Management of the perimenopause

http://womenshealth.med.monash.edu.au

The 'perimenopause' means 'about the menopause'. It is the time during which menstrual cycles become irregular and hormonal changes start to occur, through until 12 months after the last menstrual bleed. During this time women might experience a range of symptoms due to fluctuating hormone levels. Therefore some symptoms may be a result of waves of too much oestrogen (painful breasts) and other symptoms a results of phases of low oestrogen (hot flushes and sweats). Treatment at this time is directed at:

- controlling irregular cycles and/or heavy bleeding;
- ensuring contraception if required; and
- providing relief from other symptoms at the lowest effective dose.

Most women are seeking improvement in quality of life.

For the perimenopausal woman needing contraception, the combined oral contraceptive pill provides contraception, regular predictable and lighter withdrawal bleeds, and relief from vasomotor and other symptoms. It also preserves bone density, helps prevent ovarian and endometrial cancer and treats acne that can occur at this time. Each woman's risks must be assessed to determine the suitability of this approach even though the dose of hormones is low.

Factors that increase the risk of serious side effects from the combined oral contraceptive pill include: cigarette smoking, elevated blood pressure, elevated cholesterol, migraine with visual changes (aura), past superficial thrombosis and previous deep venous thrombosis (an absolute contraindication to the oral contraceptive pill).

A new oral contraceptive pill containing ***oestradiol valerate*** is the preferred option to minimise ardiovascular risk and will be effective for both contraception and cycle control and is used as first line treatment. Alternatively, a low dose oral contraceptive pill containing 20ug of the synthetic oestrogen, ethinyl estradiol and a progestin such as levonorgestrol 100ug could be used. **Hot flushes and sweats** should diminish over the first few weeks. Transdermal and monthly intravaginal contraceptive options containing ethinyl estradiol convey a similar benefit and risk profile as oral therapy. Women can transition from the contraceptive hormone therapy to HT when contraception is no longer required.

Managing heavy bleeding with a progestogen IUD:

In the menopause transition the ovaries have variable activity due to fluctuating levels of the pituitary hormone FSH. This can lead to random hypo- and then hyper-oestrogenic states. During the late menopause transition phase growth of the uterine lining (endometrium) is stimulated, and thickens with the increase in oestrogen production. The **levonorgestrel releasing intrauterine device (LNG-IUD)** protects the lining of the uterus from oestrogen stimulation and provides contraception at this time if required. Therefore it reduces bleeding and provides contraception.

Although initially spotting is not uncommon after insertion, about 80 per cent of women no longer have any menstrual bleeding after about one year. The LNG-IUD is effective for five years after which time it needs to be changed. The low dose minimises the side effects. If menopausal symptoms progress oestrogen can be used with this UIUD still protecting the uterine lining.

Low Dose Hormone Therapy (LD-HT) has been studied in women not needing contraception. It has been shown to control both irregular bleeding and flushes and sweats. The lower dose of HT compared to conventional dosing of HT may be effective because during the perimenopausal time women the ovaries still produce some oestrogen. The low dosing means a lower rate of side effects.

For a woman with a uterus this therapy is taken cyclically with oestradiol for 14 days, followed by 14 tablets of oestradiol with a progestogen (day 15 – 28 of a 28 day cycle). Ultra low dose transdermal oestrogen at 14ug/day has been shown to have a bone sparing effect and this is enhanced by adding a progestogen. Women who have had a hysterectomy can just take low dose oestrogen alone without a progestogen.

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What about progesterone therapy?

Oral progestogen only regimens (medroxyprogesterone acetate and micronized progesterone) have been shown to provide relief from hot flushes when given in high doses. However side effects of the progesterone/progestogen such as weight gain, breast pain, fluid retention, vaginal discharge and dry mouth can be a problem at these doses. Short-term use may be applicable in women who do not want to take oestrogen. It can be used cyclically for the first 12 – 14 days of the cycle and produce predictable bleeding in the majority of women. Progesterone can cause sedation and if used should be taken at night. A number of progesterone creams to be applied to the skin, that have been studied show very poor absorption and little evidence of any benefit.

Testosterone therapy can be considered by women who have low libido not due to other identifiable causes (see information on testosterone) in addition to other hormonal and non-hormonal therapies or as a sole therapeutic agent.

Women unable to use, or who choose not to use hormonal therapy in the perimenopause may get some relief from other treatments for example selective serotonin or noradrenaline reuptake inhibitors gabapentin or clonidine, although effects are less than for oestrogen (see non-hormonal management of the menopause).