The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Management of the menopause

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

RANZCOG acknowledges the contribution of the Australasian Menopause Society (AMS) in the compilation and continuous review of this statement.

A list of Women's Health Committee Members can be found in Appendix A.

First endorsed by RANZCOG: March 1995
Current: November 2014
Review due: November 2017

Objective: To provide advice on the management of the menopause.

Target audience: All health practitioners providing gynaecological care, and patients.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women's Health Committee in March 1995 and most recently reviewed in November 2014.

Funding: The development and review of this statement was funded by RANZCOG.

1. Patient summary

The menopause is a significant reproductive life stage for women and may have other implications for emotional, metabolic and cardiovascular health as well as quality of life. Menopause may be physiological, pathological or iatrogenic. It is incumbent upon fellows and members of RANZCOG to ensure awareness of these changes are promoted amongst the medical profession and the wider general community.

2. Discussion and summary of recommendations

2.1 The menopause refers to the final menstrual period. A woman is postmenopausal 12 months after her final menstrual period. The early menopause transition is marked by persistent difference of 7 days or more in length of consecutive cycles. The late menopause transition is marked by periods of amenorrhoea of 60 days or more, frequent anovulation and the onset of perimenopausal symptoms.[1] The menopause transition commonly starts around 47 years and the average age of natural menopause is 51 years. Smokers may have an earlier menopause.[2]

2.2 The diagnosis of menopause is made clinically, based on the cessation of menstruation for a period of 12 months. If required, such as in cases of premature menopause, the diagnosis can be confirmed by elevation of gonadotrophins (FSH) and a low oestradiol. A low AMH is not a diagnostic test for menopause.

2.3 Vasomotor symptoms (VMS) are the most common reason for women to seek advice and treatment at menopause. Symptoms commonly start during the menopause transition with an average duration of 4-5 years. In around 10% of women symptoms may persist for more than a decade.[3] Women may report a broad range of physical and psychological symptoms at menopause. However, the key symptoms likely to improve with HRT include vasomotor symptoms, vaginal dryness, sleep disturbance and joint symptoms.[4,5]

2.4 Midlife women should be offered information and advice about normal menopausal changes and symptoms and, if required, individualised discussion of management options for troublesome symptoms. This consultation should also be an opportunity for midlife health assessment. Current national breast and cervical screening guidelines should be followed. Fracture risk can be calculated using an online tool such as FRAX (http://www.shef.ac.uk/FRAX) and bone density can be measured using Dual X-ray Absorptiometry (DXA) for those at increased fracture risk.

Recommendation 1	Grade
Midlife women should be offered information and advice about normal menopausal changes and symptoms and, if required, individualised discussion of management options for troublesome symptoms. This consultation should also be an opportunity for midlife health assessment. Current national breast and cervical screening guidelines should be followed.	Consensus-based recommendation
Recommendation 2	**Grade**
Bone density should be measured using DXA in those at increased risk of fracture (www.osteoporosis.org.au/health-professionals/general-practitioners/). Measurement of cardiovascular markers should be guided by age and risk factors (https://www.heartfoundation.org.au/images/uploads/publications/aust-cardiovascular-risk-charts.pdf)	Consensus-based recommendation

2.5 Symptoms of anxiety and depression are common in women and may be increased during the menopause transition, particularly in those experiencing troublesome vasomotor symptoms. Menopause may be a time of vulnerability for the development of clinical anxiety and or depressive disorders. Women with a history of affective disorders and those with premature/ surgical menopause or following a cancer diagnosis may be at greater risk. Consider mental health referral in those with symptoms of mood disorder.[6]

Recommendation 3	Grade
Women with a history of affective disorders and those with premature/ surgical menopause or following a cancer diagnosis may be at greater risk of developing anxiety and or depressive disorders during menopause. Consider mental health referral in those with symptoms of mood disorder.	Consensus-based recommendation Reference [6]

2.6 Women seeking relief from menopausal symptoms should first be offered advice on life style changes including stress reduction, regular exercise, optimal weight management, appropriate diet and avoidance of smoking and excessive alcohol and caffeine intake should also be addressed. Recent high quality evidence suggests that mindfulness training and cognitive behaviour therapy may reduce both the impact and severity of vasomotor symptoms.[7]

Recommendation 4	Grade
Women seeking relief from menopausal symptoms should first be offered advice on life style changes including stress reduction, regular exercise, optimal weight management, appropriate diet and avoidance of smoking and excessive alcohol and caffeine intake should also be addressed.	Consensus-based recommendation Reference [7]

2.7 The principal indication for using HRT is the relief of menopausal symptoms. The decision to start and to continue HRT will depend on the nature and severity of menopausal symptoms, their impact on function and the individual health profile of the woman. Dose is generally titrated to symptom relief and side effects, but most clinical guidelines advise starting with low dose therapy and review at least annually.[5] There are no fixed guidelines on duration of use.

