What is menopause?

KEY POINTS

- The term "menopause" refers to the final menstrual period.
- Symptoms occur during the peri-menopause as a result of fluctuations in hormone levels
- These symptoms last on average 4-8 years, but are usually most frequent and severe in the year around the final menstrual period
- Being informed about what may happen during the menopause transition is a very good starting point in managing the symptoms

The menopause is sometimes called 'the change of life' as it marks the end of a woman's reproductive life. At menopause, ovulation no longer occurs and production of oestrogen and progesterone ceases. The word "menopause" refers to the last or final menstrual period a woman experiences. When a woman has had no periods for 12 consecutive months she is considered to be "postmenopausal".

Most women become menopausal naturally between the ages of 45 and 55 years, with the average age of onset at around 50 years. Premature menopause or premature ovarian insufficiency may occur before the age of 40 due to natural ovarian function ceasing, following surgery to remove the ovaries, or as a result of cancer treatments. Menopause is considered "early" when it occurs between 40 and 45 years. (For more, see the information sheets Early menopause due to chemotherapy and radiotherapy and Spontaneous Premature Ovarian Insufficiency).

What is peri-menopause (the menopausal transition)?

Peri-menopause refers to the time leading up to menopause when a woman may start experiencing changes in her menstrual periods such as, irregular periods or changes in flow. Cycles can be shorter or longer in length. Symptoms may also include hot flushes and night sweats, aches and pains, fatigue or irritability as well as premenstrual symptoms such as sore breasts. These changes may be caused by fluctuations in the production of hormones from the ovary. Some women can experience menopausal symptoms for 5-10 years before their final menstrual period[1]. There is no way to predict the age at which a woman's menopausal symptoms will start or how long they will last.

Contraception in the peri-menopause

A woman's fertility declines naturally in her 40s and the risk of pregnancy after the age of 50 years is estimated at less than one per cent but women may ovulate twice in a cycle and as late as three months before the final period. Women are advised to keep using contraception until two years after their last period if they experience the menopause under the age of 50, and for one year after the last period if aged 50 years or more[2]. Women using combined oral contraception (the Pill or the vaginal ring which contain oestrogen and a progestogen)

are generally advised to cease by the age of 51 years and switch to a non-hormonal or progestogen-only method. The risks of ethinyl oestradiol-containing methods increase with age, especially if the woman is a smoker over the age of 35 (for detailed information on the advantages and disadvantages of contraceptive methods in the peri-menopause and advice on stopping contraception at menopause see the information sheet Contraception).

Physical symptoms of menopause

Symptoms commonly reported by peri- and post-menopausal women include hot flushes and night sweats, bodily aches and pains, dry skin, vaginal dryness, loss of libido, urinary frequency, and sleeping difficulties. Some women may have unwanted hair growth, thinning of scalp and pubic hair and skin changes. Not everyone finds the symptoms bothersome but about 60% of women will have mild symptoms for around 4-8 years. Twenty per cent of women will have no symptoms at all while another 20% will be severely affected, with symptoms continuing into their 60s or later[3].

Now that women live around one third of their lives after menopause, optimizing physical and mental health during this period is becoming more important. (For more, see the information sheets on Weight management and healthy ageing and Osteoporosis)

Psychological symptoms of menopause

Hormonal changes and sleep deprivation can contribute to mood changes, anxiety, irritability, forgetfulness, and trouble concentrating or making decisions. Low levels of oestrogen are associated with lower levels of serotonin, a chemical that regulates mood, emotions and sleep. Depression is not more common at menopause than at other stages of life, but a past history of depression, particularly post-natal depression, and stress during the peri-menopause may make a woman more likely to succumb to mood problems. (For more, see the information sheet "Mood problems at menopause").

How is menopause diagnosed?

Doctors diagnose the menopause based on a woman's symptoms and changes in menstruation. The diagnosis is obvious where a woman has had her ovaries removed surgically. (For more, see the information sheet Diagnosing Menopause). A symptom score sheet can be a useful way to sort out what a woman is experiencing and whether any treatment is indicated.

It is not necessary to have hormonal tests to "prove" a woman is menopausal. However,

a doctor may order tests if there is concern that physical changes are a sign of illness, such as a thyroid disorder, rather than natural ageing, or if spontaneous menopause occurs at an early age. A single hormone test, such as a measurement of elevated follicle-stimulating hormone (FSH) is not a reliable indicator of the peri-menopause, as during this time women's hormone levels fluctuate from day to day.

While some practitioners recommend saliva tests to determine hormone levels, there is no evidence that the result will be accurate or useful. The Australasian Menopause Society does not endorse the use of these tests. Measurement of AMH (anti-Müllerian hormone) can help to predict age of menopause but it is not a test routinely used except in the specialist setting.

