a pretty printout from the lab. If hormone levels are necessary in your case, request blood levels, not salivary levels. Recent research shows that due to huge variations between individuals and from day to day in the same individual, salivary levels are useful only if done five times daily – which gets expensive!

What about safety? All medicines have benefits and risks, and NOT taking medicines has upsides and downsides too. The risk of stroke, heart attack, and blood clots is slightly increased in women who take estrogen and progesterone. If you are low risk for these conditions, your risk is extremely small. If you are an older, heavier, diabetic smoker, with high blood pressure and phlebitis, you are NOT a good candidate for hormones! Breast cancer is increased 1% per year of hormone use, so short term use is very safe, especially in women who are low risk. If you are high risk, short term use is still very safe, but limiting medications to 3 – 5 years is prudent. Vaginal estradiol, via an every 3 month ring or twice a week tablets is extremely safe for almost everyone, even breast cancer survivors

A word about the safety of bioidentical hormones – their risks are the same as synthetic hormones. The Million Women Study from Britain used estradiol (the natural estrogen found in patches and used by the compounding pharmacies too) almost exclusively and showed the same increases in heart disease, stroke, breast cancer and blood clots as the synthetic estrogens used in the US Women's Health Initiative Study, published in 2002.

Deciding when to go off hormones is another tricky area. Usually once you feel stable, balanced, "over the hump" of perimenopause, you can begin to gradually taper down, and eventually off, your medicines. The slower you go, the easier it will be, although some women can go "cold turkey" and do fine.

Negotiating the menopause transition is always an opportunity for growth, sometimes a physical challenge, sometimes a breeze, but should never be a nightmare. We can shepherd you through "the change" if you need help – just ask!

For additional information go to the following links of the North American Menopause Society:

<http://www.menopause.org/edumaterials/guidebook.aspx>

<http://www.menopause.org/edumaterials/earlyguidebook/emgtoc.aspx>