Recommendation 5	Grade
HRT should be avoided in women with pre-existing cardiovascular and cerebrovascular disease, previous history of venous thromboembolism (VTE) or breast cancer. Use with caution in women with a history of endometrial cancer, active SLE, high cardiovascular risk and abnormal liver function. Abnormal bleeding should be investigated prior to starting HRT.	Consensus-based recommendation Reference [5]
Recommendation 6	**Grade**
Women with premature (less than 40 years) or early (less than 45 years) menopause should be offered HRT at least until aged 50-51 years unless otherwise contraindicated.[8] Menopausal symptoms may be more severe in younger women and sexual dysfunction may be a greater concern.	Consensus-based recommendation Reference [8]
Recommendation 7	**Grade**
HRT should contain a progestogen for at least 10 days per month in women who retain their uterus to provide endometrial protection.[5] Unopposed estrogen increases the risk of endometrial cancer.	Consensus-based recommendation Reference [5]

Recommendation 8	Grade
For women with vaginal symptoms only, local vaginal estrogen is the most effective therapy.[9] Non-hormonal vaginal moisturisers (e.g. Replens), acidic gels or silicone based lubricants may be also useful for vaginal dryness.	Consensus-based recommendation Reference 9

2.8 HRT increases bone density and reduces fracture risk. Prevention or treatment of low bone density is not considered a primary indication for HRT use but may be used in women for whom other treaments are considered inappropriate. HRT should be considered for symptomatic women who have reduced bone density but have not sustained a fracture.[8]

Recommendation 9	Grade
HRT should be considered for symptomatic women who have reduced bone density but have not sustained a fracture.	Consensus-based recommendation Reference 8

2.9 Randomized clinical trials and observational data as well as meta-analyses provide evidence that standard-dose estrogen-alone HRT may decrease coronary heart disease and all-cause mortality in women younger than 60 years of age and within 10 years of menopause. Data on estrogen plus progestogen HRT in this population show a similar trend for mortality but in most randomized clinical trials no significant increase or decrease in coronary heart disease has been found.[8] HRT should not be given for primary or secondary cardiovascular disease protection.

Recommendation 10	Grade
HRT should not be given for primary or secondary cardiovascular disease protection.	Consensus-based recommendation Reference 8

2.10 HRT increases breast density and combined oestrogen-progestogen increases the risk of breast cancer, especially in women over 59 years. Whether oestrogen only HRT increases breast cancer is controversial as the WHI oestrogen-only study showed no increase in breast cancer risk after seven years and a decreased risk on 11 year follow up.

Recommendation 11	Grade
Breast cancer risk increases with duration of HRT use. Whilst there is no optimum duration of HRT use for all women, annual review is recommended. Continuation beyond 5-7 years should be based on an individual woman's needs with regard to the benefits and risks of continued HRT.[8]	Consensus-based recommendation Reference 8

2.11 Oral HT use doubles the baseline risk of VTE in women of all age (RR 2.14 (1.64-2.81) and may be dose related.[10] Transdermal HRT may have a more favourable effect on VTE risk and may be a safer option in those at increased VTE risk (http://www.rcog.org.uk/). Thromboembolic risk with HRT is additive to other established risk factors such as obesity and smoking. Previous history of VTE is a contraindication to HRT use. Oral HRT increases the risk of stroke and this effect is independent of years since menopause.[11] Observational studies suggest low dose transdermal HRT may not increase stroke risk.[12]

Recommendation 12	Grade
Previous history of VTE is a contraindication to HRT use. Oral HRT increases the risk of stroke and this effect is independent of years since menopause. Observational studies suggest low dose transdermal HRT may not increase stroke risk.	Consensus-based recommendation Reference 10-12
Recommendation 13	**Grade**
Cessation of HRT may lead to a recurrence of VMS in around 50% of women. There is no clear evidence on the optimum method of discontinuing HRT.	Consensus-based recommendation

2.12 Non-hormonal therapies may be effective for VMS. Agents shown to be superior to placebo in randomised controlled trials include gabapentin, venlafaxine, desvenlafaxine, paroxetine, fluoxetine, citalopram and escitalopram; however, these are short term trials and long term efficacy and safety data is lacking.[12] Paroxetine and fluoxetine should not be used in women taking tamoxifen as they may interfere with tamoxifen metabolism.[13] It is not yet known whether this impacts on breast cancer recurrence.

