ALETHEA LEARNING SESSION RECAP

Menopause: Guidelines, Updates and Pearls Presented by Dr. Wynne Leung

DR. WYNNE LEUNG

Dr. Wynne Leung, an Obstetrician and Gynecologist with expertise in high-risk obstetrics and surgical gynecology, led a comprehensive learning session on the diagnosis, treatment, and management of menopause in clinical practice.

The discussion emphasized practical strategies for primary care providers (PCPs), with a focus on aligning care with current Canadian guidelines while addressing real-world challenges such as patient misconceptions, therapy risks, and time constraints.

KEY TAKEAWAYS FROM THE SESSION

Understanding Menopause

Menopause is a **clinical diagnosis** made retrospectively after 12 consecutive months of amenorrhea without another pathological cause, most commonly occurring between ages 45 and 55. The transition leading up to this point, known as **perimenopause**, is characterized by menstrual irregularity and the gradual onset of menopausal symptoms.

In women over 45, the diagnosis is usually based on symptoms and menstrual history; routine lab tests such as FSH or estradiol are not typically necessary unless the presentation is atypical, for example, in younger patients or those with a hysterectomy (The 2023 Practitioner's Toolkit for Managing Menopause).

Common symptoms include: (The 2023 Practitioner's Toolkit for Managing Menopause)

- Vasomotor symptoms (hot flashes, night sweats)
- Sleep disturbances
- Mood changes such as anxiety, irritability, or depression
- Genitourinary symptoms including vaginal dryness and urinary urgency
- Cognitive complaints often described as "brain fog"
- Musculoskeletal aches and joint pain

Menopause Hormone Therapy (MHT) (Canadian Menopause Society)

Dr. Leung emphasized that MHT remains the first line for the treatment of moderate to severe vasomotor symptoms in women without contraindications. It can also help prevent bone loss in early menopause (Canadian Menopause Society).

Treatment options include: (Canadian Menopause Society)

- Estrogen therapy alone (oral or transdermal) for women without a uterus
- Estrogen + progestogen therapy for women with an intact uterus to prevent endometrial hyperplasia
- Transdermal estrogen is often preferred due to its lower associated risk of venous thromboembolism (VTE) and stroke compared to oral formulations

Contraindications include unexplained vaginal bleeding, history of estrogen-sensitive cancers, history of VTE or stroke, uncontrolled hypertension, and active liver disease.

Treatment Principles: (Canadian Menopause Society)

- Use the lowest effective dose for the shortest duration needed to control symptoms.
- Reassess annually to determine ongoing need.
- No fixed upper limit on duration, long-term use may be considered in select patients after risk-benefit discussion.

Risks and Benefits of MHT

The **benefits** of MHT include significant symptom relief, reducing vasomotor symptoms by up to 90%, and improvements in sleep, mood, and quality of life. It also provides protection against osteoporosis and fractures (Canadian Menopause Society).

Potential risks include: (North American Menopause Society)

- A small increase in breast cancer risk with combined therapy beyond five years
- Increased risk of VTE and stroke, particularly with oral estrogen
- Higher risk of gallbladder disease with oral formulations

Many of these risks can be mitigated by careful patient selection, preferring transdermal estrogen when appropriate, and incorporating lifestyle counseling for cardiovascular and cancer prevention.

Non-Hormonal Treatment Options (Canadian Menopause Society)

For patients who cannot or choose not to use MHT, several alternatives are available.
Pharmacologic (Canadian Menopause Society)

- SSRIs/SNRIs (e.g., venlafaxine, paroxetine)
- Gabapentin (particularly for nocturnal symptoms)
- Clonidine (less effective, used rarely)

Non-Pharmacologic

- Cognitive behavioral therapy (CBT)
- Mindfulness, yoga, and paced breathing
- Lifestyle modification (cool environment, layered clothing, avoiding triggers such as alcohol or spicy foods)

Genitourinary Syndrome of Menopause (GSM) (Elfaki, 2024)

GSM results from estrogen deficiency and can significantly affect quality of life, causing dryness, burning, dyspareunia, and urinary symptoms. Dr. Leung stressed that local vaginal estrogen is the first-line treatment, is safe for long-term use, and has minimal systemic absorption (Canadian Menopause Society) (North American Menopause Society). For mild cases, vaginal moisturizers or lubricants can be considered.

Special Populations

Premature Ovarian Insufficiency (POI), defined as menopause before age 40, requires systemic estrogen therapy until at least the average age of menopause to protect against bone loss and cardiovascular disease (Canadian Menopause Society) (North American Menopause Society).

For women with a history of breast cancer, systemic MHT is generally avoided; however, vaginal estrogen may be considered for GSM after careful oncology consultation (Canadian Menopause Society).

In patients with high cardiovascular risk, transdermal low-dose estrogen is preferred over oral estrogen when MHT is indicated (Canadian Menopause Society).

Bone Health in Menopause

Estrogen loss accelerates bone resorption, making osteoporosis prevention an important part of menopause management. While MHT can be protective, it should be complemented with adequate calcium and vitamin D intake, weight-bearing exercise, and osteoporosis screening when indicated (Canadian Menopause Society).

Practical Primary Care Approach

Dr. Leung recommended a structured approach:

1. Assess the patient's symptoms and their impact on quality of life (The 2023 Practitioner's Toolkit for Managing Menopause).
2. Rule out secondary causes for abnormal bleeding or other red flags (Canadian Menopause Society).
3. Discuss all treatment options, including MHT and non-hormonal choices (The 2023 Practitioner's Toolkit for Managing Menopause).
4. Screen for contraindications before prescribing MHT (Canadian Menopause Society).
5. Tailor therapy to the patient's individual risk profile and preferences (Canadian Menopause Society).
6. Provide regular follow-up for monitoring and dose adjustment (Canadian Menopause Society).

She noted that symptom diaries can help monitor progress, and that GSM treatment, particularly local estrogen, is underutilized. Many patient fears about MHT stem from early media campaigns about the WHI, and education plays a key role in addressing these concerns.

Using Alethea to Support Menopause Care

Dr. Leung concluded by highlighting how Alethea can support menopause management in primary care. eConsults provide quick access to specialist input, helping clarify complex cases, interpret labs in atypical presentations, and navigate nuanced treatment decisions.

Example eConsult Questions

- “Is MHT appropriate for this 52-year-old with controlled hypertension?”
- “What’s the safest estrogen formulation for a patient with migraine with aura?”
- “How should I manage GSM in a breast cancer survivor?”

Conclusion

Menopause care should always be individualized, balancing symptom relief with long-term health considerations. MHT remains the most effective treatment for vasomotor symptoms in eligible women, while non-hormonal therapies and GSM treatments are valuable alternatives (Canadian Menopause Society). Primary care providers play a critical role in early intervention, patient education, and ongoing monitoring.

Platforms like Alethea can enhance this care by offering rapid, specialist-guided decision-making, ensuring patients receive timely and evidence-based management during this important life stage.