How can symptoms be handled?

Being informed about what may happen during the menopause transition is a very good starting point.

Women are encouraged to pay attention to their health, including quitting smoking, eating well, exercising regularly and incorporating some relaxation techniques. Self-management strategies such as carrying a fan, dressing in layers, always having a cool drink and a facial water spray can be helpful. Avoiding spicy foods, caffeine and alcohol will also reduce flushing.

Some women may find relief from menopausal symptoms with herbal or alternative remedies, however most have not been studied or shown to be of benefit scientifically and some, like black cohosh, have been occasionally linked to serious side effects. Bioidentical hormones – mixtures of hormones supplied by compounding chemists – may be touted as beneficial and more "natural" than menopause hormone replacement therapy (MHT) but there is inadequate evidence for their safety and effectiveness (For more, see the information sheets Bioidentical custom compounded hormone therapy and Bioidentical hormone preparations - History of development.).

MHT, as patches or tablets, has been demonstrated scientifically to reduce menopausal symptoms. However, for each individual woman its benefits must be weighed against the increased risk of side effects such as thromboembolism and breast cancer. For younger menopausal women (below the age of 60, or within 10 years of menopause), the latest Global Consensus Statement on Menopausal Hormone Therapy states, "The dose and duration of MHT should be consistent with treatment goals and safety issues and should be individualized. In women with premature ovarian insufficiency, systemic MHT is recommended at least until the average age of the natural menopause"[4]. Some women may need to continue MHT if symptoms persist, and they should seek their doctor's advice to weigh up the risks and benefits. Her doctor should review any woman taking MHT annually. (For more, see the information sheets Combined menopausal hormone therapy, Oestrogen only menopausal hormone therapy, Risks and benefits of MHT/HRT and Venous thrombosis/thromboembolism risk and menopausal treatments).

Doctors may prescribe other drugs to relieve symptoms, such as anti-depressants (which have been shown to reduce hot flushes), gabapentin, and clonidine. (For more, see the information sheet Nonhormonal treatments for menopausal symptoms).

Feeling positive about the menopause

Women may experience physical and emotional changes during menopause but that doesn't mean life has taken a turn for the worse! Many women are prompted at this time to 'take stock' of their lives and set new goals. The menopause occurs at a time when many women may be juggling roles as mothers of teenagers, as carers of elderly parents, and as members of the workforce. Experts suggest that creating some 'me time' is important to maintain life balance. Menopause can be seen as a new beginning: it's a good time to assess lifestyle, health and to make a commitment to strive for continuing 'wellness' in the mature years.

Symptom score sheet *(5)*

This valuable diagnostic tool can be completed together with the woman, or she can do it herself in the waiting room. The woman judges the severity of her own symptoms and records the score. A score of 15 or over usually indicates oestrogen deficiency that is intrusive enough to require treatment, but this is only a guideline. Women are very variable in their tolerance of discomfort, often tolerating quite severe symptoms before they will even consider treatments. Scores of 20-50 are common in symptomatic women, and with adequate treatment tailored to the individual, the score will reduce to 10 or under in 3-6 months.

Using the symptom score sheet at subsequent follow-up visits is a useful method of judging whether adequate oestrogen is being taken to alleviate symptoms. Generally, there is a halving of the symptom score after 2-3 months on MHT and if the woman is still experiencing a lot of symptoms, she may require a dose increase. If symptoms still persist, changing from the oral route to transdermal may help if the problem is oestrogen malabsorption. Women with irritable bowel syndrome, or taking H2 antagonists commonly absorb oral oestrogen poorly.

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References

1. McKinlay SM, Brambilla DJ, Posner JG. The normal menopause transition. Maturitas 1992;14:103.
2. www.ffprhc.org.uk/admin/uploads/ContraceptionOver40
3. Col NF, Guthrie JR, Politi M, Dennerstein L. *Menopause* 2009;16(3):453-457
4. de Villiers TJ, Gass ML, Haines CJ, Hall JE, Lobo RA, Pierroz DD. Global Consensus Statement on Menopausal Hormone Therapy *Climacteric 2013;16:203–204*
5. Greene JG. Constructing a standard climacteric standard. Maturitas 1998;29:25-31

SYMPTOM SCORE (Modified Greene Scale) [5]

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS

SCORE: None =0; Mild =1; Moderate =2; Severe =3

NB. The symptoms are grouped into 4 categories, vasomotor, psychological, locomotor and urogenital. If one group does not respond to MHT, look for other causes and specific treatments for that group.

Not all of the symptoms listed are necessarily oestrogen deficiency symptoms.