

Advancing menopause care in Australia: barriers and opportunities

Lack of clinician knowledge, poor access to services, negative attitudes, and lagging research have led to substandard menopause-related health care

The menopause is the permanent loss of ovarian reproductive function. Irrespective of symptoms, menopause causes silent biological changes that may increase women's risks of cardiovascular disease, diabetes, osteoporosis, and some cancers.¹ Consequently, it should be expected that health care providers, especially general practitioners, are equipped to provide evidence-based menopause advice to the 3.28 million Australian women aged 40–59 years. Sadly, this is not the case.

Hot flushes and night sweats, low wellbeing, anxiety, depressive symptoms, and disturbed sleep are common symptoms. Moderate to severely bothersome hot flushes/night sweats are experienced by 28% of post-menopausal women younger than 55 years² (Box 1). Yet despite readily available, safe menopausal hormone therapy (MHT) and non-hormonal interventions, over 85% of Australian women with bothersome symptoms are not receiving effective, approved therapy.⁵ Although over 50% of post-menopausal women have vulvovaginal atrophy symptoms (vaginal dryness, itching, burning, dyspareunia, and urinary symptoms), fewer than 7% are prescribed effective, safe vaginal oestrogen therapy.⁵ Menopause causes accelerated net bone loss. This commences about two years before the final menstrual period in naturally menopausal women, peaking about two years after menopause,⁶ setting the stage for the development of osteoporosis and fragility fracture. In Australia, post-menopausal MHT is approved for the prevention of bone mineral density loss as well as for symptom relief.

First line management of menopause-associated issues should be occurring at the level of primary care, yet menopause is not among the top 15 conditions most frequently managed by GPs.⁷ Our research has shown that GPs, gynaecologists and pharmacists understand that some women have severe symptoms that may last many years.⁸ However, GPs and specialists mostly lack the skills and confidence in managing menopause, and frequently recommend unproven and mostly ineffective complementary and alternative medicines before prescribing MHT or effective non-hormonal

therapy.⁸ Concurrently, Australian women rely on self-help and complementary and alternative medicines to manage menopausal symptoms, as they view MHT negatively, with concerns about cancer risk and overprescription.⁹ Furthermore, most women are unaware that menopause is associated with bone loss or that it affects their cardiometabolic health.⁹ Contributing to this health care knowledge gap are two decades of widespread dissemination of conflicting, and often frightening, information about menopause treatment, and omission of menopause from most undergraduate and post-graduate medical and allied health training. Thus, state-of-the-art menopause care is not available to most Australian women.

New treatment options in menopausal therapy

Meanwhile, treatment options and recommended prescribing have changed. After publication of the early findings of the Women's Health Initiative Study, the strong recommendation was that MHT use be limited to five years.¹⁰ This has been superseded. The current guidance is not time-limited but the duration of therapy should be based on an individual's symptoms and personal risk–benefit evaluation.¹¹ Unfortunately, Australian prescribing information has not caught up and continues to recommend women receive treatment for the shortest duration. Consequently, the authors' experience is that many women are incorrectly told they must cease MHT after five years, including women with premature ovarian insufficiency, who should be using MHT at least until the age of 50 years.¹²

With respect to hormone therapy, the general leaning is now towards transdermal oestrogen (specifically as oestradiol), as observational data indicate that non-oral oestrogen confers a lower risk of venous thromboembolic events (VTE) than oral therapy.¹³ Thus, diabetes, smoking and overweight and obesity are considered indications for non-oral oestrogen.¹ However, for women at low VTE risk, the absolute difference in risk between low to standard dose oral

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1 Menopausal symptoms and prevalence in Australian women

- 74% of post-menopausal women aged < 55 years have VMS²
- 28% of post-menopausal women aged < 55 years have moderate to severely bothersome VMS²
- 42% of women aged 60–64 years are still experiencing VMS²
- Women with moderate to severe VMS are almost threefold more likely to have moderate to severe depressive symptoms than other women³
- > 50% of post-menopausal women aged 40–64 years have symptomatic vulvovaginal atrophy¹
- 30% of women in the mid-life age group have low libido associated with significant personal distress⁴

VMS = vasomotor symptoms. ♦

(≤ 1 mg/day) and non-oral oestradiol (≤ 50 μ g/day) appears small.¹³

Concurrently, progesterone and dydrogesterone are now viewed as the preferred progestogens for endometrial protection for women with a uterus using oestrogen therapy.¹⁴ This has been driven by studies suggesting progesterone may have a better cardiovascular safety profile than other progestogens,¹⁵ and observational data indicate that less than five years of oestrogen with either progesterone or dydrogesterone is not associated with increased breast cancer risk.¹⁶ However, clinicians need to be aware that major cardiac event data for these progestogens are lacking and breast cancer risk beyond five years remains uncertain.¹⁶ In addition, the evidence for adequate endometrial protection is limited to standard dose continuous progesterone (100 mg/day) or cyclical progesterone (200 mg for at least 12 days per month) paired with oral oestrogen (≤ 1 mg)¹⁷ and conjugated oestrogens (0.625 mg).¹⁸ Standard dose progesterone may not provide endometrial protection for women requiring high dose oestrogen therapy, and caution in that context is advised. So, although progesterone and dydrogesterone may be safer progestogens for women needing combined MHT, clinicians should not overstate the cardiovascular or breast safety of these preparations and exert considerable caution when prescribing standard dose progesterone with high dose oestrogen until more data are available.