Recommendation 14	Grade
Paroxetine and fluoxetine should not be used in women taking tamoxifen as they may interfere with tamoxifen metabolism.[13]	Consensus-based recommendation Reference 12, 13

2.13 Over the counter complementary/ alternative medications, such as black cohosh and phytoestrogens, have not consistently been shown to be effective for VMS. Improvement of VMS has been demonstrated in studies of mindfulness training and cognitive behavioural therapy.[7]

2.14 Tibolone, a synthetic steroid with oestrogenic, progestogenic and weak androgenic effects, is also effective for vasomotor and urogenital symptoms.[14] Tibolone should only be used in women >12 months since menopause as it may cause irregular bleeding in younger women. Tibolone also increases bone density and reduces fracture risk. The risk of breast cancer with tibolone is unknown. Tibolone may increase the risk of stroke in older women >65 years.[15]

Recommendation 16	Grade
Tibolone should only be used in women >12 months since menopause as it may cause irregular bleeding in younger women.	Consensus-based recommendation Reference 14, 15

3. Glossary of Terms

Menopause: The permanent cessation of menstruation. The definition is made retrospectively, 12 months after the final menstrual period.
Premature Menopause: Menopause before the age of 40.

Early Menopause: Menopause before the age of 45, but after the age of 40.

Perimenopause: The period of time immediately prior to the menopause (when the endocrinological, biological, and clinical features of approaching menopause commence) and the first year after menopause.

4. References

1. Soules MR, Sherman S, Parrott E, Rebar R, Santoro N, Utian W, Woods N. Executive summary: Stages of Reproductive Aging Workshop (STRAW). Fertil Steril 2001; 76: 874-8.

2. Politi MC, Schleinitz MD, Col NF. Revisiting the duration of vasomotor symptoms of menopause: a meta-analysis. J Gen Intern Med 2008; 23: 1507-13.

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5. MacLennan AH, Lester S, Moore V. Oral oestrogen and combined oestrogen/ progestogen therapy versus placebo for hot flushes. Cochrane Database of Systematic Reviews 2004; 18::CD002978.

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11. Rossouw JE, Prentice RL, Manson JE, Wu L, Barad D, Barnabei VM, Ko M, LaCroix AZ, Margolis KL, Stefanick ML. Postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause. JAMA 2007; 297: 1465-77.

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5. Links to other related College Statements

(C-Gyn 15) Management of the menopause after breast cancer

(C-Gyn 16) Hormone Replacement Therapy Advice

(C-Gyn 12) Tamoxifen and the Endometrium

(C-Gen 02a) Consent and provision of information to patients in Australia regarding proposed treatment

(C-Gen 02b) Consent and provision of information to patients in New Zealand regarding proposed treatment

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology

6. Other useful links

National Breast Screening Programme (BreastScreen Australia)
http://www.health.gov.au/internet/screening/publishing.nsf/Content/breastscreen-about

National Cervical Screening Programme (Australia)
http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-about

National Breast Screening Programme (New Zealand)
http://www.nsu.govt.nz/

National Cervical Screening Programme (New Zealand)
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The risk of breast cancer with HRT use. Media release of the Australasian Menopause Society. 2002.

Advice to members of the Australasian Menopause Society: Indications for Prescribing Oestrogens and Progestogens in Menopausal Women. Update September 2003.

7. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:
https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Associate Professor Stephen Robson	Chair and Board Member
Dr James Harvey	Deputy Chair and Councillor
Associate Professor Anusch Yazdani	Member and Councillor
Associate Professor Ian Pettigrew	Member and Councillor
Dr Ian Page	Member and Councillor
Professor Yee Leung	Member of EAC Committee
Professor Sue Walker	General Member
Dr Lisa Hui	General Member
Dr Joseph Sgroi	General Member
Dr Marilyn Clarke	General Member
Dr Donald Clark	General Member
Associate Professor Janet Vaughan	General Member
Dr Benjamin Bopp	General Member
Associate Professor Kirsten Black	General Member
Dr Jacqueline Boyle	Chair of the ATSIWHC
Dr Martin Byrne	GPOAC representative
Ms Catherine Whitby	Community representative
Ms Sherryn Elworthy	Midwifery representative
Dr Nicola Quirk	Trainee representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 1995 and was most recently reviewed in November 2014. The Women's Health Committee carried out the following steps in reviewing this statement:

- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the November 2014 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part ii)

ii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.[17] Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.