For symptomatic women choosing not to take (or unable to take) MHT, several prescribed non-hormonal therapies are available, but all are substantially less effective than MHT.¹ Fezolinetant, a selective neurokinin 3B receptor antagonist that acts in the brain to reduce vasomotor symptom frequency and severity, is presently under consideration for approval for this purpose in the United States.¹ Estetrol, a novel oestrogen produced by the fetal liver, is also being evaluated for the treatment of menopausal symptoms, and holds promise as a new treatment option. Estetrol has neutral lipid effects and does not appear to have significant procoagulant effects.¹⁹

Treatment options during the menopause transition

A troubling time for many women is the menopause transition, when menstruation is erratic, symptoms fluctuate, and contraception is often required. At this time, oestradiol-containing combined oral contraceptives (COCs) can provide cycle control, contraception, and symptom relief. Alternatively, the newly available COC that contains estetrol and drospirenone may offer symptom relief with potential, but yet to be established, lower VTE risk than other COCs.²⁰ An off-label alternative, when oral oestrogen

is contraindicated (eg, high VTE risk, migraine with aura), is the drospirenone (progestogen-only) oral contraceptive to inhibit ovulation combined with transdermal oestradiol for symptom relief.

The role of testosterone treatment

Presently, Australia is the only country in the world with an approved testosterone formulation specifically for women. Its prescribing indication is in line with the evidence of efficacy of transdermal testosterone for the treatment of post-menopausal women with low sexual desire associated with personal distress (hypoactive sexual desire disorder).²¹ Important caveats on the evidence are that studies supporting efficacy were of testosterone preparations that resulted in blood levels that approximated physiological concentrations of pre-menopausal women, as opposed to supraphysiological dosing, and that most studies excluded women with major morbidities, such as concurrent depression and antidepressant use.²¹ However, one study has shown benefit of transdermal testosterone for women with antidepressant-emergent hypoactive sexual desire disorder.²² Despite public opinion being expressed to the contrary, evidence from randomised, placebo-controlled trials that testosterone will improve mood, wellbeing, musculoskeletal health or cognitive function remains lacking.²¹ Internationally, there is agreement that testosterone should not be prescribed for any symptoms, including low mood or depressive symptoms, or any condition other than hypoactive sexual desire disorder in post-menopausal women without new evidence.²³

Improving health at menopause

Education is key to improving the lives of women at menopause and beyond. This can be achieved with public information campaigns, improved sexual and reproductive health education and accurate information in the media. Evidence-based education reduces fear and stigma for women and equips them to optimise their health at menopause. Another potential setting for menopause education is in the workplace.

Ideally, women at perimenopause or menopause should have a comprehensive assessment in primary care, including evaluation and management of risk of future diseases, updating relevant screening activities and offering appropriate lifestyle advice. For women with symptoms, an individualised discussion about MHT and other treatment options should occur. However, menopausal women have been underserved in Australia, and many struggle to access appropriate assessment and treatment.⁹ This is due to a combination of lack of education of health professionals and poor access to appropriate services that urgently needs to be addressed (Box 2).⁸

2 Proposed education of health professionals about menopause

- Ensure menopause is included in all undergraduate medical, nursing and allied health degrees
- Include menopause as core curriculum of graduate training of general practitioners
- Embed menopause training in specialties such as gynaecology, endocrinology and psychiatry
- Develop an accredited training in menopause to enable practitioners to manage more complex cases, including early menopause and menopause following breast cancer

In addition, poor clinical care at menopause is limited by the existence of structural barriers to long consultations in general practice. The Medicare system incentivises short consultations for simple issues. Due to underfunding and staff shortages, GPs are under pressure to increase throughput and find it increasingly difficult to offer longer appointments. This especially affects patients in rural or disadvantaged areas. Another barrier to patient-centred comprehensive menopause care is the lack of integration of health services in primary care. Nurses and allied health practitioners, such as physiotherapists, exercise physiologists, dietitians and psychologists, can play an important role in promoting health at menopause. Current systems make it difficult or expensive for patients to access these practitioners. Specialist menopause clinics or accredited menopause practitioners may improve access to treatment, particularly for women with complex care needs. However, most clinical care of women at menopause will continue to occur in general practice, and GPs need to be educated and supported to fulfil this role.

Research to inform policy and improve clinical practice

Further research is needed in areas such as the safety of MHT and the role of hormones in treatment of mood disorders at perimenopause and menopause. The impact of menopause on women's work engagement in Australia is not known. Research is also needed to determine the impact of menopause on employment and the work performance of women in paid and unpaid employment, including roles as carers and volunteers. Equally important is an understanding of the impact of menopause on workplace retention or as a potential barrier to engagement in paid or unpaid work. This information is essential before evidence-based and effective workplace policies around menopause can be developed and implemented.

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